UNIVERSITY OF SURREY

Faculty of Health and Medical Sciences (FHMS)

Practitioner Doctorate in Psychotherapeutic and Counselling Psychology (PsychD)

Research Dossier

Including an investigation of: Parents’ experiences of, and contributions to, their child’s psychological therapy.

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November 2018
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Statement of Anonymity

To preserve the anonymity and confidentiality of clients, research participants, supervisors, and placements, all names and identifying markers have either been omitted or replaced with pseudonyms throughout the portfolio.
Acknowledgements:

A special thank you is made to the therapists and parents who participated in my two research projects. I am truly grateful for their generosity in sharing their experiences and feel honoured to have been allowed to bear witness to this. Furthermore, I would like to acknowledge and thank the clients I worked with during each of my four clinical placements and the supervisors who supported me in my development as a counselling psychologist.

I would like to pay particular thanks to my original research supervisor, Dr Lucy Gorvin, who offered me both guidance and encouragement during this journey. I would also like to thank Dr Cristina Harnagea for stepping in as acting research supervisor during my final months on the course and for the valuable guidance and feedback offered during this brief time.

Thank you to my mentor Sissy, without whom I may have taken a very different path. Her encouragement and friendship guided me to the course and has offered me valuable support during the journey. In addition, I would like to thank my personal therapist whose support has been essential to my ability to keep going and provided me with respite in some very difficult times.

A huge thank you is made to my friends. They have offered me moments of relief through their kindness and support, as well as ensuring that my breaks from the course have been filled with laughter. I am so lucky to have you all in my life.

Finally and most crucially I would like to say a huge thank you to my family for the support, guidance and comfort they have offered me. In particular I would like to thank my parents. Not only has their generosity allowed me to complete this training but their kindness and patience has been the key to my perseverance. I dedicate this work to them: Thank you for all of your love, your unwavering support has inspired me and offered me the strength and confidence to continue to follow my ambitions.
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Abstract:

This research dossier represents the completed research works towards the fulfilment of the Practitioner Doctorate in Counselling and Psychotherapeutic Psychology (PsychD). It offers an overview of my research journey followed by a literature review, and two qualitative studies: one Thematic Analysis (TA) and one Interpretative Phenomenological Analysis (IPA). The literature review explored the role of the therapeutic alliance when working with children and adolescents. The first qualitative research study explored therapist’s perspectives of how parents impact the therapeutic alliance when working with children and employed a TA methodology. The second qualitative research study analysed parents’ experiences of their child accessing psychological therapy and utilised an IPA methodology.
Introduction to Research Dossier:

The development of my research was somewhat unconventional and followed a slightly less straightforward path. Prior to starting the course I had been volunteering with a psychotherapist who ran a group for pre-school children with emotional, behavioural and social difficulties. This work alerted me to both the rising number of children experiencing emotional health difficulties and the value of early intervention. However, upon beginning the course I was struck by the lack of emphasis on working with children and young people. I therefore chose to complete a literature review which considered counselling psychology’s relationship to working with children.

Unfortunately at this stage in the training I did not adequately understand the role of the literature review and the criteria needed to conduct research at this level. This resulted in my literature review being unsuccessful. With the feedback received after a borderline successful re-submission, along with how my knowledge and understanding had grown, it was collaboratively agreed with my research supervisor that it was more appropriate to alter the direction of my research. This change enabled more viable research projects to be pursued which could make a more relevant contribution to counselling psychology. While continuing to draw upon my interest in therapeutic work with children and young people, a new focus upon the therapeutic alliance was established. It was agreed that I would therefore complete an additional review of this literature to guide the specific direction my research would take. This literature review was entitled ‘Exploring the role of the therapeutic alliance when working with children and young people’ and is included within this portfolio.

From this literature review, it was viewed that existing research had demonstrated that the therapeutic alliance was considered to play an important role within child focused work, contributing to the outcome of therapy as well as supporting engagement in the work. The review also demonstrated the different factors which were proposed as influencing the quality of this alliance. One of the factors which stood out across a number of studies was the influence of parents. While the existing literature highlighted that parents seemed to have an impact on the therapeutic alliance, there was little research providing an understanding of how this
impact manifested. Therefore my first research project considered the ways in which parents impact the alliance between therapist and child. It utilised Thematic Analysis (TA) to consider the perspectives of psychologists and psychotherapists on this topic.

Using TA to explore therapists’ views on how parents impacted the alliance aimed to support therapeutic practice. Through noting patterns and themes, tentative predictions could be made regarding effective ways to support the positive ways in which parent’s impact alliance between therapist and child. Furthermore, it was viewed that through understanding any negative impacts, therapists might be better place to mitigate these and avoid premature termination of therapy. The themes which I identified within the study (Power negotiation, Parent’s relationship to therapeutic boundaries, Parent’s ambivalent attitude towards therapy and the Parental role in therapy) highlighted how many of the therapists viewed open communication and collaboration with parents to be important contributors to a strong therapeutic alliance between therapist and child. The findings appeared to emphasise the importance of drawing upon early intervention strategies which involved parents and the child’s wider network of care, in order to promote sustainable emotional wellbeing.

It was in line with this finding that my second research project emerged. Although it had been noted that therapists valued collaboration with parents, it seemed that in order to support such collaboration, it was necessary to have an understanding of how parents experienced their child’s engagement in therapy. After reviewing the available literature it appeared that there was limited research which had previously explored this in a qualitative way. In addition, as my experience working with children and their parents developed through my final clinical placement, I became more aware that opportunities for therapists to hear and understand the experiences of parents were sparse. This highlighted the importance of further investigating this and offered me the focus for my second research project 'Parents’ Experiences of Their Child Accessing Therapy'. The research question was deliberately broad in order to be able to gain insight in to what parents asserted as important to them. Much of the existing qualitative literature on this topic focussed on adolescents. Taking this into account, alongside an understanding of the significance of parents for younger children, my study focussed on exploring the experiences of parents of children aged 6-12. An Interpretative Phenomenological Analysis (IPA)
was conducted. I initially felt optimistic regarding the process of engaging in the IPA methodology and the value which could be gained from exploring parents' experiences in this way. However, in practice, finding the right balance between empathic and suspicious interpretations was more challenging than I had anticipated.

I felt that the superordinate themes which I identified as being present within parents' experiences of their child's therapy ('I got left with everything': Therapy as an isolating experience; ‘Hang on, I am his mother’: Perceived impact on parenting capacity; ‘Walking on a cliff edge’: Responsible but unable to help) each captured an important part of the phenomenon and helped to give voice to the challenges and value within their journey. The analysis raised a number of potential questions regarding how these perspectives can be integrated and heard within children's therapeutic services, while also retaining an emphasis on the child and their right to confidentiality and a boundaried therapeutic space.

The findings of both research projects arguably have important implications for the way in which therapists, including counselling psychologists, engage in work with children and their parents. Through contributing to the qualitative literature and giving voice to these experiences they have helped to emphasise that both parents and therapists have significant roles in the children’s therapy and that their skills, while different, can be regarded as complimentary. The emphasis on collaboration, where appropriate, demonstrates that the whole is more than the sum of its parts, and there can be value in acting ‘in concert’ with the significant others in a child’s life.

The research journey has proven to be an integral part of my capacity to integrate the different components of the course and CoP identity. For example the process of deciding which methodology would be suitable as well as critically evaluating existing research helped me to develop a firmer grasp upon the epistemological pluralism within counselling psychology. Through understanding how different ontological positions inform epistemology and the way in which knowledge is viewed as being constructed and in turn shapes the methodologies used within research. This helped me to understand their application within counselling psychology. In addition, it helped me to utilise the clinical experience I had gained through contributing to generating research questions as well as the findings
informing my practice. Finally, the research process has also contributed to my own personal development through supporting my capacity to be open and reflective about my failures and use the feedback in a constructive way and continue to learn.
Literature Review:
‘Exploring the role of the therapeutic alliance when working with children and adolescents: A review of the literature’

Assignment: Literature Review (Additional Formative Submission) – Year 2a

Title: ‘Exploring the role of the therapeutic alliance when working with children and adolescents: A review of the literature’

Student: Emma Fredman

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Word count: 7928 words
Exploring the role of the therapeutic alliance when working with children and adolescents: A review of the literature

Abstract:

The therapeutic alliance is consistently noted as being an important factor in positive therapeutic outcomes (Horvath, Del Re, Flückiger, & Symonds, 2011). Although the therapeutic alliance and the factors which contribute to sustaining it effectively are well researched within adult psychotherapy, less attention has been paid to this within therapeutic work with children and adolescents. Developing our understanding of the therapeutic alliance with this population is important within the field of counselling psychology due to its commitment to work across the lifespan (Sugarman, 2010). Furthermore, counselling psychology emphasises the importance of the therapeutic relationship as the key to therapeutic change (Strawbridge & Woolfe, 2010). Therefore understanding the role of therapeutic alliance when working with children and considering the determinants of its quality can support counselling psychologists to work effectively with this client group. This literature review focussed upon existing research concerned with the role of the therapeutic alliance within individual therapy with children and adolescents. Findings from both quantitative and qualitative research demonstrate that the therapeutic alliance seems to make important contributions to engagement and outcomes of therapy when working with children and adolescents. In addition, many factors including the setting of the therapy, therapist qualities and skills, the therapeutic modality and the role of parents have been noted as having an impact on the therapeutic alliance. However, further investigation is required in order to better understand the processes behind how this impact manifests. Future avenues for research are considered in light of this identified gap in particular the role of parents in this process.
Introduction:

“It’s the relationship that heals, the relationship that heals, the relationship that heals”

(Yalom, 1989, p. 91)

Research has found that half of all lifetime mental health difficulties develop before the age of 14 and that one in five children and adolescents experience significant mental health problems (Carr, 2000; Kessler, Berglund, & Demler, 2005). Experiencing mental health difficulties including anxiety and depression have been found to have a negative impact on children’s academic attainment and their capacity to form social relationships. Furthermore, they are associated with a greater risk of involvement with the justice system and substance misuse (Boulter & Rickwood, 2013; Singer, 2009). In the United Kingdom the number of children experiencing mental health difficulties is rising (Ellyatt, 2011; Young Minds, 2016). It is arguably therefore important for therapists working with this population, including Counselling Psychologists (CPs), to explore effective therapeutic approaches to ensure young people are receiving the best possible care.

The therapeutic alliance has been recognised by clinicians as one of the most important factors for effective change in therapy (Horvath et al., 2011). In addition, research has found a positive association between the therapeutic alliance and the outcomes of therapy, regardless of the modality or orientation of the therapy (Martin, Garske & Davies, 2000). This assertion fits with the view held within Counselling Psychology (CoP) that a successful therapeutic encounter is less dependent upon the use of structured therapeutic techniques, but rather is related to the emphasis placed upon the relationship (Clark, 2013; Strawbridge & Woolfe, 2010). This stems from CoP’s understanding of mental health difficulties as reflecting human distress which demonstrates a normal and understandable part of human experience and is inherently relational rather than being a sign of illness (BPS, 2011). It seems that developing our
understanding of the therapeutic alliance, how it operates and the factors which can impact this appears important in offering appropriate care to individuals experiencing distress.

**What is the therapeutic alliance?**

It is noted that both the terms therapeutic relationship and therapeutic alliance have been used above. However, these have been considered to be distinct, but overlapping concepts (Luborsky, 1994). Based on the earlier conceptualisations of the therapeutic relationship, including the work of Freud (1913) with his emphasis on the transference relationship and Rogers’ (1957) emphasis on the core conditions; Bordin’s (1979) research provided a ‘pan-theoretical’ definition of the concept of ‘alliance’. He suggested that ‘alliance’ was a key factor in producing therapeutic change across different psychotherapy models. Bordin proposed that the alliance between therapist and client was made up of positive affective bond, agreement of therapeutic goals and agreement of therapeutic task. These key features were viewed by Bordin to be important within all forms of therapeutic approaches, but it was recognised that they may develop differently in different psychotherapies.

Building upon the work of Bordin (1979) and the three components he regarded as comprising the therapeutic alliance, in addition to existing measures of therapeutic alliance, Hougaard (1994) created an empirically generated two-factor model. Within this model, task alliance and personal alliance were emphasised as together forming the therapeutic alliance. Task alliance related to the agreement of goals and contractual components of the relationship, whereas the personal alliance was centred upon relational connection fostered by authenticity, warmth and mutual understanding. He explained that it was in the combination of these factors that a strong alliance could be achieved.

These conceptualisations provide the basis to contemporary understandings of the therapeutic alliance. The alliance is often defined as an “umbrella term for a variety of therapist–client interactional and relational factors” which take place during therapy (Green, 2006 p.426). More generally, it can be thought of as the collaborative bond between therapist and client (Krupnick et al., 1996). It is this definition which will be utilised with the current review.
Why is it necessary to consider the alliance when working with children and adolescents?

As noted above, existing research has demonstrated that the development of a strong therapeutic alliance has been associated with positive therapeutic outcomes. Research has demonstrated that alliance is able to account for approximately 30% of improvements within therapy, irrespective of modality (Horvath et al., 2011; Martin et al., 2000). Furthermore, research highlights that there are many factors which can impact the therapeutic alliance (Ackerman & Hilsenroth, 2003; Keller, Zoellner, & Feeny, 2010; Zuroff, et al.,2007). However, research has frequently centred upon the role of the therapeutic alliance in adult populations. As a result of this, adult models of therapeutic alliance are used to guide clinical work with children which may not be appropriate.

Therapeutic work with children and adolescents is arguably distinct from therapy with adults for a number of reasons. Firstly, a child’s developmental stage impacts language and communication abilities. This may impact the development and maintenance of the therapeutic alliance because it affects the way children understand and engage with the therapeutic process (Kazdin, Whitley & Marciano, 2006; Shirk & Saiz, 1992). Furthermore, for young children it may even be questioned whether these developmental limitations limit their understanding of the purpose of the treatment in the first place (Green, 2006; Shirk & Saiz, 1992). In addition, in contrast to adults who have the autonomy to seek out their own therapy, children are more likely to be brought to therapy by their parent or caregiver (Green, 2006). This can have important implications for the motivation they have to engage. This is because if clients are not engaging in therapy voluntarily it may be difficult to agree the purpose and goals of therapy with them. This is significant, given the importance placed on collaboratively forming goals in supporting a positive therapeutic alliance (Bordin, 1979; Hougaard, 1994). Therefore, it is recognised that developing an understanding of the role of therapeutic alliance, when working specifically with children and adolescents, is important in order to appropriately inform practice.
Rationale:

As explored within this introduction, the therapeutic alliance is widely considered to be an important factor within adult therapy. However, given the differences between adult and youth work, the existing research cannot be generalised to therapy with children and adolescents. Although the available literature exploring the therapeutic alliance with children is limited, evaluating existing research can help to highlight commonalities and/or discrepancies which can support the development of appropriate ways to establish the therapeutic alliance and work effectively with young people (Sugarman, 2010). In addition, identifying gaps within the existing research can help to guide future research. Although the importance of the therapeutic alliance may seem intuitive to many practitioners, further study and reflection is required to facilitate further progression in this area (Green, 2006).

Drawing attention to the role of relational quality and the therapeutic alliance within child and adolescent therapy appears to be particularly relevant at this time when there is an increasing focus and demand for manualised evidence based practice within the public health sector. While manualised approaches do not necessarily, negate the value of the alliance, their emphasis on skills can leave relationship variables neglected. Therefore, considering alliance in greater depth can be regarded as offering a counterweight to this. In addition to this, the wider social context within which current therapeutic practices exist represents an additional basis to consider this topic further. This is because the number of children experiencing mental health difficulties has been described as reaching a level of crisis (Ellyatt, 2011; YoungMinds, 2016). With our emphasis on engaging with social justice issues and a commitment to working effectively across the lifespan (BPS, 2015), CP’s are well placed to engage with this topic and contribute to supporting understanding of the alliance and potentially improving therapeutic practice.

Aims:

This review aimed to examine the literature on the therapeutic alliance when working with children and adolescents, as well as consider and critically evaluate the importance of the therapeutic alliance in shaping therapeutic outcomes. This review also intended to explore existing research on the determinants of the quality of the
therapeutic alliance and offer up-to-date knowledge on this topic. The present review used a narrative approach to support a broad exploration and analysis of the literature. In doing so it aimed to consider the knowledge available in this area and highlight gaps which could guide future research.

As a trainee counselling psychologist, in addition to the CoP values noted above, my personal ontological position is aligned with critical realism. This meant that while exploring and evaluating the literature I held an assumption that there is a degree of reality in the concept of the therapeutic alliance. However, it means that I also understand that the alliance is also impacted by the wider context rather than being an isolated entity which remains stable and independent of the environment it exists within (Bhaskar, 1993; Jenner, 2005; Ussher, 1999). This is important for me to acknowledge as I am aware this will have impacted how I have approached the literature.

Although the therapeutic alliance is considered as a distinct concept, this review initially considered literature which focussed on therapeutic relationship variables including the therapeutic relationship and the therapeutic alliance. Each study was then reviewed to identify how they defined ‘therapeutic alliance’ or ‘therapeutic relationship’. They were then included based on how this aligned with the definitions offered by both Bordin (1979) and Hougaard (1994) and contemporary conceptualisations of the alliance (Green, 2006). Therefore, unless otherwise stated, the literature reviewed here shares a broad understanding of the therapeutic alliance as the quality and strength of the collaborative and interpersonal relationship between therapist and client based on a shared agenda, goals, methods and focus (Cooper, 2008; Hougaard, 1994; Nissen-Lie, Havik, Høglend, Rønnestad, & Monsen, 2015). The rationale for this inclusion criteria is arguably further supported by the meta-analysis of Karver, Handelsman, Fields, & Bickman (2006) which found that despite the diversity in some of the scales used for measuring the phenomenon, and differences in referring to a the therapeutic alliance or relationship, the studies covered the same areas, focussing upon; bond, emotional connection, task and agreement on goals and client participation component.
For the purposes of this review the terms children, adolescents, youth, and young people are used interchangeably and refer to individuals aged 18 years and below. In line with this, the term *alliance* from here on refers specifically to the ‘therapeutic alliance between child and therapist’. I have primarily focussed on studies which look at individual work with children and young people as opposed to group therapy or family therapy. This is due to the differences within how the therapeutic alliance might develop and be measured when there are multiple individuals present, rather than in a dyadic context. The research is organised thematically according to the purpose and aims of the study, for example considering the impact of *alliance* on outcome, or dropout from therapy.

**Section 1: What does current research tell us about the role of *alliance* within child and adolescent therapy?**

Does the *alliance* play a role in therapeutic outcomes?

Much of existing research considering the therapeutic alliance within youth therapy has explored the association between *alliance* and the outcome of therapy. Within much of the quantitative research in this area, the term outcome is used to refer to change in the symptoms experienced by the child. This has been regarded as important because through developing understandings about what contributes to positive therapeutic outcomes it is viewed that therapeutic practice can be improved and the best care offered to young people.

A meta-analysis of 23 studies examining associations between therapeutic relationship variables and treatment outcomes in youth therapy was conducted by Shirk and Karver (2003). They established that there was a modest but robust *alliance*-outcome association (r= .24) which was comparable to findings within the adult population (Martin et al., 2000). They found that this association was independent of the type of treatment offered and the child’s age. However, one issue noted with this meta-analysis was that the way in which *alliance* was reported varied. Some studies used the therapist’s report of the *alliance*, and others used the clients’ report of the *alliance*. Hazell (2003) highlighted the value of including both the client
and therapist’s rating of **alliance** due to the therapeutic alliance being regarded as an interpersonal construct. Furthermore, the assessment of the outcome of the therapy is regarded to be best assessed by a blind rating to avoid bias. This is because, if the therapist reports both the **alliance** and the outcome, their perceptions of one are likely to impact the perceptions of the other (Hazell, 2003). A further limitation of many of the studies was that **alliance** was measured at only one time point. This may be regarded as problematic, particularly if **alliance** is measured at the end of therapy as this makes it unclear whether it is the change in symptoms which influences the rating of **alliance** i.e. positive outcomes lead young people to rate **alliance** as stronger; rather than a strong **alliance** contributing to positive therapeutic outcomes (Haan, Boon, Jong, Geluk & Vermeiren (2014).

As a result, more recent research studies which made attempts to address these methodological issues were reviewed here in order to gain the best possible insight into the nature of this association between **alliance** and outcome within individual therapy for children and adolescents.

In one such study, Fjermestad et al (2016) looked at whether therapeutic alliance in youths experiencing an anxiety disorder was related to therapeutic outcome. There were 91 participants with a mean age of 11 years. **Alliance** was measured using the Therapeutic Alliance Scale for Children and the accompanying therapist rating scale (TASC-C; Creed & Kendall, 2005; TASC-T; Accurso, Hawley, & Garland, 2013). Reports were collected during the third and seventh sessions during a course of ten Cognitive Behavioural Therapy (CBT) sessions. Both the child and therapist completed these measures. Addressing one of the methodological issues of previous research highlighted by Hazel (2003), Fjermestad et al. ensured that the **alliance** and outcome was not reported by the same person. Although outcome was judged by diagnosis loss and reduction in clinicians’ severity ratings it was also based upon a parent report at the posttreatment stage. They found that **alliance** scores from the first time point during the third session positively predicted treatment satisfaction at post treatment. This could be viewed to demonstrate that the therapeutic alliance was not an artefact of the symptom reduction, but in fact came before this. This finding can be considered to be particularly strong due to their use of parent ratings, because these were not
confounded by also measuring alliance. They also found that higher levels of agreement on change between client and therapist rated alliance scores early and late in treatment predicted diagnosis loss. This could be interpreted as demonstrating that it was the agreement, rather than individual ratings of alliance which supported positive outcomes in the therapy. This aligns with an understanding of the therapeutic alliance as an intersubjective construct (Nissen-Lie et al., 2015). The researchers concluded that their findings highlighted the potential value in promoting a ‘joint understanding of the collaborative relationship’ in order to support therapeutic outcomes for children experiencing anxiety disorders. These findings go some way in highlighting the importance of the therapeutic alliance when working with children due to its role in supporting both treatment satisfaction and symptom reduction. However, it is important to bear in mind that these findings relate to a particular presentation of anxiety, and a particular therapeutic modality (CBT). While this limits the generalisability of the findings, it does offer a step towards understanding the role of the alliance.

Labouliere, Reyes, Shirk, and Karver (2017) conducted a study looking at the role of therapeutic alliance within CBT for youth experiencing depression. Thirty-eight adolescents took part in the study which aimed to consider the relationship between alliance and outcome early in therapy. They aimed to specifically consider the direction of this relationship in order to more rigorously examine whether there was a causal relationship. Alliance was measured via the deployment of objective coders who used the Alliance Observation Coding System (AOCS; Karver et al., 2007) to code audiotapes from the first and fourth sessions. Outcome was judged in relation to change in symptomology, which was measured using the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). Through the use of Autoregressive path analyses, they found that alliance in the first session significantly predicted depression symptoms in the fourth session but the reverse was not found, even after controlling for pre-treatment levels of symptoms. This suggests that there is potentially a causal relationship between alliance and symptom reduction within CBT for adolescents experiencing depression. However, although the application of the reciprocal effects model required a larger sample size to be significant, it did highlight that it is possible that there are other smaller transactional influences between
therapeutic alliance and symptomatology. This leaves the findings regarding the degree of the role of alliance unclear within this study. Despite this, the researchers conclude that these findings do support that it is critical to establish alliance early in therapy in order to support symptom reduction.

Ornhaug, Jensen, Wentzel-Larsen, and Shirk (2014) examined how alliance contributed to the outcome of therapy when working with traumatised youths in Norway. The traumatic events included sexual and physical abuse, being exposed to domestic violence or traumatic loss and they resulted in the participants having clinically elevated symptoms of post-traumatic stress. Participants included 156 adolescents with a mean age of 15 years. They were randomly assigned to Treatment As Usual (TAU) which comprised a range of psychodynamic, CBT and family based therapies or to a Trauma Focussed Cognitive Behavioural Therapy (TF-CBT) treatment condition. They measured symptoms at three time points; pre-treatment, mid-treatment and post-treatment. This served to address one of the methodological issues identified in previous studies (Shirk & Karver, 2003) and avoided confounding the findings. Therapeutic alliance was measured using the Therapeutic Alliance Scale for Children Revised Version (TASC-R; Shirk, 2003). They found that alliance measures at mid-treatment, significantly predicted symptom reduction, as measured by self-report questionnaire and clinician delivered interview. However, this was only found in the TF-CBT condition but not within the TAU condition. Through measuring whether post-traumatic stress symptoms and finding that these did not predict alliance they were able to establish that this relationship could not be explained by early treatment gains. This is a strength of the study as it helps to establish the direction of the correlation and provided evidence that alliance was a predictor rather than a consequence of change in symptoms. The researchers concluded that although their results did support the assertion that therapeutic alliance plays a role in the outcome of therapy, there was an interaction of therapeutic approach. This was because the significant findings were only found within TF-CBT, rather than TAU. They reported that this demonstrated that establishing a positive therapeutic relationship was particularly important in the ‘context of evidence based treatment’. An interesting difference between the conditions of TAU and TF-CBT was that in TF-CBT parents were involved throughout the process through parallel
and co-joint sessions. In contrast to this, while some of the practitioners within the TAU conditioned involved parents, this represented only 51% of the sample and was not a consistent involvement. This may raise a question about whether parental involvement represents an additional factor which explains the difference in alliance-outcome association. Despite the study identifying the direction of the relationship, the findings remain correlational rather than causal. Therefore it is important to hold in mind the potential for other process variables to also be related to outcome.

These studies go some way in supporting the importance of the role played by alliance in the outcomes of therapy across a variety of presentations including anxiety, depression and PTSD. From a CoP perspective, a focus on diagnosis and symptom reduction is not regarded as the only way to assess therapeutic success; subjective client experience is viewed as equally important. However, it is understood that the emphasis on diagnostic labels and symptom reduction within these studies represent the need for measurement within quantitative methodologies. It is noted that within the existing alliance-outcome research there is a dominance of CBT based therapies. The lack of quantitative studies considering other therapeutic approaches may be understood as a consequence of other modalities such as psychodynamic therapy being more difficult to quantify or measure. This may serve to demonstrate one of the limitations of only using quantitative approaches to explore the role of alliance in child and adolescent therapy. Furthermore, while it is acknowledged that this is not their aim, they tell us little about how alliance is experienced by young people, particularly when alliance is rated by an observer, and what this might tell us about its role.

It seems that considering qualitative and experiential studies can further contribute to building a picture of the role of alliance, as these might be better able to capture the depth of relational quality and subjective meaning rather than only measuring outcomes.
Do young people identify the *alliance* as playing an important role in their experience of therapy?

Qualitative research has been utilised to explore young people’s experiences of the therapeutic encounter. Qualitative studies which utilise semi-structured/unstructured interviews enable more depth to be gleaned from participants’ responses as they have the flexibility to pursue unexpected areas which emerge, thereby supporting new insight (Rubin & Rubin, 1995). Understanding from the child or adolescents’ point of view how certain factors are experienced, in addition to how they make meaning of this, align with the subjective interpersonal nature of therapy and therefore demonstrates the value of qualitative approaches (Macran, Ross, Hardy, & Shapiro, 1999).

Donnellan, Murray and Harrison (2013) conducted an investigation into adolescents’ experience of CBT within a child and adolescent mental health service. They interviewed three females between the ages of 12 and 16. Using semi-structured interviews, they gathered in-depth accounts of the girls’ experiences of individual CBT therapy and focussed on which components of the therapy worked well for them and which aspects could have been changed to enhance their experience. Their accounts were then analysed using Interpretative Phenomenological Analysis (IPA). This resulted in four superordinate themes being identified as components which were important within participants’ experiences of therapy. The themes included; engagement, the therapeutic relationship, the impact of CBT on change and the manner in which CBT was delivered. Within the superordinate theme of the therapeutic relationship, participants highlighted that feeling understood supported them to trust their therapist and feel confident that they were able to help. It was also noted that the collaborative nature of the relationship and open communication allowed the young person to feel better able to generalise this way of relating outside of the therapy to other relationships. This was viewed by participants as beneficial to the quality of their wider relationships. These findings demonstrate that the therapeutic alliance was noted as meaningful and important to these adolescents. Their experiences highlighted that even if they had not been able to achieve the relationship they had hoped for, the contact with the therapist was still regarded as supporting personal progress. However because they only interviewed those young
people who had completed the contract of therapy, it could be viewed that these young people were a self-selecting group and that those young people who are more motivated to complete therapy, may also be better able to form a therapeutic relationship. However, the experiences reported by one participant that the *alliance* was not helpful suggests this was not necessarily the case.

A further study was conducted by Bury, Raval and Lyon (2007). They explored young people’s experiences of individual psychoanalytic psychotherapy. They interviewed 6 young people aged between 16 and 21. The IPA analysis conducted revealed that the participants gave particular importance to the ‘affective relationship’ with their therapist. Participants reported that their relationship with the therapist was the ‘pivot to everything’ indicating the centrality of the relationship and associated *alliance*. The young people reported that feeling they were accepted and listened to, and that their concerns were taken seriously offered a feeling of validation and comprised positive aspects of their psychotherapy experience. It was reported that this enabled them to feel relaxed enough to be able express themselves and engage in the process. In addition they found that a significant factor in young people’s experiences was that they felt involved in the decisions made around their care. This could be linked to ideas of collaboration which theoretically are associated with the therapeutic alliance (Bordin, 1979). While this only represents the idiographic experience of a select few adolescents, as well as an experience of a particular modality, it still provides a an important reflection that *alliance* is a factor which is identified by young people as significant in their therapeutic experience and demonstrates a good reason to continue to research this area with broader samples and across multiple modalities if it is to be generalised. However, this does not take away from the value of idiographic research.

One limitation of both of these studies was that they focussed only on adolescents. While the findings offer a valuable insight into their experiences and acknowledge the importance of the *alliance*, it demonstrates that there is a need for qualitative and experiential research which also considers a younger age range to see whether *alliance* is noted in the same way.
These findings also suggested that directing greater attention, within research and practice, to young people’s views of psychotherapy may support their initial engagement. The role of the *alliance* in promoting engagement or conversely reducing premature drop out from therapy has been studied in greater depth.

**Does alliance have a role in the rate of young people who drop out of therapy?**

Another area of the literature considering the role of the therapeutic alliance when working with children and adolescents has considered how it impacts engagement in therapy and premature termination. This research suggests that while *alliance* may not have a direct impact upon the outcome of therapy, it might serve to support participation in the work, and therefore promote better outcomes and satisfaction.

Haan et al. (2014) investigated the relationship between the therapeutic alliance and drop-out rates in youth mental health care of children and adolescents from ethnic minorities. There were 70 participants aged 6-20 with a variety of diagnoses including; anxiety, mood disorders, hyperactivity and/or relational disorders. Measures of *alliance* were taken at the end of every session using the Child version of the Session Rating Scale (C-SRS; Duncan Sparks, Miller, Bohanske, & Claud, 2006). They found that there was a significant difference in reported scores between those participants who completed the therapy and those who dropped out. As sessions progressed those who dropped out scored lower and decreased their *alliance* scores while the scores of completers increased. The researchers suggest that this supports the idea that when such a drop in *alliance* is detected, this provides an opportunity to intervene and work with the ruptures in the *alliance*. However, they did suggest that it would have been useful to gain the therapist’s reports of the quality of the *alliance* to further explore this area.

Garcia and Weisz (2002) used a questionnaire to explore the reasons as to why child focused therapy ended. The children who had engaged in the therapy were aged between 7 and 18 years, however it was their parents who completed the questionnaire. In total 344 parents completed the questionnaire. A strength of the
study was that they used $t$ tests and chi-square to establish how representative their sample was of cases generally seen within the ten clinics used and found it to be comparable. There was no difference across age, gender proportions, ethnic composition, socio-economic status or presentation. Therefore this suggests that the findings could be considered representative and therefore supporting their generalisability. A factor analysis identified six factors, which all had good internal consistency test–retest reliability. Of these six factors, the factor which accounted for the most variance (16%) and separated those who completed therapy from those who dropped out, was ‘problems within the therapeutic relationship’. Interestingly, they found that premature termination of treatment was a result of the child’s or parent’s dissatisfaction with the therapist. This may suggest that parents’ perceptions of the relationship were as influential as the children’s.

Considering the findings of these studies, it seems that they highlight that alliance does appear to play a role in mediating engagement vs. dropout from therapy. In addition, they serve as a reminder that children and their alliance with the therapist, do not exist in isolation. Therefore it is important to be mindful of other factors which might impact the alliance such as their wider system of care. This brings us to second section of this review which considers such factors in greater depth. It considers what existing research can tell us about what impacts and facilitates the therapeutic alliance between therapists and children.

Section 2: What can current research tell us about what facilitates the therapeutic alliance with children and adolescents?

While recognising the limits of the individual studies reported above, together they form a picture which suggests that alliance plays an important role in children’s therapy for both engagement and outcomes. As a consequence, this highlights the importance of understanding what contributes to the quality of alliance and the determining characteristics which might support or interfere with alliance formation. Understanding what the existing literature can tell us represents an important step towards guiding practice and future research. Therefore, the second section will review literature pertaining to this. This section will be presented in four segments.
which broadly represent the areas which existing research has focussed upon. These include; the setting of the therapy, therapist qualities and skills, the therapeutic modality and the role of parents.

The Setting of therapy:

McLeod et al (2016) conducted a study in which they measured to what extent the setting of therapy in comparison to treatment type impacted the therapeutic alliance when working with children and adolescents. They achieved this through comparing three conditions; CBT in a research setting, CBT in a community setting and treatment as usual (TAU) in a community setting. TAU was largely made up of client centred family focussed interventions. The participants who took part were 89 children aged between seven and fifteen years, who had been given a label of primary anxiety disorder. Therapy in the research setting was delivered by clinical psychology trainees and some qualified clinical psychologists. The therapy in the community setting was delivered by a variety of psychologists, social workers, and people within the ‘other’ category. Based on the ratings of alliance, as assessed by coders using the Therapy Process Observational Coding System Alliance Scale (TPOCS-A; McLeod & Weisz, 2005), they found that alliance was significantly stronger in the research context. However, no significant difference was found in alliance strength between the treatment types in the community setting. This might tell us something about how the nature of each of these settings impact alliance. The researchers explore the possibility that differences in ‘caseloads, productivity requirements, and/or paperwork’ could have impacted the practitioners’ job performance. However, although this acknowledges the practical impact, it arguably misses the impact such factors including being overwhelmed by the combination of high case load and quotas to be reached, could have upon the therapists’ personal emotional resources. This seems crucial given the potential importance of such resources in forming a personal bond with the client (Hougaard, 1994). While it is important to be clear that there is great variety within community based settings, there is recognition that many services are under greater pressure due to increased demand and being understaffed and resourced (O’Hare, 2018). Therefore, this study serves to highlight an important
point about the wider context of the therapy and how this can also play a role in alliance formation, and the need for further research and reflection within this area.

**Therapist qualities and skills:**

Creed and Kendall (2005) examined therapist behaviours that may be related to a strong therapeutic alliance with an anxious child receiving manualised CBT. They explored the specific behaviour of therapists that contributed to child clients’ perceptions of a therapeutic alliance. The sample was made up of 56 children aged between seven and thirteen years. The children were referred to an anxiety disorders clinic and received 16 sessions of manualised CBT. Child and therapist ratings were collected after the 3rd and 7th sessions using the Therapeutic Alliance Scale for Children Revised Version (TASC-R; Shirk, 2003). The researchers also developed a measure to be used by an observer, the Therapist Alliance-Building Behaviour Scale (TABBS) which was also administered at the 3rd and 7th session. The TABBS was comprised of a measurement of four behaviours regarded to generate low child ratings of alliance, and seven behaviours regarded to generate high child ratings of alliance. Observers rated these components while observing video tapes of the sessions. Unfortunately, this measure was developed using only observations from CBT sessions. Therefore this might limit the generalisability of the therapist behaviours noted within it. Bearing this limitation in mind, the researchers found that out of the behaviours they had predicted to be contributing to alliance formation, only collaboration was found to significantly positively predict early child ratings of alliance. Finding common ground and pushing child to talk were found to negatively predict child’s ratings of alliance. Unfortunately, directionality of these associations was not established and therefore it could also be that these results demonstrate that some children have a tendency to form strong alliances due to their collaborative natures. Despite this, the findings do offer potential for future research to further understand this relationship and consider if there are tangible qualities and behaviours that can support alliance, particularly based on a range of modalities rather than only CBT. Speaking directly to therapists offers a potential avenue for research and could shed further light on the nature and direction of this association.
Through the use of grounded theory, Bayliss, Collins and Coleman (2011) presented a cross-theoretical framework to guide clinical interactions that enhance the development of a therapeutic alliance with children. The framework was based upon qualitative interviews which explored child participant’s experience of *alliance*. The most factors identified were separated into four levels and ranged from those which were regarded to be most proximal to those which were more distal. The first level, and considered proximal, was associated with personal characteristics of the therapist such as the therapist being experienced as patient, nice, caring. The second level was more related to ‘micro skills’ which participants valued such as the expression of sincere caring, patience, active listening, validating feelings, and less talk, and more doing activities. The third level represented the implementation of a plan, as this was regarded by participants as containing anxiety and supported problem solving. Finally, the fourth level demonstrated the importance of creating a sense of privacy and confidentiality. As this theoretical framework was built upon the lived experiences of children it supports its application within practice. It also highlights the potential complexity of *alliance* and the different levels at which these connections are viewed to be formed. This is arguably in line with the original conceptualisations of both Bordin (1979) and Hougaard (1994) as they too highlighted the different components which together were viewed to represent the therapeutic alliance.

**Therapeutic modality:**

Much of existing research has considered the *alliance* within the context of CBT informed therapies. It appears important to consider the way in which treatment modality might impact the *alliance*, to better evaluate and understand existing research.

Langer, McLeod, & Weisz (2011) investigated whether the use of manuals in treatment of youths undermines the formation of the therapeutic alliance. They compared manualised CBT with usual care. The participants were 76 clinically referred youths experiencing anxiety or depression. In the study they used the Therapeutic Alliance Scale for Children (TASC; Shirk & Saiz, 1992) and this was administered post treatment. Furthermore, sessions were observed and coded at 4
time points during treatment. They found that those youths who had received manual guided CBT had significantly higher observer rated *alliance* than usual care youths early in treatment. However, over time the two groups became more similar and there was no longer a significant difference in the observer rated *alliance* by the end of treatment. The youth report of *alliance* demonstrated the same findings and showed no significant difference in *alliance* between conditions. Therefore, the findings demonstrate that using a manual guided CBT treatment did not negatively impact or harm the establishment of the therapeutic alliance. Interestingly, their findings suggest that the manualised treatment showed some superiority in forming an early *alliance*. Although it might have been assumed that the structure and focus upon skills within manualised therapy would leave less space for the relational variables and therefore impact *alliance* negatively, in fact the converse is arguably true. When considering the findings through a developmental lens, it seems that the more structured approach combined with therapists taking on a role that could be regarded as more similar to that of a ‘teacher’ and ‘coach’, may have been more familiar to young people. As a result, it could be viewed that young people may feel more accustomed to this way of relating and therefore regard and rate the *alliance* as stronger (Ormhaug et al., 2014).

**Role of Parents:**

Across many of the studies already reported within this review, parents have featured as an important potential influencer of the therapeutic process and potentially the *alliance* (Garcia & Weisz, 2002; Ormhaug et al., 2014). A small number of studies have looked more directly at the influence of parents in relation to children’s therapy and *alliance*.

One such study was completed by Campbell and Simmonds (2011). They completed a mixed methods study and explored therapists perspectives and personal understandings of the therapeutic alliance when working with children and adolescents. A total of 53 qualified psychologists, psychiatrists, psychotherapists and social workers, who worked with children between the ages of two and seventeen, completed a questionnaire to rate the extent to which they viewed therapists, parents
and children contributed to creating barriers to the *alliance*. Their findings indicated that for children aged 2-11 years, therapists reported that the most common barriers to *alliance* were: parental support, payment, attendance and transport. They found that for the older age group (12-17 years) therapists viewed a lack of goal focus and motivation to be the most typical barriers to *alliance*. The barriers to alliance, for younger children, appeared to be dominated by aspects in which parents were involved. However, for older children this was not reported, therefore it seems, from therapists’ perspectives, parents had a particular impact on the *alliance* for children under the age of 12. In the second phase of their research, they used semi-structured interviews with five participants to explore therapists’ experiences of developing and maintaining *alliance*. Through the use of IPA they developed four themes including; the collaborative nature of the therapeutic alliance, parental alliance, therapist resources and therapist self-awareness and well-being. While their findings indicated the importance of demonstrating empathy and establishing trust in the relationship, they highlighted that the only non-therapist factor which was regarded to impact *alliance* was parents. This contributes to a growing understanding of the important role of parents within child and adolescent therapy, and demonstrates their role might extend to the *alliance*. However, although this provided a step towards understanding the way this impact manifested, it seems more focussed research in this area would be useful to better understand this relationship and their contributions.

Hawks (2015) conducted a qualitative study which considered therapists perspectives of maintaining a positive therapeutic alliance with adolescents and their caregivers. They interviewed nine Caucasian family and marriage therapists who had experience working with adolescents. They used phenomenological analysis, which considered the experiences of therapists in great depth. They found that if adolescents associated therapists with their parents, this generated a barrier to the *alliance*. While this study did not intend to look specifically at how parents impacted the alliance between therapist and child, it seems that their findings demonstrated that parents may impact this *alliance* in in-direct ways. As a result, this may then influence engagement and outcomes.

Hawley and Weisz (2005) conducted a study investigating whether the therapeutic alliance between children and their therapists, and parents and their child’s
therapist were associated with therapy retention, satisfaction, and outcome, as measured by a reduction in symptoms. Both parents and children completed measures to assess satisfaction and symptom reduction. A strength of the study was that its sample of 65 youths ages 7 to 16 years, their parents, and their therapists, came from community-based outpatient mental health clinics. This supports the generalisability of it to real world settings in contrast to being completed within a research setting, which, as noted in the study by Mcleod et al. (2016), can impact the alliance. Hawley and Weisz (2005) found that the child-therapist alliance, as rated using the Therapeutic Alliance Scale for Children (TASC; Shirk & Saiz, 1992), was associated with symptom reduction whereas a strong parent-therapist alliance was associated with less frequent cancellations, and greater agreement regarding when to end therapy. This suggests that parents play a role in therapeutic engagement which forms an important tenet of alliance (Bordin, 1979). The researchers concluded that the alliance may be considered an important component in therapy with children and adolescents but that it was important to consider both youth and parent connections to the therapist.

Given the role of parents highlighted here, it seems that developing a more detailed understanding of the ways in which parents impact the therapeutic alliance between therapist and child or contribute to the quality of an alliance is important.

Conclusion:

While some of the quantitative literature is mixed or not causal it does seem to establish that alliance is not an artefact of a successful process but rather is a contributor to the success of therapy. Evaluating this research also demonstrated the limits of quantitative literature in understanding in greater detail the ways in which alliance operates to have this impact on outcomes. It seems that, as noted by Marcus et al. (2011), “the association between alliance and outcome may be more complex than can be described by a simple correlation” (p.450). However, the qualitative and experiential findings from the perspectives of young people also reflected that the alliance was regarded as important to their overall experience including satisfaction and therapeutic outcomes. Therefore, taken together, the existing quantitative and
qualitative research appears to strengthen the rationale to take the *alliance* seriously and continue to explore this area with additional research. In line with this, considering the range of factors which can impact *alliance* and facilitate its quality, more in depth study can support these components to develop.

**Future Research Directions:**

One of the issues raised within the literature evaluated in this review was the importance of agreement between therapist and child on the *alliance*. Research demonstrated that higher agreement led to symptom reduction (Fjermestad et al., 2016). Furthermore, qualitative studies such as the one conducted by Donnellan et al. (2013) highlighted that although young people felt there was potential for the relational experience to be improved, without being offered an opportunity to discuss the *alliance*, the discrepancies could not be addressed. Therefore it seems that exploring how therapists are able to communicate their understanding of the *alliance* to the young person and establish a dialogue could support practice and the establishment of a strong *alliance*, as well as allowing for a more rapid response when ruptures occur. It may also be of value to further understand what gets in the way of such dialogue and what therapists regard as potentially supporting it.

A further area which appears pertinent to future research is the role of parents. It has been noted that a key difference between child and adult therapy is that within youth therapy they are often accessing therapy through/with the help of their parents. Throughout much of the literature exploring the therapeutic alliance with children, parents are noted for the role they play (Garcia & Weisz, 2002). This seemed to include their own alliance to the therapist, the practical ways in which they might influence the child’s engagement and even their impact on the alliance between therapist and child (Campbell & Simmonds, 2011). Therefore, it seems there is a need for additional qualitative research which can further clarify the role and contributions of the parents, considering not only the evidence which demonstrates that parents have an impact on the *alliance*, but how they have this impact, could support more positive *alliance* formation and in turn positive therapeutic outcomes. Future research needs to consider therapeutic alliance with children and adolescents without omitting
the broader systems within which the relationships are embedded (Feinstein et al., 2009).

Westergaard (2011) emphasised the significance of the relationship between therapist and child and highlighted that it is an area which requires further consideration. Particular value may come from focussing on the alliance from a therapist perspective, as this has received less attention in the literature. When considered in relation to the understanding that the therapeutic alliance is a dyadic and intersubjective construct, shaped by both the client and the therapist, considering therapist perspectives appears to be an important endeavour (Zilcha-Mano et al., 2015). Therefore, one possibility is to explore if and how therapists perceive parents to impact the therapist-child alliance.

**Final summary:**

As noted in the introduction, in the United Kingdom the number of children experiencing mental health difficulties is rising (Ellyatt, 2011; Young Minds, 2016). Although research has contributed to advances within evidence-based treatments for children experiencing mental health difficulties, statistics reveal that over half of those children who engage in therapy terminate prematurely (Ginsburg et al., 2014; Wolk, Kendall, Beidas, 2015). With high prevalence rates and limited engagement in care, it seems that a better understanding of how practitioners can effectively sustain children within therapy is important. As highlighted by this review, the alliance can contribute to engagement. Therefore continuing to conduct practice based research regarding the therapeutic alliance with children and young people is arguably an important avenue to be explored.
References:


Year 2 empirical study:
‘Contamination vs. Collaboration: A Thematic Analysis of Therapist’s Perspectives of How Parents Impact the Therapeutic Alliance When Working with Children’

Assignment: Research Report B8 (Re-Submission) - Year 2b

Title: Contamination vs. Collaboration: A Thematic Analysis of Therapist’s Perspectives of How Parents Impact the Therapeutic Alliance When Working with Children

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Word Count: 11000
Abstract

Background: Research suggests that the therapeutic alliance is central to positive outcomes in therapy across modalities, including when working with children (Shirk, Karver & Brown, 2011). Parents have been found to impact the therapeutic alliance between therapist and child. However, existing research has not provided a clear understanding of how the impact of parents manifests in practice. With counselling psychology working across the lifespan, advocating a client focussed approach to therapy and encouraging ongoing improvement to services; engaging with this gap in the current research is pertinent to the field. As a result, this research explored therapist’s perspectives of how parents might impact the therapeutic alliance between therapist and child.

Method: Semi-structured interviews were conducted with five female psychologists/psychotherapists. Interview transcripts were analysed using thematic analysis and aimed to explore patterns and themes. The analysis was conducted from a critical realist perspective and in line with the method described by Braun and Clarke (2006).

Results: Four themes were identified; “Power negotiation”, “Parental role in therapy”, “Parent's ambivalent attitude towards therapy” and “Parent's relationship to therapeutic boundaries”.

Conclusions: The findings enabled an understanding to be developed of the similarities and differences found across therapist perspectives of how parents impact the alliance. This provides a step towards guiding therapeutic practice with children. Areas for future research are proposed, including; exploration of parents experiences of having a child in therapy.

Keywords: Therapeutic Alliance, Children, Parents, Therapist Perspectives, Thematic Analysis.
Contamination vs. Collaboration: A Thematic Analysis of Therapist’s Perspectives of How Parents Impact the Therapeutic Alliance When Working With Children

Introduction:

The therapeutic alliance is commonly regarded to be of central importance to engendering therapeutic change. Some suggest that a good therapeutic alliance provides the frame within which therapeutic change can occur, whilst others argue that the alliance effects therapeutic change in and of itself (Hubble, Duncan, & Miller, 1999; Richards, 2011). A significant body of research finds that therapeutic alliance accounts for more change than therapeutic modality (Horvath, Del Re, Flückiger, & Symonds, 2011; Martin, Garske & Davies, 2000).

Counselling Psychology (CoP) emphasises the importance of developing a purposeful relationship with clients (Strawbridge & Woolfe, 2010). The importance of the relationship in enabling change is a key competence underpinning CoP, with the therapeutic alliance comprising part of this (HCPC, 2015). However, there has been less focus on the therapeutic alliance when working with children in the CoP literature and the wider psychological field. This seems an oversight, since many CoP practitioners work therapeutically with children (Heywood, 2010; Sugarman, 2010).

Within existing research, parents have been proposed as impacting the therapeutic alliance (Campbell & Simmonds, 2011; Robbins, Turner, Alexander & Perez, 2003). Understanding how parents impact the alliance would be more directly useful to therapeutic practice. This is because it would generate a more tangible understanding of the forms this impact takes, enabling practitioners to manage it effectively. Unfortunately, current research has not adequately addressed this. As a result, the current study will focus on the ways in which this impact might manifest. It aims to generate insight into the ways in which parents influence the therapeutic alliance between therapist and child. In order to provide a shared understanding for the purposes of this study, the definition of ‘therapeutic alliance’ is considered below.
What is the Therapeutic Alliance and why is it important?

As psychological therapies have developed, so too have theories of the therapeutic relationship. From the early conceptualisations of the therapeutic relationship described by Freud (1913) and Carl Rogers (1957); Bordin (1979) suggested that ‘alliance’ was a key factor across different psychotherapy models. Bordin suggested that the alliance between therapist and client was made up of positive affective bond, agreement of therapeutic goals and agreement of therapeutic task. Contemporary definitions conceptualise the therapeutic alliance as an “umbrella term for a variety of therapist–client interactional and relational factors” which take place during therapy (Green, 2006 p.426). More broadly, it can be thought of as the collaborative bond between therapist and client (Krupnick et al., 1996). However, it could be questioned how far these definitions apply to therapeutic work with children, given that they were developed in relation to adult work. While bearing this limitation in mind, for the purposes of the current research project, the therapeutic alliance is understood as the quality and strength of the collaborative and interpersonal relationship between therapist and client based on a shared agenda, goals, methods and focus (Cooper, 2008; Hougaard, 1994; Nissen-Lie, Havik, Høglend, Rønnestad, & Monsen, 2015).

From this point, alliance refers specifically to the ‘therapeutic alliance between child and therapist’ as defined above. This definition fits with CoP’s understanding, that a successful therapeutic encounter depends more on our emphasis on the relationship, than on our ability to expertly utilise techniques for diagnosing and treating specific difficulties (Strawbridge & Woolfe, 2010). Currently in the public health sector, technical expertise is prioritised. Therefore, research into the therapeutic alliance is valuable in strengthening evidence for the importance of relational quality.

Research has indicated that a strong therapeutic alliance accounts for approximately 30% of ‘improvements’ across therapeutic modalities (Horvath, 2001; Martin et al., 2000). In their review, Horvath et al. (2011) present evidence that the effect is ‘ubiquitous’ irrespective of how it was measured, when it was measured and
who made the evaluation i.e. therapist or client. The important role of therapeutic alliance in engendering change goes some way to demonstrate the value in understanding what can impact it, so that practitioners can better facilitate this.

These findings refer to adult populations, and have limited application to working with children because of the qualitative differences between adults and children. A child’s developmental stage impacts language and communication abilities. This may impact the development of alliance because it affects the way children engage with and understand therapy (Kazdin, Whitley & Marciano, 2006). Children also lack the autonomy of adults. It is often a parent or third party who refers them to therapy rather than attendance representing an independent choice. This has potential implications for a child’s motivation and goals in therapy. This is significant, given the importance placed on collaboratively forming goals in supporting a positive therapeutic alliance (Bordin, 1979). As a result, it is important to better understand the role of therapeutic alliance when working specifically with children. As counselling psychologists work across the lifespan, relevant research could help to inform practice with children (British Psychological Society [BPS], 2015).

Although research investigating the significance of therapeutic alliance when working with children is limited, a number of quantitative studies have measured the association between alliance and outcomes (Chiu, McLeod, Har, &Wood, 2009; Fjermestad et al., 2016). These studies suggest a significant correlation exists between the therapeutic alliance, which they define in line with Bordin (1979) and therapeutic outcomes, which were assessed using psychometrically sound measures. They found that when children provided high ratings of alliance this was associated with reduction in symptoms and increased treatment satisfaction (Chiu et al., 2009; Fjermestad et al., 2016). Furthermore, existing research has identified factors which are regarded to impact the alliance including: therapeutic setting, specific therapist behaviours and parents (Creed & Kendall, 2005; Hawks, 2015; Mcleod et al., 2016). However, out of these factors, parents’ impact on the alliance appears to have received less attention in research; despite their role in typically initiating and maintaining the therapeutic process.
Why are parents and their impact on the alliance important?

Shirk and Karver (2003) noted that the therapeutic alliance in youth therapy is complex in nature with both the child and parents forming connections to the therapist. Feinstein, Fielding, Udvari-solner and Joshi (2009) highlight that parents’ form part of the child’s wider system of care and undoubtedly impact the therapeutic encounter. This is supported by Attachment and Social Learning Theory, which argue that parents play a crucial role in how children learn strategies to manage their emotions and wider relationships (Bandura, 1977; Bakermans-Kranenburg, van IJzendoorn & Juffer, 2003). It is likely that parents also have an impact on how the child manages the therapeutic relationship and as a result might significantly impact the alliance.

Much of the existing research has not directly investigated parents’ impact on the therapist-child alliance (Garcia & Weisz, 2002); however, a quantitative study by Hawley and Weisz (2005) revealed some interesting associations. They examined the relationship between therapist-parent alliance and retention, satisfaction with services and reduction in symptoms. They found that strong parent-therapist alliance was associated with less frequent cancellations, and greater agreement regarding when to end therapy. This suggests that parents play a role in therapeutic engagement which forms an important tenet of alliance (Bordin, 1979).

In connection with this finding, using a mixed factors analysis, Robbins et al. (2003) investigated the relationship between therapeutic alliance and retention within family therapy. Interestingly, although individual alliances did not predict retention, drop-out was predicted by lack of agreement and consistency between parent-therapist and child-therapist alliances. They noted that this suggests alliance operates at a systemic level. This highlights the importance of not considering the therapist-child alliance in isolation, but considering how the wider system which it exists within might shape it. However, given the correlational nature of many of the reported findings, it suggests that parents’ attitude to and evaluation of the therapy is linked to the quality of the alliance, but does not denote causality or direction. This limits the practical application of such findings.
In contrast to quantitative methodologies, qualitative research might enable us to better understand the process of how parents impact the alliance. A qualitative study by Hawks (2015) considered therapists' perspectives of maintaining a positive therapeutic alliance with adolescents and their caregivers. Using phenomenological analysis, which considered the experiences of therapists in great depth, it was found that if adolescents associated therapists with their parents, this generated a barrier to the alliance. Despite this finding, the study did not consider how parents' attitudes or behaviour, impacted the alliance between therapist and child; instead it largely focussed on therapist-client and therapist-caregiver alliances separately. As a result the question of how parents impact the alliance between therapist and child remains unanswered.

A mixed method study by Campbell and Simmonds (2011) provides a partial answer. Their study aimed to gain therapist’s perspectives of what factors significantly contribute to the therapeutic alliance with children. Using a questionnaire, they asked participants to rate the extent to which therapists, parents and children contributed to creating barriers to the alliance. They found that the most frequently identified barriers to alliance for children aged 2-11 years were; parental support, payment, attendance and transport. These barriers all implicate the role of parents and highlight that, for this age group, they were perceived as having an important impact on the alliance. In contrast, for older children (12-17 years) barriers included lack of goal focus and motivation. This demonstrates that a parent’s impact on alliance may be most significant for children under the age of 12. It seems that following the age of 12, shifts in their developmental stage result in young people having qualitatively different relationships with parents as a result of changing needs and possibilities in accessing therapy (Fitzpatrick & Irannejad, 2008). This is supported by findings that adolescents are often provided with greater independence from their parents and are afforded opportunities to appropriately develop their autonomy (Spear & Kulbok, 2004). Therefore, focusing on children under 12 may generate more detailed findings to develop our understanding of how parents impact the alliance.

In the second stage of their research, Campbell and Simmonds (2011) aimed to understand the experiences of developing and maintaining alliance. Five
participants were interviewed and transcripts were analysed using Interpretative Phenomenological Analysis (IPA), which considers in depth idiosyncratic experience. They developed four themes, three of which centred on therapists qualities and one which highlighted the impact of parent/carer alliance. Aside from the therapist themselves; parents were the only factor noted as equally impacting alliance, demonstrating the significance of understanding more about their role. Within the parent/carer alliance theme, parents’ commitment and support of the therapy was noted as essential to alliance. These findings offer preliminary insights into how parents impact the alliance; however, as this was not the primary focus of their study, considering patterns across therapists’ perspectives on the role of parents in isolation could build on the in-depth experiences shared in their study. Having this focus could extend the utility of the findings and better inform therapeutic practice through equipping therapists to better manage negative impacts of parents and support positive effects.

What is the value in considering therapist perspectives?

Although both Campbell and Simmonds (2011) and Hawks (2015) highlight the importance in exploring therapists’ experiences and perspectives, therapist perspectives have generally received less attention in this particular area (Elvins & Green, 2008). In previous research, clients’ views have been emphasised in order to support client centred practice (Bedi, Davis & Williams, 2005). However, as therapeutic alliance is an interpersonal and intersubjective construct created between therapist and child, it could be argued that the therapist perspective is also valuable (Nissen-Lie et al., 2015).

Furthermore, empirical findings have demonstrated that the factors which influenced therapists when evaluating the therapeutic alliance were notably different to those which influenced the clients (Nissen-Lie et al., 2015). This divergence between client and therapist views illustrates the value in focussing specifically on therapist perspectives in order to gain a comprehensive understanding of this subject, and, as a consequence, support effective therapeutic practice with children. Considering therapist perspectives reflects a ‘practice based evidence model’ and
aligns with CoP’s valuing of knowledge derived from the subjective views of clients and practitioners (Strawbridge & Woolfe, 2010).

**How can the current research gap be addressed?**

In summary, there is a gap within the current research on the role and impact of parents on the *alliance* when working with children. Research into the therapeutic alliance with children is particularly relevant to CoP at this time as there appears to be a growing discourse within the division considering the importance of therapeutic work with children and CoP’s role in this. This is paralleled by societal concerns regarding the rapidly rising numbers of children experiencing mental health difficulties in the UK (Ellyatt, 2011, YoungMinds, 2016). Therefore, the following research aims to develop an understanding of the ways in which parents impact the therapeutic alliance between child and therapist. This objective will be mobilised through exploring the question:

**When working with children, what are therapist’s perspectives of how parents might impact the therapeutic alliance between therapist and child?**

**Method:**

**Ontological and Epistemological position**

The ontological position of the current study is based on critical realism, which can be regarded as proposing a middle ground between positivist and interpretivist ontologies (Sims-Schouten, Riley & Willig, 2007). Critical realism suggests that a single reality exists in which objects, institutions and ideologies are considered to be constant (Bhaskar, 1993; Jenner, 2005). However, it argues that this single reality is interpreted in a multitude of ways and that our perception of it is influenced by our personal experiences and historical, political and cultural contexts (Ussher, 1999, p.45).

In line with this, the epistemology of critical realism offers a view that knowledge cannot be fully derived from observation and measurement. This is because the way in which we observe, measure and research phenomena, will always
be in relation to existing constructs of it (Jenner, 2005; Sayer, 2004). Qualitative research methods are aligned with the ontology and epistemology of critical realism as they permit an understanding of individual realities, but also the role of the socio-political environment on shaping this interpretation of reality (Collier, 1994). In relation to the current research, this means that in considering the perspectives of therapists, it is acknowledged that they will be influenced by the context they exist within.

Thematic analysis can be used in conjunction with a wide variety of epistemologies. This flexibility enables it to align with critical realism because it considers individual perspectives as offering a mediated insight into larger patterns of meaning, although the limits of these are acknowledged. This is relevant given that the study aimed to gain a deeper understanding of therapists’ perspectives of how parents impact alliance. This is in line with CoP’s recognition that different research approaches can offer different but valid understandings (BPS, 2015).

In addition to my ontological and epistemological position, as the primary researcher in this project, my experience working with children and families in a therapeutic group setting has shaped how I relate to this topic and, in turn, the interpretation of the research (Ethrington, 2004). Specific efforts to bracket this were made to allow space for new perspectives to emerge. In practice, this was not always entirely possible. However, when the material presented by participants resonated or contrasted with my own thoughts and experiences, I worked to ensure I was facilitating the exploration of their perspectives in all areas, not only those which I related to. I also noted these times to ensure I reflected carefully on these elements when analysing the data.

**Design**

I selected Thematic Analysis (TA) (Braun & Clarke, 2006) as the most appropriate method to investigate the research question. This was due to the limited research currently available that explored patterns and themes in therapists’ perceptions of parents’ impact on the therapeutic alliance. Exploring patterns and themes may enable tentative predictions to be made regarding effective ways to work with this and improve therapeutic outcomes (Ragin & Amoroso, 2011). This is
supported by TA’s capacity to describe individual perceptions whilst simultaneously identifying themes that represent many participants, enhancing its use in informing practice (Guest, 2012). Although IPA as a method considers themes, its focus remains on investigating in depth idiosyncratic experience and prioritises the details of participants experiences rather than considering the processes involved (Holloway & Todres, 2003). A further advantage of TA is its capacity to be flexible which also enables unanticipated insights to be generated (Braun & Clarke, 2006). This is particularly useful given the limited research available in this area. In relation to this, due to the exploratory nature of the topic, Grounded Theory was also considered, however, as the aim of the research was to initially describe the perceptions of processes, rather than generate a theory to explain them, this was better addressed through TA (Joffe & Yardley, 2004). Six phases of analysis were followed: familiarizing oneself with the data, generating initial codes, searching for themes; reviewing themes; defining and naming themes; and producing the research report (Terry, 2015). These steps are described in greater depth within the analytic approach section.

Participants

Recruitment:

Purposive sampling was used to select participants who could offer rich information and in-depth understanding of the topic (Patton, 2002). A snowballing recruitment method was used based on a number of professional contacts within non-NHS organisations. Participants were contacted via an email invitation (Appendix 1) and after an initial response, were sent a participant information sheet which offered further details of the study (Appendix 2). Five participants were interviewed. This ensured that there was a balance between quality of data and adequate time to engage with material during analysis (Patton, 2002).

Inclusion criteria:

Participants were required to be psychotherapists/psychologists: ‘Type’ of practitioner was not specified further as research suggests alliance is important regardless of modality (Martin et al., 2000). The second criterion was that participants
should have a minimum of 3 years of experience post-qualification. This degree of experience was considered sufficient to enable therapists to have a wide range of experiences to draw upon, rather than basing their perceptions on a few select examples. This was deemed to be important as the chosen method aimed to represent an overview of patterns and themes within and across participants, which becomes more challenging if participants have limited examples to share. A threshold of three years post-qualification also reflects the threshold used for supervisory accreditation, further supporting the view that this signifies a substantial degree of experience (UKCP, 2012). Finally, participants were required to have worked with children aged 6 – 12 as the research base suggested that parents have an important impact on therapy from age 6 (Campbell & Simmonds, 2011). Age 12 marked the upper end of the inclusion criteria to ensure some homogeneity of the sample. After this age, developmental changes produce different needs and relationships with parents, and possibilities in accessing therapy (Fitzpatrick & Irannejad, 2008). Furthermore research with this age group is currently limited.

Participant demographics:

Five participants were recruited to take part in the study. Two were clinical psychologists, two were accredited psychotherapists and one was a counselling psychologist. Their experience working with children ranged from between 10 to over 20 years. All of the participants who took part in the study were women. All participants had worked across both community and private settings with children. Two currently worked mostly in private practice, one worked only in community settings and two currently worked in both community and private settings.

Procedure

Data collection:

To allow greater depth and opportunity to explore individual perceptions, individual interviews were chosen rather than using a focus group (Rubin & Rubin, 1995). All interviews were digitally recorded and transcribed verbatim. A semi-structured interview approach was chosen to provide consistency in the broad
questions participants were asked, but also enable flexibility to explore individual issues which emerged through the interview (Rubin & Rubin, 1995). The interview schedule (Appendix 3) was developed through considering the elements which were regarded by research as forming the therapeutic alliance. Open ended questions were then devised to explore how participants may perceive parents to impact these elements. Interviews began by asking participants about what stood out to them when they considered the ways parents might impact the alliance. Using a general question to open the interview aimed to ensure that there were opportunities for new perspectives to emerge. The interviews were conducted in a location chosen by the participant, including private offices. Participants were given a copy of the participant information sheet (Appendix 2) and a consent form (Appendix 4). Interviews lasted between 45 and 65 minutes.

Analytic approach:

An inductive approach was taken, with codes and themes being grounded in the data (Braun & Clarke, 2006). Both semantic and latent meaning were coded for and interpreted within a broadly critical realist framework (Willig, 1999). This enabled the client’s perspectives and experiences to be analysed to some degree as ‘real’, without ignoring the role which the context might have had on shaping them.

The data was analysed using the thematic analysis method described by Braun and Clarke, involving six phases (2006). The first phase involved becoming familiar with the data; this was achieved through transcribing the interviews and then reading and re-reading the transcripts. The next phase involved generating initial codes for individual transcripts. This was accomplished through carefully considering each transcript line by line and noting the semantic meaning. The transcripts were also coded at an analytic level to infer what else could be viewed as being communicated. Following this, the third phase ‘searching for themes’ was completed through a process of organising and reorganising codes seeming to relate to or share a common component and checking the codes were consistent within themes but distinct from other themes (See Appendix 8). The fourth phase involved reviewing themes. Themes were re-organised into sub-themes and overarching themes. The next phase involved defining and naming the themes. I attempted at all times to apply high levels of
reflexivity. For example, I initially created a theme around negative parental attitude. However, through a process of returning to my literature review, I noticed how the pre-conceived ideas I may have held as a result of existing literature had influenced the way in which I was viewing certain elements of the transcripts. I therefore adapted the theme to better represent the data and as a result focussed on parental ambivalence. Finally, the sixth phase was producing the research report and communicating the themes which I had identified.

The chosen method required me to make decisions about how the data was analysed and take an active role in defining the themes. I developed these particular themes because I viewed them as giving insight into the data within the context of existing research. They aim to shed light on the research question, albeit through a particular lens.

**Ethics:**

This research was conducted in accordance with the core principles of the BPS ethical code of human research ethics (2010) and received ethical approval from the University of Surrey Faculty of Health and Medical Sciences Ethics Committee (Appendix 6). Throughout the study, respect for autonomy and dignity of persons was met through maintaining privacy and confidentiality, obtaining informed consent from participants and ensuring self-determination (Appendix 4). Maximising benefit and minimising harm was achieved through ensuring the participants were well informed, confidentiality procedures were adhered to and all data was anonymised and stored securely using password protected USB’s in accordance with University of Surrey guidelines based on the data protection act (Parliament, 1998). It was ensured that participants received adequate time to read the information sheet offering details of the study and were provided with the opportunity to ask questions. They were reminded of their right to opt out of the study and withdraw, without any negative consequences. This aimed to avoid exposing participants to distress. Furthermore, debriefing at the end of the interview and offering space for questions to be raised. Two of the participants were known to me prior to this research. The ethical implications of this was carefully considered before proceeding; including any
assumptions I might hold around their experiences as well as possible power dynamics. As a CoP researcher, I was mindful of the potentially harmful effects of contextual factors including power and attempted to address these through these ethical research practices (Kasket, 2012).

**Findings:**

Four main themes were identified during the analysis: “Power negotiation”, “Parental role in therapy”, “Parent’s ambivalent attitude towards therapy” and “Parent’s relationship to therapeutic boundaries”.

Identifiable information within the extracts used have been removed in order to maintain anonymity. Some extracts have been modified to enhance readability but have been documented with symbols to note this (Appendix 10).

**Theme and Sub-Theme overview (Diagram 1):**
Power negotiation

Research and theory reflects that childhood is a time of conflict between dependency and independence (Holmes, 1996). As a result of children’s dependence upon them, parents hold a large degree of control over the child. This power dynamic appeared to be significant within the perspectives shared by therapists of how parents impacted the therapeutic alliance. Although therapists did not directly comment on this, their insights around the child being dependent on the parents to bring them to therapy, and potentially pay for it, highlighted parents’ control over the relationship. This was illustrated in Participant C’s account as she described the reality she had experienced in which, without the parent’s engagement, no therapy is able to take place:

“If I don’t have the parent on board, they’re not going to bring the child to therapy and you are not going to see them” (Participant C)

This quotation depicts parents as holding a powerful position, as it appears Participant C felt that without building rapport with the parent there was an obstacle to the alliance, because the parent may not bring the child to the session. It appeared that from the therapists’ perspective, they needed to be mindful of the parent’s position of power and establish alliance with the parent before it was possible to form an alliance with the child. The way in which the therapists’ described their experiences appeared to bring to light that careful negotiation was required to manage the relationship and power dynamic with the parents of their clients. Participant C noted the importance of finding a way to work with the parent even when they held a different perspective:

“You don’t want to alienate the parent even if you think they’re wrong” (Participant C)

It seems there is an underlying communication that there was a pressure on therapists’ to find a way to establish a positive relationship with the parent, even when their agenda or understanding of the work differed from that of the therapist. It seemed that without an alliance with the parent, which facilitated attendance and engagement, there was no opportunity to form an alliance with the child. This
illustrates the way in which perceived parental power can be viewed as impacting the alliance.

However, therapist perspectives highlighted that power in the relationship was not exclusively held by the parents. It seemed that power was negotiated between parent and therapist. This was particularly evident when participants reflected on managing safeguarding issues in their work. In such circumstances, therapists were perceived as holding a powerful position as their actions, in relation to child protection concerns, could affect the parents’ custody of the child. It seemed that, in this instance, it was the parental response to the therapist’s power that was regarded as impacting the alliance. This was illustrated across a number of participant accounts, including participant E:

“Where I have noticed serious rupture in the alliance is when social services are involved because of the safeguarding issue, and then the parent, understandably, sometimes gets very angry and hostile towards me as the therapist, and the therapeutic relationship”

She goes on to explain that:

“It’s a rupture in the therapeutic relationship, not only in the relationship with the parent” (Participant E)

These extracts appear to highlight the difficulty in negotiating power within this context and resulted in rupturing the relationship with parent and, as a consequence, the alliance with the child. This appears to demonstrate the power the parent has, perhaps unknowingly, over the child’s relational engagement in the therapy, not only their physical attendance.

This theme suggests that parents impact the alliance, not only through the power that they may hold, but through the negotiation of power in the relationship with the therapist and their response to this. It is noted that how participants perceive parents to impact the alliance through this negotiation of power, is likely to be shaped by the contexts of their experiences. For example, the power that the parent could assert financially is only relevant to those therapists working in private practice.
Whereas, for those therapists working in community settings or schools, the power dynamic around child protection issues seemed to be more pertinent.

**Parental role in therapy**

As the participants described their perspectives of working with children and their parents, it was observed that the behaviours and responses of parents seemed to fall within two broad categories. Several participants described the positive and active engagement of parents. Others reflected on experiences of parents as somewhat failing to engage, possibly due to their own difficulties. However, in both instances, there seemed to be an acknowledgement that their role had shifted from being purely a parent. Some parents were viewed as taking on the role of a co-therapist, whilst others were perceived as moving into the position of an additional client. To illustrate these perspectives and their differing impact on the *alliance*, this theme was divided into two sub-themes; ‘parent as co-therapist’ and ‘parent as an additional client’.

**Parent as co-therapist:**

Four of the therapists described parental behaviours including a supportive attitude to the work and active encouragement of participation. It was noted by several participants that parents were seen as a helpful tool that could promote and support the therapeutic work that took place between therapist and child. It is such engagement which seems to be well described as co-therapist behaviours (Fuggle, Dunsmuir & Curry, 2013). Participant B’s comment suggested that when the parent was able to explicitly show their support for the therapy, they were encouraging the child to engage:

“If the parent is very supportive of the therapy and says, I think this is a good thing, it’s a positive thing, then they are reinforcing . . . this is something to help you” (Participant B)

This suggests that the parent’s supportive attitude played a role in supporting the work. This may have been the result of allowing the child to develop trust in the relationship. However, the accounts shared by therapists described more than parents
holding a positive attitude to the work, they seemed to reflect the value of an active therapeutic role, and it was this which in turn helped to facilitate the **alliance**. As participant A implies in her account, parents were viewed as playing an important part in the facilitation of the work outside of the therapeutic context:

„Often it's about looking after their emotions and relationships, and the way they[the child] see themselves in the world, and that's really delicate work, and it does need to be held and understood by the people who are closest to them. I can't do that on my own because I'm only there in that space” (Participant A)

Participant A’s view communicates the important role parents have in supporting the child’s emotional development and the impact this has on the success of therapy. This could be regarded as serving an important role in supporting the **alliance** because with parents providing an approach which is consistent with that employed by the therapist, there is a communication to the child that it is safe to engage and supports the development of trust in the relationship with the therapist (Bachelor, 1995). This demonstrates how parents’ role as co-therapists can be viewed as supporting the **alliance**. This is further illustrated by participant D’s view that children require support in accessing the therapy and applying what they learned outside of the therapy room:

„For a child of 8 to go [to therapy] on their own, they wouldn't be able to use it, they need someone to scaffold that, so that they're able to make use of it” (Participant D)

It seems that through supporting and scaffolding the child’s learning, the parents were viewed as supporting the **alliance** as they were promoting engagement and trust in the therapy due to the child's increased understanding. This sub-theme demonstrates that from the therapists’ perspective, when parents occupied the role of co-therapist there was a great potential for a positive impact on the **alliance**, through their support of the work and role in building trust.

**Parent as additional client:**

In contrast to the co-therapist role, some participants perceived a number of parent behaviours as being unhelpful in relation to promoting their **alliance** with the
child. These behaviours included, bringing their own difficulties to the therapy, taking up the therapeutic space and the therapists’ time. When consolidated, these behaviours seemed to present the parent as an additional client. Therapist’s perspectives highlight that this role impacted the alliance in a negative way. Participants described that when the parent brought their own difficulties it limited the child’s sense of entitlement to the space:

“It did need a lot of definition of the boundaries about who’s working with the mother who’s working with the child and I, I do feel for the parent because for each parent who has this needy attitude they obviously need some support too but it can’t be the support that I can give them.

How did that or did that have an impact on the relationship with you?

They were quite confused initially about to whom I belong” (Participant E)

As noted by participant E, when the parents needs appeared to be permeating into the therapeutic space, this could negatively impact the alliance because of its impact on the child’s understanding of what the space is for, which might interfere with collaboratively agreeing goals and tasks (Bordin, 1979). It was noted that some parents who were experiencing their own difficulties required additional support. This was evident in participant A’s comment:

“Some parents won't need as much supporting through the process where individual work is happening, and other parents will need a lot of support and will be very anxious. They may even need sessions for themselves intermittently ... so that they can actually talk about some of their own anxieties but unless that dynamic is addressed, the therapy with the child could be tricky, so it's a balance” (Participant A)

It seems that in the circumstances described by participant A, attempting to simultaneously support the parent and the child could create difficulties within the therapy with the child. The balance she refers to seems to highlight the tension in finding appropriate ways to support the parent without this detracting from the time available to work with the child. Particularly as in the examples discussed by participants, they were only contracted to work with the child. This seems to
demonstrate one way in which parents impacted the alliance between therapist and child through reducing the time and opportunity available to build their *alliance* with the child. Within this theme, the context of the therapists’ and their work appeared particularly salient. This is because despite the proposed negative impact of parents occupying the role of an additional client and potentially taking away from the child’s experience, it seems that in many instances, therapists did not feel parents had anywhere else to share their distress. Participant E described that this lack of support or care available to parents meant that she had to adapt her way of working as a result of the distress she witnessed in the mother of her client:

“She really wanted to see me to discuss this with me . . . for that specific occasion I had to change my way of working because I could see the desperation from her” (Participant E)

For those therapists working in a community setting, it seemed a particularly difficult position to negotiate as there were such limited alternative opportunities for parents to engage in their own therapy or to access support. As noted by participant E, it was necessary to find a compromise between maintaining the child as primary focus, and also responding to the present distress of the parent. It seems this placed the therapist in a difficult position where her response to the parent might contribute to the impact on the *alliance* through reducing the time available for the child.

This theme highlights the impact of the roles parents might occupy during therapy and their impact on *alliance*. It also suggests that these roles are, in part, the result of wider contextual factors for example the lack of available parental support. In addition, it demonstrates that parental impact on the *alliance* may not always be direct, but may be mediated by therapist responses to the parent (i.e. allowing them to relate as an additional client or supporting them in the role of co-therapist).

In line with this, an important reflection involves considering what shaped the therapists’ perspectives in relation to this theme. It seems that the co-therapist sub-theme was more prominent with those therapists who worked predominantly in private practice. One way to understand this difference is that within private practice there may be more time to offer support and encouragement of co-therapist behaviours and greater freedom to build a collaborative relationship with the parent.
Whereas for practitioners working within community settings, which are often characterised by high levels of pressure generated by long waiting lists, may limit the time therapists have to support parents as co-therapists. In contrast, participants who worked largely in community settings shared more experiences of parents as additional clients. This difference could be interpreted as a result of the wider social context. It suggests that the setting of the therapy plays a role in affecting the way in which parents interact with the therapeutic process, but also the way in which therapists perceive parents impact on *alliance* to manifest.

**Parents’ ambivalent attitude towards therapy**

The tension between parents acknowledging their child’s need for support but being unable to fully engage, was a view widely shared by participants. Their perspectives on the therapeutic encounter appeared to highlight that parents’ ambivalence limited the child’s sense of safety in the therapeutic environment and, as a result, impacted the *alliance*. Within this broader theme depicting parents’ ambivalence, a separate sub-theme of ‘child’s loyalty to parent’ was created to provide a space to consider the child’s response to this parental ambivalence and the impact of this.

When considering parents ambivalence towards the therapy, it seemed participants regarded it as impacting how supportive and engaged in the work parents could be. This is illustrated by participant E:

> “At the beginning there was a bit of hesitation from the parent to allow their child to have therapy and for them to engage in their child’s wellbeing”

(*Participant E*)

The hesitation described by participant E appeared to be characterised by anxiety and an uncertainty about whether therapy would be valuable. Given the influence parents have over their children’s attitudes (Jodl, Michael, Malanchuk, Eccles & Sameroff, 2001) it is likely that if the parent is hesitant, the child may be too. As a result, this might limit their engagement which could negatively impact the
alliance (Karver, Handelsman, Fields, & Bickman, 2005). This impact was also noted by participant A, who highlighted that the parents ambivalence towards the therapy can be regarded as sabotaging the therapy. It seems to demonstrate how the parent’s uncertainty can infiltrate the child’s sense of confidence in the work and permission to engage:

“If there is] some kind of sabotage maybe going on in the background, and if a child becomes aware of that, maybe finding that the child is starting to close up again because, [they are not sure] ‘is this ok? Is this actually ok? Because when I come out of therapy, my mum and my dad are not that happy, what’s this about? Do they want me to come or not? Am I saying the wrong things?’” (Participant A)

Participant A’s description of the child’s response illustrates how parents’ ambivalence can negatively impact the alliance through generating uncertainty and lack of trust in the therapeutic process (Bachelor, 1995). In line with this, additional perspectives suggested that parental ambivalence could impact how far the child was able to feel comfortable in the space. This is demonstrated by participant B who highlights the way in which parental ambivalence could influence what the child could bring to therapy:

“The mother's anxiety [about the child attending therapy], I feel, is not contaminating the therapeutic alliance, but it is contaminating what could be brought to the session” (Participant B)

While she explains that it did not directly impact the alliance, it seems that the parents’ anxiety, impacts the extent that the child could share their difficulties. Without the child bringing their problems freely, suitable goals cannot be developed. It is in this way that alliance could be impacted as setting appropriate goals form an important aspect of the alliance (Bordin, 1979).

It seems that parents’ ambivalence arguably has a mediated impact on the alliance through its bearing on the child’s sense of freedom and safety to share.
Child’s loyalty to parent:

A number of therapists commented on the child's’ loyalty to their parent which appeared to be triggered by the ambivalent attitude towards therapy. This seemed to interfere with the *alliance*. It was noted that if the therapist was encouraging engagement but the parent remained ambivalent, then the child was presented with a dilemma. This was illustrated by participant E’s comment:

“*Who am I going to support as a child, my therapist or my parent?*” (Participant E)

Whilst within the perspectives shared, loyalty was not explicitly demanded by the parent, it seemed to be implicitly evoked in the child by the nature of the situation. This is because children usually attend therapy over the course of a number of weeks, whereas they are likely to remain within the environment of their parent for many years. This may result in children choosing to support their parent and, as a result, sharing their parent’s ambivalence towards therapy. This was noted by participant E. She shared how she attempted to manage this sense of ambivalence through encouraging reflection:

“I make sure the child has space to explore their ambivalence to the *relationship with me or the therapy, but it does feel like walking on eggshells and very fragile, it’s very exhausting*” (Participant E)

Participant E’s description of her attempt to manage this obstacle to the *alliance*, and the therapy as a whole, highlights that this process did not appear to be straightforward. Her experience demonstrates the challenges inherent in negotiating a triadic relationship and the energy this might consume for all involved. This links to the quality of the *alliance*, as with energy being spent elsewhere, the *alliance* may be compromised (Feinstein et al., 2009). Within the accounts of other participants, their perspectives seemed to coalesce around a view that the child’s loyalty could negatively impact the *alliance* as it impacted engagement with the goals and focus of therapy. Participant B described that if the child begins to feel that the parent might be upset by the relationship between the therapist and child, or the topics discussed, they might find it more difficult to engage in it:
“I felt [the therapy] could only go so far because there was no way that child would ever say anything negative about his dad especially because his mum left him when he was a baby so it was like, ‘that’s all I've got’ I guess” (Participant B)

As demonstrated by this example, wanting to remain loyal to their parent seems to result in the child not being able to fully engage in the work or form a collaborative bond with the therapist, a central tenet of alliance (Krupnick et al., 1996). This illustrates the way in which parents’ impact on the alliance might be mediated by the child’s loyalty to their ambivalent position.

This theme offers some further insight into how parents are perceived by therapists to impact the alliance. It demonstrates that parental ambivalence and a child’s loyalty to supporting this position was viewed to interfere with the core elements of the alliance being implemented.

Parents’ relationship to therapeutic boundaries

It has been found that providing clients with clear consistent boundaries can provide a sense of safety and facilitate the therapeutic encounter (Borys, 1994). Although parents relationship to therapeutic boundaries was viewed by participants as an important way that they impacted the alliance; it seemed to be spoken about in two ways. Some participants were aligned with Borys (1994) and regarded boundaries as important in maintaining safety, and that parents could negatively impact the alliance by intruding upon the boundaries. In contrast to this, a number of participants reflected that, when working with children, there was value in upholding a flexible approach to boundaries. They described how this enabled a greater degree of open communication with parents and that this positively impacted the alliance. As a result, this theme has been divided into two sub-themes to explore their differential impact on alliance; one being ‘Parental intrusion of therapeutic boundaries’ and the second being ‘Parents engagement in communication and flexible boundaries’.
Parental intrusion of therapeutic boundaries:

Maintaining therapeutic boundaries was viewed by many participants as providing containment to the child and their difficulties. The therapists’ perspectives emphasised that offering this consistency helped to facilitate trust in the relationship and contribute towards a strong alliance. As reflected in the perspective of participant A, the maintenance of boundaries created a sense of safety:

“I think it is about that holding … and feeling the therapist is confident about these boundaries and therefore that makes for the safe space” (Participant A)

It seems that the safe space she describes provides an environment conducive to establishing a bond with the client which is an important element of the alliance (Bordin, 1979). When parents were perceived as behaving in ways that were felt to be intrusive, for example putting pressure on the child to disclose what they had discussed or attempting to engage the therapist in ulterior agendas for the work, this was perceived as negatively impacting the alliance. Participant E described how such invasive behaviours by parents might do this, as she noted its effect on the child’s understanding of their privacy and limited how much they shared in therapy:

“It impacts how they can experience their own privacy which might then be transferred in the therapeutic relationship because they might think that I might be talking to their parents telling them [what is happening], therefore there might be a bit of hesitation in how much they share” (Participant E)

Participant E’s acknowledgement of the child’s hesitation also implicates a lack of trust in the therapist. This is significant given the important role of trust in strengthening positive affective bond which is an important tenet of alliance (Bordin, 1979). This is further supported by Participant E’s reflection that when boundaries are not respected by parents, it damages the extent that a child feels their difficulties are contained:

“When boundaries leak everywhere, symbolically, the space is not shared; the space is taken by one person from the system” (Participant E)
The therapists’ perspectives highlighted that the parents’ lack of respect for this boundary meant that the child no longer felt like the space was their own. This might create a degree of confusion about how much freedom they had to express what was really going on for them which in turn could damage the alliance. The view was shared that in certain instances, it was important for the child to have a space which was separate from the parent in order to engage and form a strong alliance:

“Perhaps it's hard for the child to be able to talk with a parent [in the room], this is when it's useful to see the child on its own because they won't be able to say what they need to say because the parent is there. Domestic violence, tricky divorce all that kind of stuff falls into that category” (Participant C)

It is implied in participant C’s comment that without boundaries that are respected by the parent, it could leave key difficulties unattended to. This is likely to have implications for the alliance because it would mean the goals for the work would not be accurate and the therapy would not be addressing the prominent issues. It seems therefore that parents have the potential to positively impact the alliance if they respect boundaries but negatively if they intrude upon the child’s space.

Parents’ engagement in communication and flexible boundaries:

The view that holding a position of flexibility and communication positively impacted the alliance was shared across many accounts. When parents respected the child’s space, but were appropriately involved, it was suggested to be valuable in fostering trust, and promoted psychoeducation for the parent. This, in turn, enabled the parent to provide a supportive parent-child relationship. This was illustrated by the perspective of participant A:

“It’s not helpful for a child to go in to individual work with absolute . . . rock solid confidentiality. Because I think that can disconnect them from the family, and if the family doesn’t know anything about that work, then they can’t support the child appropriately” (Participant A)
Participant A highlights that, in her experiences, maintaining an inflexible boundary was not advantageous for the child’s wellbeing or the alliance. There is an acknowledgement within her statement of the crucial role parents play in supporting the work. This cannot be utilised if they are kept completely separate to it. This was further demonstrated in participant A’s comment regarding the importance of appropriate communication between therapist and parent:

“[There is a] fine line around confidentiality and consent and what that's for, and the meaning of that to children and families, that yes of course you need consent, you need confidentiality, but you also need communication” (Participant A)

Participant A demonstrates the value of striving to achieve a balance between boundaries which offer containment, and communication which offers support. It seems that it in establishing a balance between these positions, the alliance can be supported. Participant D also perceived communication to be important. She noted the value of encouraging openness and communication between therapist, parent and child:

“I just think parents are the ones who are helping their child … even if there's tension or issues I want them to talk about it, it's better for them to be talking about it with each other [rather] than me really” (Participant D)

Participant D’s statement illustrates the importance of strengthening the parent-child bond, through communication. It seemed that through operating in this collaborative way, the therapists’ felt the child could feel secure that the parent and therapist were working together. As a result, the child was not required to manage tension between the parent and therapist. It seems that this positively impacted the alliance, through facilitating the child’s belief that it was appropriate for them to form a bond with the therapist and allowed them to engage more confidently in the therapy.

It is important to note that the sub-themes presented were not mutually exclusive; most therapists’ shared both perspectives demonstrating that different situations might require different responses to boundaries. This theme offers insight into the importance of how parents relate to the boundaries of the therapy and how
this is viewed to impact the *alliance*, but again demonstrate the importance of considering this within the wider context.

**Discussion:**

The current research aimed to explore therapist’s perspectives of how parents impacted the therapeutic alliance when working with children. It was found that the way in which therapists perceived parents as impacting the *alliance* took many forms and was shaped by the context of their experiences. These themes are now considered in relation to existing research.

The “power negotiation” theme illustrated that parents were viewed to impact the *alliance* through the control they held over giving consent and bringing the child to therapy. This builds upon the findings of Campbell & Simmonds (2011) who noted how practical issues which parents had control over, including payment and attendance, could affect *alliance*. The findings of the current study appear to offer more detail regarding how these practical issues manifested and were experienced by therapists. It seemed the impact of parental power was not always direct, but was mediated by the effect it had on therapist behaviours. In response to perceived parental power, it was viewed that therapists could feel under pressure to ensure they establish a positive relationship with the parent. It seemed that without this, there was an expectation that it would limit the likelihood of consistent attendance and engagement and, as a result, impact the *alliance*. This is in line with existing research emphasising the contribution of parent-therapist alliance to outcomes of therapy (Hawley & Weisz 200; Kazdin et al., 2006). However, the current findings suggest that this contribution to outcome may be as a result of parent’s impact on the *alliance*. The negotiation of power between therapist and parent was viewed to affect the child’s sense of safety and trust in the relationship, limiting the strength of the *alliance*. This finding is supported by research that demonstrates the importance of trust in developing the therapeutic alliance (Bachelor, 1995; Baylis, Collins & Coleman, 2011). This theme offers insight into how power might operate within this triadic relationship and play a role in impacting the *alliance*. While it may not be possible to entirely avoid these interactions of power, being aware of the way in
which it might operate can allow practitioners to respond appropriately, through building a positive alliance with parents whilst keeping the child at the centre of our practice.

Therapists’ perspectives also highlighted that the role parents occupied during the course of therapy, impacted the alliance. When parents were perceived as an “additional client”, therapists indicated that this negatively impacted the alliance. This was because they perceived the parent bringing their own difficulties reduced the time available for the child and could generate confusion as to whom the space belonged. Although not directly related to alliance, this is partially supported by findings that parental history of difficulties including anti-social behaviour and adverse child rearing practices, along with the stress associated with socio-economic disadvantage, was related to higher dropout rates of children in therapy (Armbruster & Kazdin, 1994). This offers some support to the view that unsupported parental difficulties have the potential to negatively impact the therapeutic process including the alliance.

In contrast to this, when parents acted as “co-therapists” and held a supportive attitude to the work, therapists viewed this to facilitate alliance. It seemed that the co-therapist role helped to scaffold the child’s learning and processing, allowing them to better access the therapy and, in this way, strengthen the alliance. This is supported by the findings of Howgego et al. (2013) who noted that if the child is better able to understand the process of therapy, this facilitates the development of trust, leading to a stronger alliance. Overall, it seems that the theme of “parental role in therapy” offers an understanding that can support therapeutic practice through highlighting the way in which the roles parents might take within the therapy can support or damage the alliance. It offers therapists working with this population an insight into the benefits of, where appropriate, involving the parent as an active supporter of the work and promoting a dialogue between therapist and “co-therapist” to support alliance and potentially the outcomes of therapy.

Participants also noted that “Parents ambivalent attitude towards therapy” could discourage children from engaging. This was viewed to negatively impact the alliance because it reduced the opportunity for the therapist to build a bond with the
child and limited the focus on appropriate goals when the child did not fully share
their experiences. This offers further support to the finding of Campbell and
Simmonds (2011) who highlighted that parental commitment to and support of the
therapy was essential for the development of alliance. However, the finding that
therapists regarded this to be partly mediated by the child’s loyalty to the parent,
extends the findings of Campbell and Simmonds, through offering new insight into
how this support, or lack of support, impacts alliance. Therapists’ perspectives
recognised that at times, parental ambivalence led children to withdraw from the
therapy and the affective bond with the therapist in order to support their parent. This
finding arguably demonstrates the importance of considering the parents’ perspective
when beginning work with the child and gaining their support. This is because the
parent can have a powerful influence on how, and to what extent, the child engages in
the relationship, which is important for positive outcomes (Fjermestad et al., 2016).

Therapists’ perspectives also highlighted how parents could impact the
alliance through their “relationship to therapeutic boundaries”. Parents, who engaged
respectfully with therapeutic boundaries and were supportive of open communication,
were regarded as positively impacting the alliance. This is in line with research which
emphasises the importance of flexibility and open communication when working
therapeutically with children (Campbell & Simmonds, 2011; Geldard & Yin Foo,
2013). It was viewed that facilitating flexible and communicative boundaries enabled
the child to be more open to the relationship with the therapist and build a strong
alliance. This seemed to be a consequence of children not having to manage concerns
around secrecy, and through enabling parents to be better placed to support
therapeutic goals. This finding appears consistent with the assertion made by Robbins
et al. (2003); that alliance operates at a systemic level and therefore it is important to
consider alliance in relation to the wider relationships and promote appropriate
collaboration.

However, it was also noted that when parents were viewed as intruding upon
the therapeutic boundary, this negatively impacted the alliance. This is in accordance
with existing research that emphasises the therapeutic frame and confidentiality of the
relationship as being key to the development of the therapeutic alliance (Catty, 2004).
However, while Catty reviewed evidence pertaining to adult therapy, the present
findings demonstrate that, based on therapists’ perspectives, this also seems to be important in therapy with children. Research has suggested that without protecting the therapy as belonging to the child, their difficulties are unlikely to feel held and contained (Raval & Smith, 2003). However, confidentiality and boundaries should serve therapeutic ends. Therefore, boundaries should help to define the communication that is possible, rather than completely prevent it (Feinstein et al., 2009). It seems that through doing this and making boundaries clear; collaboration can be improved and the alliance strengthened. This theme draws therapists’ attention to the continued importance of managing the therapeutic boundary. However, even more than with adults, it emphasises the value of holding a position of curiosity. This is because this allows the therapist to thoughtfully respond to the particular context of each child, and in so doing aim to facilitate the alliance.

The themes explored here present the impact of parents as embedded within social contexts. Parents’ socio-economic background and their own emotional/psycho-social difficulties were highlighted as important factors in the way that they impacted the alliance. It was noted that without their own resources it was more challenging for parents to positively support the alliance. This demonstrates the importance of not only working directly with children but also working on wider early intervention strategies which engage the family and operate at a societal level. Through supporting parents and facilitating their understanding of the child and their current difficulties, we can avoid perpetuating a system which attempts to ‘fix’ the child but simultaneously return them to a ‘broken’ system.

Collectively these themes have important implications for the development of CoP’s who work with children, through deepening our understanding of how parents impact the alliance it can contribute to our capacity to work with this effectively. This is important given our obligation to ensuring our competence in working across the lifespan (Sugarman, 2010). For individuals who work with children, these insights may not be entirely novel. However, as CP’s we aim to be led by a research base grounded in professional practice, therefore; the gap within existing findings warranted the exploration and documentation of these perspectives (BPS, 2015).
Reflections:

As noted within the findings, it seemed that the context in which the therapists were working played a role in shaping their perceptions of how parents impacted the alliance. Interestingly the training background of therapists was not regarded to have this impact. The sample in the current study consisted of two clinical psychologists, one counselling psychologist and two psychotherapists. The underlying philosophies and training involved in these professions have both similarities and differences, including the extent to which they train in multiple therapeutic approaches and the way in which they understand and conceptualise mental health difficulties (Davy & Hutchinson, 2010; Strawbridge & Woolfe, 2010). As a consequence, during both the interview and analysis stage, I was mindful that the training background and professional identity the participants held may shape the way in which they perceived how parents impacted the alliance. However, the findings did not reflect this. One way to understand this is through considering that many of the participants had been qualified and working with children and young people for more than ten years. Therefore, it could be that factors which initially may have been perceived to be differences between professionals were outweighed by the values they shared including being child focussed, viewing the child holistically and considering the child in their broader environment. This contributes to understanding why the context of their work may have been perceived to have a greater impact on the perspectives, rather than the training background.

Evaluating the research

It is possible to evaluate the current study in relation to the flexible and open ended ways of assessing the quality and utility of qualitative research set out by Yardley (2000). This study aimed to demonstrate sensitivity to context through referring to relevant literature and maintaining a focus on participant’s perspectives. Using Braun and Clarke’s (2006) 15 point checklist, to guide and evaluate the analysis, supported methodological competence in the study. Furthermore, attempting to clearly describe the rationale for how the study was conducted and how this led the data to be presented in this way aimed to evidence transparency and coherence.
Providing links as to how the current findings can inform the work of practitioners and enhance their confidence and competency when working with this client group intended to demonstrate the impact and importance of the topic (Kasket, 2012).

Limitations

One element of the current study which could be raised as a limitation was that all the participants were women. This was not an intentional decision but might instead reflect the disproportionate balance of females working within the field of psychology and, more specifically, with children (Health Education England NHS, 2016; Willyard, 2011). It is important to note that this feature of the sample may have contributed to the themes and perspectives described. Additional research with a more diverse sample would help to clarify whether, and in what way, this has shaped the current findings. It is acknowledged that this feature of the sample, along with its small size, limits generalisability. However, it remains important to consider the perspectives explored as valid but with an acknowledgement of the limits of their application. Furthermore, given that alliance is considered to be an interpersonal construct, simultaneously researching and analysing the perspectives of the parent or child could have offered a richer understanding of this construct. Unfortunately, as a result of the limitations imposed on the scale of this study and the available time, this was not possible. However, future research could consider these additional perspectives to provide further insight into this topic.

Future research

Within the current data there was an underlying communication that socio-economic background and context made a difference to the types of issues experienced, and that it changed both how parents engaged, and how therapists responded. Therefore, future research might consider how factors which impact alliance when working with children vary according to setting (private vs. community context). The current study has demonstrated that therapists view open communication and collaboration with parents to be important contributors to a strong alliance. However, information regarding parents’ experiences of the therapeutic
process remains limited. Future research that could help to develop a better understanding of what is it like for parents to have a child in therapy and how they can feel best supported could promote this collaboration, strengthen *alliance* and improve outcomes.

**Conclusion**

This research provides a description and summary of key features of the therapist’s perspectives of how parents impact the *alliance*. The themes in the current study draw attention to the way in which context serves to shape the way parents impact the *alliance*. As noted by Feinstein et al. (2009) developing a strong therapeutic alliance with children and with parents requires more than attending to these relationships individually, they must be considered together as part of a wider system and within a broader context. Currently, child focussed work appears to exist within a high pressure climate characterised by risk averse clinical systems that place increasing demands upon therapists that they are expected to achieve under constrained amounts of time. This seems to create an environment which impacts parents’ engagement in addition to impacting how therapists are able to effectively support the children they work with. Forming a better understanding of the processes of parental impact on *alliance* and the experiences of therapists is relevant to the field of CoP as further knowledge and understanding is necessary in order to help us identify steps toward providing improved clinical care to this client group. The findings have highlighted the importance of working with parents to empower them to promote the child’s growth and development in collaboration with the therapist, and, as a result, positively impact *alliance*. 
References:


Appendices to Year 2 empirical study:

**Appendix 1 : Example of recruitment email**

Dear (INSERT NAME HERE)

Hi, my name is Emma Fredman, I’m e-mailing you about a study that I’m conducting as part of my Doctorate in Psychotherapy and Counselling Psychology at the University of Surrey. The study is about the therapeutic relationship when working with children and how their parents might impact this relationship. The study involves taking part in an interview regarding your experiences and thoughts on this topic. The interview will last for approximately 50 minutes. Participation is confidential and voluntary. Also, you can withdraw within an agreed time frame if you change your mind. This study has been approved by the University of Surrey Faculty of Health and Medical Sciences Ethics Committee.

If you would like to participate, or have any questions about the study please contact me via phone or email to receive more detailed information and arrange a suitable time.

Thank you for your time.

Emma Fredman
Appendix 2 : Participant information sheet

Participant Information Sheet

What are therapists perspectives of how parents' impact on the therapeutic alliance when working with children?

Introduction

I am a Counselling Psychology PsychD student and would like to invite you to take part in a research project. Before you decide you need to understand why the research is being done and what it will involve for you. Please take the time to read the following information carefully and ask questions about anything you do not understand. Talk to others about the study if you wish.

What is the purpose of the study?

This study seeks to gain an understanding of therapists’ perspectives of how parents can impact the therapeutic alliance when working with children. Research has demonstrated the importance of therapeutic alliance in achieving successful therapeutic outcomes. It has been established that a number of factors impact the therapeutic alliance when working with children, including parents. Therefore the purpose of this study aims to gain an understanding of the ways in which parents might have this impact on the alliance. It is hoped that through discussing your experiences of working with children and building and maintaining a therapeutic relationship that some insight into this process might be gained. The aim of this research is to speak about your experiences to see if there are any common themes that emerge. Out of this I hope to write up the research for my Professional Doctorate in Counselling Psychology at the University of Surrey.

Why have I been invited to take part in the study?

You have been invited to take part in this study because you are a therapist who has indicated that you work predominantly with children in your therapeutic practice.

To be eligible to take part in the study, you must meet the following criteria:

- Have worked with children for at least 3 years following qualification
- Have worked with children on a 1 to 1 basis
- Have worked with children between the ages of 6 and 12

Do I have to take part?

No, you do not have to participate. There will be no adverse consequences in terms of your legal rights, that is, if you decide not to participate or withdraw at a later stage. You can withdraw your participation at any time. You can request for your data to be withdrawn until May 2017 without giving a reason and without prejudice.
If you withdraw from the study this will mean the following for your participation and data*: Identifiable data already collected will be withdrawn from the study. No further data would be collected from you.

**What will my involvement require?**

If you agree to take part, we will then ask you to sign a consent form. If you do decide to take part you will be given this information sheet to keep and a copy of your signed consent form. The research will last 5 months but your involvement would only be a 45 – 60 minute interview on one agreed day.

**What will I have to do?**

I would like to interview you for approximately an hour regarding your experiences of working with children in relation to forming and maintaining the therapeutic alliance and how parents can impact this. The interview will be recorded and then I will transcribe the interview. The transcription will then be looked at individually and then in relation to other transcription.

**What will happen to data that I provide?**

Research data are stored securely for at least 10 years following their last access and project data (related to the administration of the project, e.g. your consent form) for at least 6 years in line with the University of Surrey policies.

Personal data will be handled in accordance with the {UK} Data Protection Act (1998).

**What are the possible disadvantages or risks of taking part?**

During the course of the interview you may find that speaking about your experiences makes you aware of things which feel difficult or brings things up that are upsetting for you. There will be a chance to talk about this after the interview, or I can provide you with details of where you can find appropriate support if you would like to discuss any topics or issues that arise in more depth.

**What are the possible benefits of taking part?**

The participants involved may benefit from the research through their cumulative input provide a step towards better understanding the therapeutic relationship when working with children and therefore have useful information which they might use to positively inform their practice as therapists/psychologists.

**What happens when the research study stops?**

The researcher will use the data collected to write up a research report which will be used as part of the fulfilment of her PsychD in counselling psychology.

**What if there is a problem?**
Any complaint or concern about any aspect of the way you have been dealt with during the course of the study will be addressed; please contact Emma Fredman, Principal Investigator via e.fredman@surrey.ac.uk in the first instance or my Supervisor Lucy Gorvin l.gorvin@surrey.ac.uk. You may also contact someone who is independent of the research team, e.g. Head of School, please see address below. If you remain unhappy you can file a complaint using the complaint procedure, e.g. Clinical Research Centre.

School of Psychology Address:

School of Psychology
AD Building
University of Surrey
Guildford
GU2 7XH

School of Psychology tel: +44 (0) 1483 689 436

The University of Surrey holds insurance policies which apply to this study. If you experience harm or injury as a result of taking part in this study, you will be eligible to claim compensation. This does not affect your legal rights to seek compensation.

If you are harmed due to someone's negligence, then you may have grounds for legal action. Regardless of this, if you wish to complain, or have any concerns about any aspect of the way you have been treated during the course of this study then you should follow the instructions given above.

**Will my taking part in the study be kept confidential?**

Yes. Your details will be held in complete confidence and we will follow ethical and legal practice in relation to all study procedures. Personal data [name, contact details, audio/video recordings] will be handled in accordance with the {UK} Data Protection Act 1998 so that unauthorised individuals will not have access to them.

The data you provide will be anonymised and your personal data will be stored securely and separately from those anonymised data. You will not be identified in any reports/publications resulting from this research and those reading them will not know who has contributed to it. With your permission we would like to use anonymous verbatim quotations from audio recordings in reports.

In certain exceptional circumstances where you or others may be at significant risk of harm, the researcher may need to report this to an appropriate authority, in accordance with the {UK} Data Protection Act 1998. This would usually be discussed with you first.

Examples of those exceptional circumstances when confidential information may have to be disclosed are:
- The researcher believes you are at serious risk of harm, either from yourself or others
- The researcher suspects a child may be at risk of harm
- You pose a serious risk of harm to, or threaten or abuse others
- As a statutory requirement e.g. reporting certain infectious diseases
- Under a court order requiring the University to divulge information
- We are passed information relating to an act of terrorism

**Full contact details of researcher and supervisor**

Researcher: Emma Fredman  
Email: e.fredman@surrey.ac.uk  
Supervisor: Lucy Gorvin  
Email: l.gorvin@surrey.ac.uk  
Work Tel: 01483 68 6908

**Who is organising and funding the research?**

This research is organised by the University of Surrey and is un-funded.

**Who has reviewed the project?**

This research has been looked at by an independent group of people, called an Ethics Committee, to protect your interests. This study has been reviewed by and received a favourable ethical opinion from University of Surrey faculty of Health and Medical Sciences Ethics Committee.
Appendix 3: Interview Schedule

1. Could you tell me a bit about what interested you in taking part in my project?
   Prompt: background, work experience

2. I wonder if you could tell me what stands out to you when you think of the ways in which parents might impact the therapeutic alliance between you and the child?
   Prompt: what do you feel is most significant? What is the most common factor in your experience?

3. What aspects of the therapeutic alliance do you feel are impacted by the parent?
   Prompt: boundaries, trust?

4. Do you experience parents as influencing the child’s engagement in therapy?
   And if so how?
   Prompt: attitude to therapy, motivation and collaboration

5. Do you feel parents have a role in how therapy is approached?
   Prompt: who’s agenda is being followed? Who determines the focus of the work? Goals!

6. Does the way in which parents impact the alliance vary across the duration of therapy?
   Prompt: engagement, beginning of therapy, endings pattern of withdrawing etc.

7. In relation to this topic, is there anything you feel we haven’t spoken about that you experience as important?
Appendix 4: Consent Form

Consent Form

What are therapists perspectives of how parents’ impact on the therapeutic alliance when working with children?

Please initial each box

- I have read and understood the Information Sheet provided. I have been given a full explanation by the investigators of the nature, purpose, location and likely duration of the study, and of what I will be expected to do.
- I have been advised about any disadvantages/risks/discomfort/possible ill-effects* on my health and well-being which may result. I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given as a result.
- I agree to comply with the requirements of the study as outlined to me to the best of my abilities.
- I agree for my anonymised data to be used for this study / future research that will have received all relevant legal, professional and ethical approvals*.
- I give consent to my interviews with the researcher to be audio recorded
- I give consent to anonymous verbatim quotations being used in reports
- I understand that all project data will be held for at least 6 years and all research data for at least 10 years in accordance with University policy and that my personal data is held and processed in the strictest confidence, and in accordance with the Data Protection Act (1998).
- I understand that I am free to withdraw from the study at any time without needing to justify my decision, without prejudice and without my legal rights being affected.
- I understand that I can request for my data to be withdrawn until May 2017 and that following my request personal data will be destroyed
- I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate time to consider my participation.
Name of participant (BLOCK CAPITALS) .................................................................

Signed ..................................................................................................................

Date ......................................................................................................................

{Please add a signature and date space if a witness is required}

Name of researcher/person* taking consent ...........................................................

(BLOCK CAPITALS)

Signed ..................................................................................................................

Date ......................................................................................................................
Appendix 5: Confirmation of Ethical approval letter

Faculty of Health and Medical Sciences
Ethics Committee

Chair’s Action

Proposal Ref: 1266-PSY-17
Name of Student/Trainee: EMMA FREDMAN
Title of Project: A thematic analysis of therapists’ perspectives of how parents impact the therapeutic alliance when working with children
Supervisor: Dr Lucy Gorvin
Date of submission: 16th February 2017
Date of confirmation email: 30th March 2017

The above Research Project has been submitted to the Faculty of Health and Medical Sciences Ethics Committee and has received a favourable ethical opinion with minor conditions. Confirmation has been received that the conditions stipulated after ethical review have now been addressed and compliance with these conditions have been documented.

The final list of revised documents reviewed by the Committee is as follows:

Ethics Application Form
Detailed Protocol for the project
Participant Information sheet
Consent Form

All documentation from this project should be retained by the student/trainee in case they are notified and asked to submit their dissertation for an audit.

Signed and Dated: 30/03/2017
Professor Bertram Opitz
Co-Chair, Ethics Committee

Please note:
If there are any significant changes to your proposal which require further scrutiny, please contact the Faculty of Health and Medical Sciences Ethics Committee before proceeding with your Project.
Appendix 6: Example of interview transcript - Extract:

Transcript key:

I = Interviewer

P = Participant

I: I wonder if initially you could tell me a bit about what interested you in taking part in this study? In this project?

P: I think that, I think in general, as in, certainly in private practice, the relationship with the parent is quite crucial I am very interested in relationships anyway because my background is attachment and trauma and family relationships and emotion regulation, so what goes on between people is crucial in terms of how my clinical practice is developed. The therapeutic relationship has become a big focus in terms of way that I work and about how you engage children and that also interested me because I recognise what you were hinting at, in terms of, sometimes the relationship with the parent can impact on the relationship with the child. Or the parent-child relationship and dynamic can have an impact on how the child can work within therapy.

I: So it sounds like really in your experience of how your therapeutic work has evolved that that's become really central, you're really aware of that, that there’s been something going on there

P: Yes definitely

I: You mentioned about, at the end there, of engagement in therapy, do you think that that’s an area that parents have an impact on?

P: I think it is, thinking about the age group that you mentioned so 6 to 12. So with younger children it’s crucial to make a good relationship and good engagement early on and sometimes even have to see the parents first so that they can feel comfortable to introduce the child to the idea of coming to see somebody and perhaps opening up to somebody. Also for, for younger children I guess right through that age group it can be quite useful to understand where the parents are coming from in terms of what anxiety they might hold and how that might impact the child, and that actually if you dive straight in and work directly with the child after, you know, one or two family sessions you might be getting what you what you need in terms of background in the story from each parent, or from one parent about their thoughts and feelings about being a parent, but also their own childhood’s will impact on how they parent their children.
I: There's a sense of something around the parents own anxiety of bringing the child that might have an impact on the therapeutic relationship, but also their own, their own up-bringing in a sense and their childhood and how their child seems to engage in a relationship with you perhaps?

I: Yes, yes I think also sometimes with parents who who've accessed all sorts of different services and different professionals, I think the therapist, so I would need to know some of their stories about interacting with services for therapists and so therefore how they would approach the relationship with me, what their hopes and fears might be. Because what we know from from research and study with parents and children is that their emotions, their attitudes and their view of life and the world, that's going to impact how they accept and receive things, how anxious their children might be about things, so yes I think it's really important to understand where they're coming from and to give them time to communicate that yeah

I: In your experience I wonder if when you’re thinking about the therapeutic alliance and the ways in which parents might impact that impact that, what stands out to you? Is there something specific or is it a range of things?

P: I mean I suppose I work quite a lot with children who are anxious for many different reasons and I think there, there can be a big impact in terms of the parents anxiety and that can impact on what happens in therapy sessions, so how open the child feels like they can be and the attitudes of parents towards maybe their fears or concerns, and therefore how open they're able to be within the sessions and how much permission they feel they have to to talk to me about it. Also I'm thinking about the area of parental separation and divorce. so where you’re working with a child who may have parents who live in different places. One of whom they may not see so often, there may be conflict between those parents and so the child is holding quite a lot within those situations and again that can impact on how the child is able to engage with me and I have to work quite hard to be neutral in those situations. I might have to work quite hard to engage with and hold those parents so that actually therapy can be understood and supported by both of them and that their conflict and dynamic doesn't come into the therapeutic relationship. So they can be quite tricky situations and leave the child in quite a difficult difficult situation

I: It sounds as though there's something there around you being able to allow the child to have that sense of it being confidential space or feeling that trust in the relationship with you, that as you said about permission for them to be able to bring what they're feeling rather than being overwhelmed and holding all the feelings the parents have. Sounds almost as though the parents own feelings have an impact on the relationship with you?
Appendix 7: Counselling Psychology Review Journal Guidelines

Counselling Psychology Review

Counselling Psychology Review is the Division of Counselling Psychology’s quarterly peer-reviewed research publication. It brings together high quality research pertinent to the work of counselling psychologists. It primarily focuses upon work being undertaken in the UK but it is also likely to be of interest to international colleagues and those in related therapeutic disciplines. The content is pluralist in nature, with its focus being on excellent work rather than methodological or paradigmatic preference, and submissions are invited in the following areas:

- papers reporting original empirical investigations (qualitative, quantitative or mixed methods);
- case studies, provided these are presented within a research frame;
- theoretical papers, provided that these provide original insights that are rigorously based in the
- empirical and/or theoretical literature;
- systematic review articles;
- methodological papers related to the work of counselling psychologists.

For more information about the peer review process for this publication please contact the Editor.

Notes for Contributors

1. Length:
Papers should normally be no more than 5000 words (including abstract, reference list, tables and figures), although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

2. Manuscript requirements:
• The front page (which will be removed prior to anonymous review) should give the author(s)’s name, current professional/training affiliation and contact details. One author should be identified as the author responsible for correspondence. A statement should be included to state that the paper has not been published elsewhere and is not under consideration elsewhere. Contact details will be published if the paper is accepted.

• Apart from the front page, the document should be free of information identifying the author(s).

• Authors should follow the Society’s guidelines for the use of non-sexist language and all references must be presented in the Society’s style, which is similar to APA style. For an electronic copy of the Society’s Style Guide, go to the Publications page of www.bps.org.uk and then click on Policy and guidelines/General guidelines and policy documents and choose Society Editorial Style Guide from the list of documents).

• For articles containing original research, a structured abstract of up to 250 words should be included with the headings: Background/Aims/Objectives, Methodology/Methods, Results/Findings, Discussion/Conclusions. Review articles should use these headings: Purpose, Methods, Results/Findings, Discussion/Conclusions.

• Approximately five keywords should be provided for each paper.

• Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc., for which they do not own copyright.

• Graphs, diagrams, etc., must have titles.

• Submissions should be sent as email attachments. Word document attachments should be saved under an abbreviated title of your submission. Include no author names in the title. Please add ‘CPR Submission’ in the email subject bar. Please expect an email acknowledgment of your submission.

• Proofs of accepted papers will be sent to authors as email attachments for minor corrections only. These will need to be returned promptly.

3. Submissions and enquiries should be e-mailed to:

Dr Terry Hanley. Email: terry.hanley@manchester.ac.uk
## Appendix 8: Theme tables and examples of coding

### Theme: Power Negotiation

<table>
<thead>
<tr>
<th>Codes:</th>
<th>Sample Quotes:</th>
</tr>
</thead>
</table>
| Fragility of relationship between parent and therapist | Participant A:  
  - “managing very delicate boundaries”  
  - “I think in private practice the financial side can be can be an issue so again it’s about the therapist being very careful about all those issues”  
  - “whenever you’re in the room with the child or a family you’re also in the room with their parents because their parents do have such a big influence”  
  - “If they (parents) feel that this is something that I am doing with their child and there are no channels like that, that's again where things can get problematic”  
  - “The child can only get to the appointment if the parent brings them it's clearly about the parent because that appointments been agreed and then then then not coming or phoning, my child doesn’t want to come” |
| Parent in control, paying for a service |  |
| Significance of parents involvement |  |
| Maintaining positive relationship between therapist and parent |  |
| Parents control over attendance |  |
| Maintaining positive relationship between therapist and parent | Participant B:  
  - “I tend to have good relationships with parents I tend to really work hard at that because I feel that that's what will support them and for them to feel I’m not someone who’s judging them”  
  - “Parents have to give consent so everything is done with their consent however that consent can be given for lots of different reasons”  
  - “It’s absolutely essential that I build a build a positive attachment with their parents”  
  - “What a parent is actually saying to the child that’s unknown to me”  
  - “The parent pulling the child out of therapy, that had a dramatic impact which was horrendous actually, I’ve never experienced that before there was a disclosure and everything was passed on, the father was furious absolutely furious, I don’t want my child to be in therapy and you know the parent gives consent when you take a child out and I suppose that also feel significant with this age group”  
  - “When I was first newly qualified I was like yeah I’ll sort it out I’ll work it out and hopefully that child will be able to internalise it, now I feel like well actually you are part of the picture and very much to parents actually you have the biggest impact and the biggest influence and this (therapy) is just support”  
  - “Because of Dad’s sort of world view around play opposed to work he could just rubbish it all and I didn’t want to risk that happening so it was sort of more important for the child to have this space because I felt |
<table>
<thead>
<tr>
<th>Topic</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influence of parental attitude</td>
<td>he was so sorted squashed by his dad straight jacketed under control controlling actually he could see in his body was so rigid I just felt he needed space a bit even though he was very ambivalent about that</td>
</tr>
<tr>
<td>Appeasement</td>
<td>• “Well I guess child protection issues because that’s where the therapeutic Alliance is damaged and I have experienced that over the years and that’s really hard because a child comes into therapy, they build a trusting relationship with you, tell you something that then you have to, because I’m bound, I have to share that and then that has a whole chain reaction and then the child can feel, even if I’ve explained everything to the child why I have to tell, the child can feel really sort of the betrayed and that can also lead to breakdown of the relationship with the parent”</td>
</tr>
<tr>
<td>Maintaining positive relationship between therapist and parent</td>
<td>• Parents as gatekeepers to the child</td>
</tr>
<tr>
<td>Influence of parental attitude</td>
<td>• Participant C:</td>
</tr>
<tr>
<td>Power struggle between therapist and parent</td>
<td>• “Coming at a really basic level it’s about the whole process of them coming to therapy in the first place”</td>
</tr>
<tr>
<td>Maintaining positive relationship between therapist and parent</td>
<td>• “If I don’t have the parent on board, they’re not going to bring the child to therapy and you are not going to see them”</td>
</tr>
<tr>
<td>Significance of parents involvement</td>
<td>• “the tone that they talk about it (therapy)”</td>
</tr>
<tr>
<td>Power struggle</td>
<td>• “You don’t want to alienate the parent even if you think they’re wrong because that’s, finding a way to work with it even if they have a different perspective to you, I think all parents really want to have good relationships with their children, so yes we set limits but also how can we support and cultivate that relationship”</td>
</tr>
<tr>
<td>Sensitivity to parents role and avoiding competition</td>
<td>• “I think you can still offer the child a space when the parents are not on board and that doesn’t mean it’s not useful sometimes for the child but, It’s Tricky, it’s not without an impact”</td>
</tr>
<tr>
<td>Potential for power struggle</td>
<td>• “When it’s not working so well and you do feel quite separate from the parent not the right word but well disconnected or that your seeing things very differently then it feels much harder the work feels much harder the and I think there is fear in that”</td>
</tr>
<tr>
<td>Parent in control, paying for a service</td>
<td>• “Also wanting to negotiate with as a therapist and not not become and certainly not become a replacement parent I think there’s something about having very clearly defined roles”</td>
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<tr>
<td></td>
<td>• “or just get angry with the parent or again when you don’t want to be in the situation where you are set up as the other warring party in this particular triangle”</td>
</tr>
</tbody>
</table>
Influence of parental attitude

- “I always meet the parents before I meet the child because I just think the messages that a child receives from a parent before they come makes a big difference in terms of engagement.”

Competition between parent and therapist

- “They might feel they have to choose between the actual parent to myself although I might feel guilty going to the sessions when Mum or Dad to say don’t go although I might feel so ambivalent who is right and who is wrong
- “It’s like walking on eggshells afterwards because as I said earlier I have to be very careful in what role I take for the child in the child’s life”
- “Something extremely tricky is safeguarding issues... if something happens then the parent might not want the child to have therapy anymore”.
- “It’s a rupture in the therapeutic relationship, not only in the relationship with the parent”.
- “Where I have noticed serious rupture is when social services are involved because of the safeguarding issue and then the parent understandably sometimes gets very angry and hostile towards me as the therapist and the therapeutic relationship.”

Theme: Parents’ ambivalent attitude towards therapy

<table>
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<th>Codes:</th>
<th>Sample quotes:</th>
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</table>

- Parental ambivalence interfering with ending
- Parental avoidant relational pattern
- Parental anxiety leaving child feeling uncertain about engagement
- Tension between being brought to therapy by parent but unsure of permission to use the space

- “Not wanting to come back for the final session and that’s certainly happened a couple of times where I’ve been really curious this has been really positive therapy but then suddenly not there and then you’re constantly chasing for this to be ended properly and there’s something about the parents avoiding the ending”
- “Can be a big impact in terms of the parents anxiety and that can impact on what happens in therapy sessions so how open the child feels like they can be and the attitudes of parents towards maybe their fears or
- Historical experiences of services contributing to parental ambivalence
- Parental ambivalence related to issues around trust

- Parental worries about therapy generating ambivalence
- Importance of understanding context of parents attitude

- Parental criticism of therapy impacting child’s opportunity to engage
- Historical experiences of services contributing to parental ambivalence
- Parental ambivalence leaving child feeling uncertain about engagement

- Bringing the child to therapy but responding dismissively/ not showing interest
- Parental criticism of therapy impacting child’s opportunity to engage
- Bringing the child to therapy but

- Concerns and therefore how open they’re able to be within the sessions and how much permission they feel they have to to talk to me about it”
- “Yes yes I think also sometimes with parents who who’ve accessed all sorts of different services and different professionals I think the therapist so I would need to know some of their stories about interacting with services for therapists and so therefore how they would approach the relationship with me”
- “Also for younger children I guess right through that age group it can be quite useful to understand where the parents are coming from in terms of what anxiety they might hold and how that might impact the child and that actually if you dive straight in and work directly with the child after you know one or two family sessions you might not be getting what you need in terms of background in the story from each parent or from one parent about their thoughts and feelings about being a parent”
- “Child says directly mum doesn’t think this is working and yeah that’s really difficult and allusions to previous therapeutic relationships”
- “Some kind of Sabotage maybe going on in the background and if a child becomes aware of that maybe finding that the child is starting to close up again because, is this ok? Is this actually ok? because when I come out of therapy with my mum and my dad is not that happy, what’s this about? Do they want me to come or not? Am I saying the wrong things?”
- “How they (Parents) greet them afterwards, you know are they preoccupied and on their phones or are they saying hello and asking them about what they’ve been doing and showing an interest so yes that
<table>
<thead>
<tr>
<th>Responding dismissively/ not showing interest</th>
<th>Can impact</th>
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<tr>
<td>• Impact of parent dismissing/not acknowledging child’s progress</td>
<td>• “The kind of subtle sort of or overt rubbing of the therapist and the therapy”</td>
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<tr>
<td>• Impact of managing conflict around parental role</td>
<td>• “Hopefully I manage it better these days but thinking about early days of practice you know when you’re not so aware of those issues you could observe things like maybe the parent doesn’t appear so interested when the child comes out of therapy so that kind of greeting their child but they might be a bit dismissive of what the child might have been doing within the therapy or they might phone calls or messages saying actually there may be changes in therapy but at home things are terrible”</td>
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<td>• Jealousy</td>
<td>• “There’s a whole raft of feelings parents can have about the therapist potentially being in the parenting role and the conflict that can come out of that”</td>
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<td>• Impact of parent self-blame response on their capacity to support work</td>
<td>• “What does that mean about me and those feelings of potentially resentment or failure or disappointment so again those feelings can impact on the child and on the therapy if you’re not aware of them”</td>
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<table>
<thead>
<tr>
<th>Tension between wanting the child to receive support but the process generating personal anxiety</th>
<th>Participant B:</th>
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</thead>
<tbody>
<tr>
<td>• Parental anxiety leaving child feeling uncertain about engagement</td>
<td>• “It’s almost like him being in therapy is increasing the anxiety in the home”</td>
</tr>
<tr>
<td>• Parental worries about therapy generating ambivalence</td>
<td>• “The mother’s anxiety I feel is, not contaminating the therapeutic Alliance, but it is contaminating in a way what could be brought to the session”</td>
</tr>
<tr>
<td>• Tension between wanting the child to receive support but the process generating personal anxiety</td>
<td>• “The mother’s so anxious about her child being in therapy”</td>
</tr>
<tr>
<td>• Parental ambivalence related to issues around trust</td>
<td>• “Her (Mother) anxiety is that the child will start to talk, things might start to come out about the domestic violence that have not come out and have ultimate fear of her children being taken away from her”</td>
</tr>
<tr>
<td>• Parental anxiety leaving child feeling uncertain about engagement</td>
<td>• “I think it’s probably mirrored isn’t it”</td>
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</tbody>
</table>
if a parent is not very trusting then that has an impact then the Child isn’t going to be trusting of the space”

| **Parental ambivalence impacting child’s trust in therapeutic alliance** |
| **Parental ambivalence impacting child’s confidence to engage** |
| **Impact of parent self-blame response on their capacity to support work** |
| **Impact of parent self-blame response on their capacity to support work** |
| **Parental criticism of therapy impacting child’s freedom to engage** |
| **Parents impact on therapist** |
| **Impact of parent self-blame response on their capacity to support work** |

**Participant C:**
- “There are other ways parents impact including how their feeling around their child coming to therapy”
- “The sigh about having to get in the car whatever it is you know the Child will pick up on and whether it’s positive or negative they’ll pick up on that and make it more difficult to engage in a relationship or to come even if it’s a hassle for their parents they might want to come but they might just feel like well it’s a hassle for mum says to drive here”
- “How they’re feeling as a parent, obviously parents you know some of them may feel that sending their child to therapist have failed in some way terrible parenting kind of whole quite tricky area of shame”
- “I think a lot of parents come with that sense of shame of or that something’s gone wrong sometimes that covered up with anger and blame of the child way of defending against all of that and that can also be very difficult for both the child and therapist to listen to”
- “One is kind of shame based and maybe that I talked about earlier that the parent feeling a failure in parenting and that you really don’t want to be the person, it’s kind of paradoxical, you really don’t want to be the the parents bringing the child to see you and it’s the same at the school the refer you know go and fix this child but actually you really you really don’t want to be the person that’s doing that”
- “It’s often about kind of fixing a child and some way but they’re actually unless they’re actually really that’s never going to work it’s never going to be helpful”
<table>
<thead>
<tr>
<th>Participants</th>
<th>Thoughts and Observations</th>
</tr>
</thead>
</table>
| N/A          | Participant D:  
N/A |  
- Parental ambivalence impacting their motive or agenda for the work making it inappropriate  
- Parental attitude towards child’s difficulties impacting child’s motivation to engage.  
- “If there’s pressure or especially pressure that you’re going to fix a child in a certain way then that’s very you can’t really work in that space”  
- “If a child is being sent to therapy, as is often the case, because they feel they’ve done something wrong or that they’re in some way deficient I suppose or in trouble, then obviously that does have an immediate impact on how willing they are to engage with the whole process of therapy”  
- Participant E:  
- “The child then brings it into the therapeutic room to our relationship in an unconscious way or the child might feel that they need to protect they’re therapeutic relationship because it is attacked by the parents in some sort of way”  
- “What the parents feel about their child being in therapy”  
- “The difficult element is when the parent discourages or accuses the therapy for something that is not good for the child”  
- “This is indeed extremely difficult because even if they don’t say anything I’m sure something is communicated to the child”  
| N/A          | Participant E:  
N/A |  
- Parental critical attitude impacting alliance between therapist and child  
- Parental ambivalence creating distrust in the child about therapy  
- Parental ambivalence impacting child’s trust in therapeutic alliance  
- Parental criticism of therapy impacting child’s freedom to engage  
- Ambivalent parental attitude impacts child’s view of therapy  
- Tension between wanting the child to receive support but the process generating personal anxiety  
- Parental jealousy impacting alliance  
- Parental resentment about therapist-child relationship impacting child’s freedom to engage  
- Impact of managing conflict around parental role  
- Parental feelings of jealousy limiting parents support of the work  
- Parental resentment about therapist-child relationship  
- “The child then brings it into the therapeutic room to our relationship in an unconscious way or the child might feel that they need to protect they’re therapeutic relationship because it is attacked by the parents in some sort of way”  
- “What the parents feel about their child being in therapy”  
- “The difficult element is when the parent discourages or accuses the therapy for something that is not good for the child”  
- “This is indeed extremely difficult because even if they don’t say anything I’m sure something is communicated to the child”  
- “At the beginning there was a bit of hesitation from the parent to allow their child to have therapy and for them to engage in their child’s wellbeing”  
- “Something interesting is when I give to the children their creations from our sessions and their box, because we use boxes, sometimes I am extremely worried what will happen when the parents see this and will the parent manage or not emotionally for their child to have something so precious that was shared with a stranger in a way and how will they react, will they destroy
- Impact of parent self-blame response on their capacity to support work
- Tension between wanting the child to receive support but the process generating personal anxiety
- Parental ambivalent attitude resulting in bringing child to be fixed – engaging from a distance?
- Parental ambivalence impacting their motive or agenda for the work making it inappropriate

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Subtheme: Child’s loyalty to parent

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<tr>
<th>Codes:</th>
<th>Sample quotes:</th>
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<tbody>
<tr>
<td>N/A</td>
<td>Participant A: N/A</td>
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</tbody>
</table>

- Child supporting parent
- Child’s fear around disappointing parent
- Child supporting parent
- Child’s dependence on parent

- Child protecting the parent
- Child supporting the parent

Participant B:
- “He wouldn’t ever say anything most children are very loyal to their parents”
- “He couldn’t play or anything because he was so worried about failing or messing up”
- “Again I felt it could only go so far because there was no way that child would ever say anything negative about his dad especially because his mum left him when he was a baby so it was like, ‘that’s all I’ve got’ I guess”
- “That sense of therapy can go no further because the child was not going to look at any of that stuff (criticism of father)”

this creation that comes from another relationship”
- “You see this even with adult clients, who share with their parents that they are in therapy that there is jealousy sometimes, and obviously affects how the child brings themselves in the session because if they pick up that their parents are jealous of the therapeutic relationship they are cautious about how much they can allow themselves to be there in the sessions”
- “For a parent to see that their 6 year old needs therapy can be very very harsh to accept so jealousy is the immediate reaction but there are many more other feelings that are communicated always in some way”
- “I have found myself highlighting and spelling it out we’re doing this for the child and it’s not an agenda for example where parent will say ‘can you prove in the sessions and write something for the social worker so we don’t have these problems anymore’ which can be very uncomfortable”
<table>
<thead>
<tr>
<th>Codes:</th>
<th>Sample quotes:</th>
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</table>
| ➢ Child protecting the parent | Participant C:  
  • “Does the child, what permission does the child have to talk about things”  
  • “I think a child can’t do their work in their place because it’s just about pleasing the parent” |
| ➢ Child’s fear around disappointing parent | Participant D:  
  • “If the parents are bit more fragile and there is an element of children protecting their parent” |
| ➢ Child protecting the parent | Participant E:  
  • “I make sure the child has space to explore their ambivalence to the relationship with me or the therapy but it does feel like walking on eggshells and very fragile, it’s very exhausting”  
  • “There is also the other thing we discussed early, who am I going to support as a child my therapist or my parent?” |
| ➢ Child supporting parent |   |
| ➢ Child protecting parent |   |
| ➢ Difficulty in holding different position to parent |   |
| ➢ Child supporting parent |   |
| ➢ Childs dependence on parent |   |

### Theme: Parental Role in the Therapy

**Subtheme: Parent as co-therapist**

<table>
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<tr>
<th>Codes:</th>
<th>Sample quotes:</th>
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</table>
| ➢ Parents positive relationship to space supports Childs’ engagement | Participant A:  
  • “Things will be smoother as parents feel safe and child feel safe and hopefully some progress is made in whatever areas we’ve agreed that were working on”  
  • “I also say, if your child is saying something to you encourage them to go back and talk to me about that, go back and ask her about that because that sounds interesting”  
  • “Sometimes even have to see the parents first so that they can feel comfortable to introduce the child to the idea of coming to see somebody and perhaps opening up to somebody”  
  • “I think that the process of contracting the work right at the beginning will kind of set the parameters for the work”  
  • “I think it’s not helpful for a child to |
| ➢ Importance of parents agreement on goals in supporting the work |   |
| ➢ Parents encouraging the child to engage with the therapist |   |
| ➢ Parents supporting Childs engagement |   |
| ➢ Parents positive relationship to space supports Childs’ engagement |   |
| ➢ Parents supporting Childs engagement |   |
| ➢ Importance of parents agreement on goals in supporting the work |   |
| ➢ Importance of parents actively supporting the work |   |
- Parents supporting Childs engagement
- Importance of parents agreement on goals in supporting the work
- Value of collaboration between therapist, parent and child
- Parents role in structuring the work
- Parents monitoring progress and change and feeding back to therapist, generating focus of sessions.
- Value of collaboration between therapist, parent and child
- Parents role in structuring the work
- Importance of parent supporting work outside of the therapy room
- Importance of parent supporting work outside of the therapy room
- Importance of parent supporting work outside of the therapy room

Participant B:  
- “It's going to have to be down to the parents coming in because the idea is that they need to be able to
go to individual work with absolute you know rock solid confidentiality because I think that can disconnect them from the family and if the family doesn't know anything about that work then they can't support the child appropriately”
- “Within assessment phase I would be meeting with the parents and the child, I might meet with the parents separately from the child or see the child individually, so that assessment process then helps draw up or what is it that we working on here”
- “I know different therapists have different feelings about this, but certainly with younger children I think it's quite important to give some sort of feedback to parents and to allow them to feedback their observations, so I'm kind of clear, and I guess within my practice I have the time to because I'm part time, to say to families if there's something you observe if it's progress, if it's something that you're concerned about, if it's something that you want me to bare in mind that might have happened during the week, do send me a quick email let me know”
- “There will be different people in the network who are supporting them in different ways but their parent or parents or carers are the key people who can support that very private and emotional experience”
- “Often it's about looking after their emotions and relationships and the way they see themselves in the world, and that's really delicate work, and it does need to be held and understood by the people who are closest to them I can't do that on my own because I'm only there in that space”
<table>
<thead>
<tr>
<th>Positive Relationship to Space Supports Childs’ Engagement</th>
<th>Value of Collaboration between Therapist, Parent and Child</th>
</tr>
</thead>
<tbody>
<tr>
<td>Importance of Parents Supporting Work Outside of Therapy Room</td>
<td>Importance of Parents Agreement on Goals in Supporting the Work</td>
</tr>
<tr>
<td>Value of Collaboration between Therapist, Parent and Child</td>
<td>Parents Monitoring Progress and Change and Feeding Back to Therapist, Generating Focus of Sessions</td>
</tr>
<tr>
<td>Parents Positive Relationship to Space Supports Childs’ Engagement</td>
<td>Parents Scaffolding Learning at Home</td>
</tr>
<tr>
<td>Value of Collaboration between Therapist, Parent and Child</td>
<td>Value of Collaboration between Therapist, Parent and Child</td>
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<tr>
<td>Importance of Parents Agreement on Goals in Supporting the Work</td>
<td>Importance of Parents Agreement on Goals in Supporting the Work</td>
</tr>
<tr>
<td>Value of Collaboration between Therapist, Parent and Child</td>
<td>Value of Collaboration between Therapist, Parent and Child</td>
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<tr>
<td>Participant C:</td>
<td>Continue that, do some of that work with him as well</td>
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<tr>
<td>Of course of course they do want to know how their children are going and want to know if they’ve said anything</td>
<td>“If the parent is very supportive of the therapy and you know says, I think this is a good thing, it’s a positive thing and they are reinforcing if you like this is something to help you”</td>
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<tr>
<td>I guess if I was working in that situation I would still be very interested in building an alliance with the parent and keep in contact with them maybe have a review meeting how are things going at home some kind of shared meeting with the parent child and me</td>
<td>“Importance of working with parents”</td>
</tr>
<tr>
<td>Maybe yes you want both the parent and the child to feel supported ideally for the therapy to work and the parent on board with it that makes for the best outcomes</td>
<td>“The parent feels because someone that is not just supporting my child but supporting my family and is supportive rather than judgemental then it will be a lot more effective because a child is more engaged in that”</td>
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<tr>
<td>I would always see the parent before and the parent with the child to try to have a really clear conversation about that in a way that kind if feels suitable to the child and also to be able to kind of come up with some metaphors around therapy</td>
<td>It’s really important to have a session where you’re talking about shared goals</td>
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<td>They can support the work you’re doing together</td>
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<td></td>
<td>Parents positive relationship to space supports Childs’ engagement</td>
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<td></td>
<td>Value of collaboration between therapist, parent and child</td>
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|   |                                                                  |   | “I just think that the involvement of
space supports Childs’ engagement

- Parents supporting Childs engagement
- Parents monitoring progress and change and feeding back to therapist, generating focus of sessions.
- Value of collaboration between therapist, parent and child

- Value of collaboration between therapist, parent and child
- Value of collaboration between therapist, parent and child
- Value of collaboration between therapist, parent and child
- Value of collaboration between therapist, parent and child

- Importance of parents actively supporting the work
- Parents scaffolding learning at home
- Importance of parents actively supporting the work
- Parents scaffolding learning at home

- Parents positive relationship to space supports Childs’ engagement
- Parents encouraging the child to engage with the therapist

- Parents role in facilitating the work
- Importance of parents actively supporting the work

- Parents monitoring progress and change and feeding back to therapist, generating focus of sessions.
- Parents encouraging the child to engage with the therapist

parents is so key particularly in the age group you're looking at”
- “Having a parent in the room I feel it helps to manage levels of anxiety”
- “I think children might struggle to remember that a bit they're on their own and it brings their issues a bit more into the room rather than me having to drag it out of them more”
- “If they’re feeling overwhelmed that’s ok and I can then Focus my conversation a bit on the parent”
- “I’ve been in independent practice for 11 years and I think I’ve got more and more structures in place in order to try and make communication as clear as possible and transparent as possible so yes you need flexibility”
- “Parent being there and helping to support them and understand the process and the language and they can facilitate CBT homework”
- “For a child of 8 to go to be on their own they wouldn't be able to use it they need someone to scaffold that so that they’re able to make use of it”
- “When they’re (parents) more solid in the understanding themselves then they can portray it to the child who are coming in a much more contained way”
- “Without his mum being there with him, not forcing him obviously, going at his pace and doing it as collaboratively as possible it would be hard to see the progress was seeing”
- “I think it's really hard for children to remember too, they don't have, especially that age group, that quite moment to moment in their experiences more and so parents are often a very helpful memory tool about how on the day the child’s feeling ok that's great but a parent would be able to say you know what about last Thursday when you came home”
<table>
<thead>
<tr>
<th>Participant E:</th>
<th>N/A</th>
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<tbody>
<tr>
<td><strong>Subtheme:</strong> Parent as additional client</td>
<td></td>
</tr>
<tr>
<td><strong>Codes:</strong></td>
<td><strong>Sample quotes:</strong></td>
</tr>
<tr>
<td>➢ Impact of parents needs</td>
<td>Participant A:</td>
</tr>
<tr>
<td>➢ Impact of parent requiring their own therapy</td>
<td>• “If you are working specifically with a child but you need to be able to find ways for them to hold their stuff that might mean their own referral to a separate therapy organisation that can help them”</td>
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<td>➢ Impact of parents needs</td>
<td>• “People (parents) are really relieved when you point something out because the very reason they’re doing it is to communicate something if you’re picking up that communication then you’re doing some good and you’re helping them with something”</td>
</tr>
<tr>
<td>➢ Therapist supporting the parent</td>
<td>• “I think it’s really important to understand where they’re coming from and to give them time to communicate that yeah”</td>
</tr>
<tr>
<td>➢ Impact of parents needs</td>
<td>• “For me that’s a freedom of working privately in that I can be maybe a little bit more flexible in terms of how I communicate with parents so it’s not the time doing work with the child and completely cut off and I’m not allowed to have time or that the time available to me means that I cannot support the parents in the process so that’s been nice and the flexibility in that is important”</td>
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<td>➢ Parent using the therapeutic space</td>
<td>• “Occasionally the parents have come in and shared the session and actually I’ve seen the parents have been able to be open with the child because they both feel that safe space a place where things can be spoken that maybe they don’t feel safe enough to speak them within the family context”</td>
</tr>
<tr>
<td>➢ Therapist supporting the parent</td>
<td>• “Also sometimes give them (parents) a space”</td>
</tr>
<tr>
<td>➢ Impact of parents needs</td>
<td>• “Also maybe a telephone conversation you know how does it”</td>
</tr>
<tr>
<td>➢ Therapist supporting the parent</td>
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<tr>
<td>Therapist supporting the parent</td>
<td>Impact of parents needs</td>
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<td>feel for them at this point and actually acknowledging those feelings so that they can feel held and be able to hold the child through the transition to being on their own again</td>
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<td>“Some parents won’t need as much supporting through the process where individual work is happening and other parents will need a lot of support and will be very anxious”</td>
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<td></td>
<td>“Can often be big impact of parent dynamic on the therapy because of the level of anxiety the parents are holding and also the high proportion of those parents having experienced those issues themselves”</td>
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<table>
<thead>
<tr>
<th>Therapist supporting the parent</th>
<th>Parent using the therapeutic space</th>
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<tr>
<td></td>
<td>Impact of parent requiring their own therapy</td>
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<td>Therapist supporting the parent</td>
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<td>Impact of parents attachment style</td>
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<td>Impact of unhelpful relational patterns</td>
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<tr>
<th>Impact of unhelpful relational patterns</th>
<th>Parents modelling expression of emotion</th>
</tr>
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</table>

**Participant B:**
- “Dad was able to open up about the difficulties that did parallel the child”
- “She just shut down, she can’t cope but she doesn’t she’s not able to talk about it, she obviously has a bit with me now over time we’ve sort of built up that relationship she’s often very tearful but there’s not really any other space”
- “Really classic ambivalent resistant stuff, kind of feelings so close to the surface and dysregulated at times, it’s it’s just the session’s just about trying to get him to an organised state and then you know it’s like when I then started to get to know his mum more and her attachment history she’s had lots of abandonment”
- “She (Mother) was able to make the connection of like well actually my son never wants to talk about when he’s sad, he just shuts down, now he’s doing what I’m doing, and suddenly this realisation of yeah he’s mirrored that, so that helping them to make that connection”

**Participant C:**
N/A
<table>
<thead>
<tr>
<th>Participant D:</th>
<th>Participant E:</th>
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<tbody>
<tr>
<td>➢ Impact of parents needs</td>
<td>➢ “Neither client nor therapist had any space because mother would take whole space and so that was a big challenge”</td>
</tr>
<tr>
<td>➢ Parents own mental health issues</td>
<td>➢ “I remember the case that I mentioned about the young child with mother with addiction issues, the mother before the child was taken away she would come every week before the session and say I need to talk to you and tell you what she did, you need to help us and then of course the chid would see this and I would always explain this is not your time and maybe you can talk to your support worker”</td>
</tr>
<tr>
<td>➢ Parent using the therapeutic space</td>
<td>➢ “It did need a lot of definition of the boundaries about who’s working with the mother who’s working with the child and I do feel for the parent because for each parent who has this needy attitude they obviously need some support too but it can’t be the support that I can give them”</td>
</tr>
<tr>
<td>➢ Impact of parent requiring their own therapy</td>
<td>➢ “(The child is) quite confused initially about to whom I belong”</td>
</tr>
<tr>
<td>➢ Therapist supporting the parent</td>
<td>➢ “There is a bit blurred understanding about who's doing what”</td>
</tr>
<tr>
<td>➢ Impact of parents needs</td>
<td>➢ “I only had to listen to the parents worries”</td>
</tr>
<tr>
<td>➢ Impact of parents needs</td>
<td>➢ “If there is severe depression (in the parent) the child needs to look after both themselves and their parent, so they become the parent … then there is the lack of opportunity because if you are a carer how</td>
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<td>Parents needs and difficulties impacting child’s engagement</td>
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<td>Parent using the therapeutic space</td>
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<td>Parents difficulties removing focus from child</td>
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<td>much, and you need to look after yourself too, how much can you live your life as a child there is this shrinking desperate way of being to try to contain all the bits so that they don’t fall apart”</td>
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<td>• “It's their relating repertoire, so if they know only one way to relate to an adult then I think the role of the therapeutic relationship, not just the therapist, but the therapeutic relationship, is to experience different ways of being with an adult ... so you don't need to be only the carer you can also allow the people to look after you or you can be equal so both people take responsibility”</td>
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<td>• “Especially younger children as they grow older I've noticed that there is this sense of distance, I’m not going to invest too much because from my experience you, the adult, will not be there forever I will have live with these parents”</td>
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<td>• “It took this child quite a long time to let go of this extremely strong sense of responsibility and to allow me to look after her which obviously is not the immediate action because I don't want to destroy something that has allowed her to survive emotionally so everything needs to be quite sensitively approached”</td>
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<td>• “She really wanted to see me to discuss this with me before she talks to him because he was frightened of talking to anyone about it but she would pick it up because she had this experience in her childhood so for that specific occasion I had to change my way of working because I could see the desperation from her”</td>
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<tr>
<td>Theme: Parents relationship to therapeutic boundaries</td>
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<tr>
<td>Subtheme: Parental intrusion of therapeutic boundaries</td>
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<table>
<thead>
<tr>
<th>Codes:</th>
<th>Sample quotes:</th>
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<tbody>
<tr>
<td>➢ Protecting child’s therapeutic space</td>
<td>➢ “I think it helps them (the child) over time to become more open, to feel like the space is theirs, that it's not somewhere where they need to look over their shoulder”</td>
</tr>
<tr>
<td>➢ Maintaining a clear boundary supports trust in therapeutic space</td>
<td>➢ “I think it is about that holding and the boundaries and feeling the therapist is confident about these boundaries and therefore that makes for the Safe Space”</td>
</tr>
<tr>
<td>➢ Importance for child to have a separate space away from parent</td>
<td>➢ Participant A:</td>
</tr>
<tr>
<td>➢ Protecting child’s therapeutic space</td>
<td>➢ “The child was quite anxious and he was checking if his dad was there, it was almost times it felt like dad was watching and I have a counter transference of Dad almost like dad was in the room or watching and I felt that that was what the child was carrying in a way, watching him all the time, this big critic in his mind”</td>
</tr>
<tr>
<td>➢ Importance for child to have a separate space away from parent</td>
<td>➢ “He’s got the space where he can process his own feelings and make sense of his experiences”</td>
</tr>
<tr>
<td>➢ Maintaining a clear boundary supports trust in therapeutic space</td>
<td>➢ “Able to be contained in the room”</td>
</tr>
<tr>
<td>➢ Importance for child to have a separate space away from parent</td>
<td>➢ Participant C:</td>
</tr>
<tr>
<td>➢ Protecting child’s therapeutic space</td>
<td>➢ “That’s when you do become more of an advocate in a way for the child, and the space is more protected”</td>
</tr>
<tr>
<td>➢ Parent unable to support the child leading relationship to become more protected</td>
<td>➢ “They (the parent) can’t really see the child for whatever reason, or see what’s happening for the child, then that’s when maybe your therapeutic space becomes more, I mean it’s still preventative your hoping but you’re thinking kind of the future whatever is happening in the family your thinking being able to provide a space for the child to work out what is happening and to kind of see that maybe what’s happening is not their fault that hopefully is”</td>
</tr>
<tr>
<td>➢ Challenging home environment creating a need for more boundaried therapeutic relationship</td>
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</tbody>
</table>
- Importance for child to have a separate space away from parent
- Maintaining a clear boundary supports trust in therapeutic space
- Challenging home environment creating a need for more boundaried therapeutic relationship
- Challenging home environment creating a need for more boundaried therapeutic relationship
- Parents invading therapeutic space
- Parents not respecting boundary
- Protecting child’s therapeutic space

preventative for their adult future. So I guess again you know seeing children who are looked after or in that kind of situation would be an example of that”

- “Perhaps it’s hard for the child to be able to talk with a parent, this is when it’s useful to see the child on its own because they won’t be able to say what they need to say otherwise because the parent is there, domestic violence, tricky divorce all that kind of stuff falls into that category”
- “I guess it’s the families you see at that end of the continuum where yeah where perhaps you know the works not going to be that effective because who knows what’s going on parents life or inability to see the child or whatever”
- “Parents coming in and saying did they tell you about something happens at school so again it’s about”
- “Having to hold both at same time I think that is what it’s like working with children you have to because they’re not adults and so you have to you have to hold their space”

- Parents invading therapeutic space
- Protecting child’s therapeutic space
- Allowing them to be a child

Participant D:
- “Even though she (the mother) is not in the room I feel like she’s somehow here”
- “if there’s been events in families that that maybe meant that the child has got more into a position of responsibility more than they might have otherwise been in and so having the parent outside of the room is actually facilitating”

- Protecting child’s therapeutic space
- Teaching the child boundaries

Participant E:
- “I was also thinking about cases of sexual abuse where I have my boundaries and body boundaries not only emotional boundaries and I would notice how much work I need to put in defining these boundaries for the child too, very weird thing for some Children to
- Parents invading therapeutic space
- Childs confusion over privacy

- Protecting child’s therapeutic space
- Childs confusion over privacy
- Teaching the child boundaries

- Parents invading therapeutic space
- Parents invading therapeutic space

realise that there are boundaries and initially that’s the response, so you don’t love me as my abuser until they realised and we processed what is going on”

- “How much the parents start asking the children about what happened in therapy, so wanting to know whether the child has shared things that happened in the family, so the child being a bit again confused about then thinking that they can keep what happens in their therapy sessions for themselves but then the parent trying in direct ways to learn more about the content of the session”

- “I always choose to see them with the child and give a very brief account on what we have been working on”

- “It impacts how they can experience their own privacy which might then be transferred in the therapeutic relationship because they might think that I might be talking to their parents telling them, therefore there might be a bit of hesitation in how much they share”

- “Well when boundaries leak everywhere symbolically space is not shared, the space is taken by one person from the system”

- “It’s like having always someone in the room somewhere there”

Subtheme: Parents’ engagement in communication and flexible boundaries

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<tr>
<th>Codes:</th>
<th>Sample quotes:</th>
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<tbody>
<tr>
<td>Parents support and communication enhance trust in relationship</td>
<td>“It’s not helpful for a child to go to individual work with absolute you know rock solid confidentiality because I think that can that can disconnect them from the family and if the family doesn’t know anything about that work then they can’t support the child appropriately”</td>
</tr>
</tbody>
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| Value of responding flexibly to boundary issues | “Experience of those relationships can gradually help you be able to” |
- Acknowledging parental response and finding a balance of communication and boundary
- Open communication/psychoeducation of value of boundaries
- Value of including parents in an appropriate way
- Helping the child to understand the limits of confidentiality
- Explaining the collaborative way that deviations from the boundary will be managed
- Helping the child to understand the limits of confidentiality
- Explaining the collaborative way that deviations from the boundary will be managed
- Value of responding flexibly to boundary issues
- Acknowledging parental response and finding a balance of communication and boundary

better spot when that's happening when those parental issues are encroaching and also to have the confidence to build that confidence to address those in the way that doesn't break the boundaries of the safety of space and that's where the flexibility comes in as well”
- “Some parents are going to be very anxious and when you set particular boundaries they might increase in their anxiety so I think sometimes you need to obviously be sensitive to that”
- “You might need to be quite firm with those boundaries and explain this is why this is happening this is why maybe it feels different this time from other times that you've seen other professionals and this is how it will help your child”
- “Feel that they're (parents) part of that process without encroaching too much”
- “With any child that I go on and see individually it is it is about that trust, It’s very much about the confidentiality and consent, making sure they understand that this is a safe space, what I might feedback to parents, when I might do that, how I might do that so all of that's really important and even down to small details so am I going to text a parent or going to email the parent how often will that be will it be after each session what kind of things might I be saying”
- “Younger children it might just be a little bit of feedback thanks them there will be two sentences for feedback to your mum and dad just to say the session went well and we happy with how things are going or it might be that I need to say a little bit more but if I do we’ll discuss that so it’s helping the child to know what’s happening”
- “Fine line around confidentiality
and consent and what that's for and the meaning of that to children and families that yes of course you need consent you need confidentiality but you also need communication you know”

- Importance of parent child relationship
- Value of supporting a positive attachment
- Building parent-child relationship supports trust in alliance and long term outcomes
- Parents support and communication enhance trust in relationship
- Importance of parent child relationship

Participant B:
- “The biggest influence is their parents and that’s where the problem often is in the attachment relationship there and if you can work with that I found it to be effective”
- “Otherwise you become you become the good attachment figure and the parents continue to be the bad attachment figures and he continues to rebel with them and we get all the behaviours carrying on so it's like how to
- “This is not going to work me just working with the child and thankfully the mother was willing to come to parent child work and that's because otherwise I could feel the split I would be good attachment mum would be bad then the mum would just keep just getting all the crap so by bringing it into the room that’s been amazing and rebuild their Bond”

- Open communication/psychoeducation of value of boundaries
- Importance of communication
- Importance of parent-child relationship

Participant C:
- “There’s something about setting up what the space is for”
- “Really you want to work on the relationship with the parents and that parent as a person is going to be looking out for them once your 12 weeks or whatever, 24 weeks if you’re lucky, is up”
- “You’re also preventing further issues by helping the child and parent relationship really your helping prevent a lot of stuff that could happen in future”
- “Interesting because I’m thinking about how does it impact the relationship between the child and the parent”
| Building parent-child relationship supports trust in alliance and long term outcomes |
| Parents support and communication enhance trust in relationship |
| • “I often feel especially, this is again when I’m working with children and parents together, but if they’re both on board and they’ve both got it and however were working is suiting them, then it’s almost like you don’t need to be there as a therapist and that is the best thing, your influence is very small your just maybe throwing out the occasional thing and when that’s working well then they’ll just leap on it and work with it and that’s really lovely work to be part of” |
| Open communication/psychoeducation of value of boundaries |
| Parents support and communication enhance trust in relationship |
| Participant D: |
| • “Able to explain so the parents are coming with an expectation this is the child’s time to speak” |
| • “I think I just think parents are the ones who are helping their child so I would always if I can keep them in because even if there’s tension or issues I want them to talk about it it’s better for them to be talking about it with each other than me really” |
| Participant E: |
| N/A |
Appendix 9: Table depicting the symbols used in transcript and extracts.

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Meaning</th>
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<tbody>
<tr>
<td>“ ”</td>
<td>Quotation marks to depict the beginning and end of a quote</td>
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<tr>
<td>’ ’</td>
<td>Quotation marks to illustrate a quote within a quote</td>
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<tr>
<td>(.)</td>
<td>Pauses and silences</td>
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<tr>
<td>...</td>
<td>Dialogue trailing off (at the end or middle of a sentence) or picking back up (at the beginning of a sentence)</td>
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<tr>
<td>(parenthesis)</td>
<td>Non-verbal cues</td>
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<tr>
<td>[ ]</td>
<td>Words added by me to ensure readability</td>
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Year 3 empirical study:
‘“It was this deep sorrow that I’ve got this child that I can’t help”: An Interpretative Phenomenological Analysis of Parents’ Experiences of Their Child Accessing Therapy’

Assignment: Research Report C6 - Year 3

Title: “It was this deep sorrow that I’ve got this child that I can’t help”: An Interpretative Phenomenological Analysis of Parents’ Experiences of Their Child Accessing Therapy.

Student: Emma Fredman

Student Number: 6327753

Supervisor: Cristina Harnagea

Word Count: 10986
Abstract:

Background: The present study aimed to explore parents’ experiences of their child accessing therapy. Rising numbers of children require input from psychological services, however, half of those who engage dropout prematurely. Parents represent a key component in children’s engagement. Exploring how parents experience their child’s therapy is viewed to be one way in which the processes surrounding the support of children experiencing mental health difficulties can be better understood to ensure that young people are able to engage in the care they require.

Method: Semi-structured interviews were conducted with six parents. Interview transcripts were analysed using Interpretative Phenomenological Analysis and aimed to explore how parents made meaning of their experiences.

Results: Three superordinate themes were identified; ‘I got left with everything’: Therapy as an isolating experience, ‘Hang on, I am his mother’: Perceived impact on parenting capacity and ‘Walking on a cliff edge’: Responsible but unable to help.

Conclusions: The findings enabled an understanding to be developed of the way in which parents’ made sense of their children’s engagement in individual therapy. It highlighted the importance of finding a way to maintain therapeutic boundaries sensitively and support confident parenting and collaboration. This offers an extension of existing research findings and supports therapists to successfully engage parents in collaborative practice and positively impact therapeutic alliance and outcomes.

Keywords: Parents, Children, Experience, Interpretative Phenomenological Analysis
“It was this deep sorrow that I’ve got this child that I can’t help”:
An Interpretative Phenomenological Analysis of Parents’ Experiences of Their
Child Accessing Therapy.

Introduction:
Within the UK, the number of children experiencing mental health difficulties continues to rise (Ellyatt, 2011; Young Minds, 2016). Experiencing mental health difficulties during childhood not only impacts children’s sense of wellbeing, but it can also have negative implications for young people’s social relationships, academic attainment and is associated with a greater risk of substance misuse (Boulter & Rickwood, 2013; Singer, 2009). Furthermore, half of all lifetime mental health difficulties emerge before the age of 14 (Kessler et al., 2005). As a result, early intervention is crucial in order to reduce distress and avoid long term difficulties. Despite advances in the development of evidence-based treatments for children experiencing mental health difficulties, research indicates that over half of those children who engage in therapy terminate prematurely (Ginsburg et al., 2014; Wolk, Kendall, Beidas, 2015). Not only is this problematic for the wellbeing of the children and their families, but attrition from therapy poses a wider societal cost and increases pressures on already overstretched children’s services (Armbruster & Kazdin, 1994).

The implications noted above demonstrate a need to develop our current understanding of the processes and experiences surrounding the support of children experiencing mental health difficulties, to ensure that young people are able to engage in the care they require. As Counselling Psychologists (CPs) we occupy a reflective-scientist practitioner role that enables us to engage with evidence based practice, value the therapeutic relationship, and engage in social justice issues (Strawbridge & Woolfe, 2010). We are therefore well placed to consider this issue, develop current understandings of the experience of therapy and contribute to addressing the growing crisis in children’s mental health (YoungMinds, 2016).
What role do parents play in therapy?

In order to support positive engagement in therapy and improve the quality of care, existing research has explored young people’s experiences of engaging in therapy (Bury, Raval & Lyon, 2007; Newton, Larking, Melhuish & Wykes, 2007). However, less attention has been paid to the experience of parents. This is significant because within children’s mental health care, children and parents are viewed as the clients (YoungMinds, 2016). This is because parents play a significant role, holding the primary responsibility for the child accessing therapy (legal consent, transportation, payment) (Boulter & Rickwood, 2013). Existing research has demonstrated the impact parents have on attendance and outcomes of therapy (Hawley & Weisz, 2005; Nevas & Farber, 2001). This demonstrates that it is important to understand parents’ experiences of therapy, in addition to those of children, to facilitate these components of therapy.

The significant role played by parents within children’s therapy was also explored by my previous study which considered the ways in which parents were viewed to impact the therapist-child therapeutic alliance. Therapist’s reported that when they were able to engage with the parent as a co-therapist and facilitate open communication, a positive impact on the child-therapist alliance was observed. Research has demonstrated the role of therapeutic alliance in generating positive therapeutic outcomes (Ormhaug, Jensen, Wentzel-Larsen, & Shirk, 2014). This emphasises the important role of collaboration between therapists and parents in producing positive therapeutic experiences. Therefore, it seems crucial to develop an understanding of parents’ views in order for such collaboration to be effective (Baker-Ericzen, Jenkins, & Haine-Schlagel, 2013). It is recognised that there can be a dilemma present within child focussed work of how far it is possible to involve parents while retaining confidentiality, particularly if there are safeguarding issues. Therefore, the emphasis on collaboration refers to contexts when this is appropriate and would not put the child at greater risk.

Parental influence seems to be particularly significant for children aged 12 and under. Following age 12, developmental changes result in qualitatively different relationships with parents due to changing needs (Bulcroft, Carmody & Bulcroft,
1996; Fitzpatrick & Irannejad, 2008). Research has documented how during adolescence, young people often become more autonomous and are afforded greater independence by their parents (Spear & Kulbok, 2004). This is further illustrated by Campbell and Simmonds’ (2011) mixed methods study in which 63 clinicians with training in varying domains (psychology, psychiatry, psychotherapy, social work and welfare work) completed a survey exploring their perspectives of the barriers to therapeutic alliance between therapist and child. Their findings demonstrated that therapists perceived that for children aged two-eleven years, parental support, payment, attendance and transport represented the most common barriers to alliance. In contrast, for adolescents (12-17 years) barriers included lack of goal focus and motivation. This finding suggests that parents’ impact on the therapy was greater for younger children. Therefore, in contrast to adolescents whose growing independence offers them different possibilities in accessing therapy, parents are likely to have a greater role in the therapeutic engagement of younger children.

Despite the potential for parents to impact the therapeutic process, little research has focused on their experiences of their child’s engagement in therapy.

What is missing from the existing research on parental experience?

Existing findings highlight that having a child who is experiencing mental health difficulties can be extremely challenging for parents at both an emotional and practical level (Brannan, 2003, Harden, 2005). A qualitative study by Stapley, Midgley and Target (2015) conducted 48 semi-structured interviews with one or both parents of adolescents who had been given a diagnosis of depression. Using thematic analysis, they found that parents own emotional wellbeing was impacted in addition to feeling helpless as a consequence of their child’s symptoms. However, this study aimed to understand parents’ experiences of their child’s ‘diagnosis’, rather than the experience of the therapeutic encounter. This focus on a medicalised understanding of the child’s distress is likely to have impacted the way in which parents’ made sense of their experiences. Extending our understanding of whether this degree of emotional impact is also present for parents’ whose children are engaging in therapy without a diagnosis, could enhance therapist’s capacity to appropriately support a broader range
of parents. Furthermore, continuing to explore this area from a Counselling Psychology (CoP) perspective which constructs mental health difficulties as human distress rather than ‘illness’ may offer a different lens through which parents experiences can be understood (Strawbridge & Woolfe, 2010).

Existing research has also focussed on exploring the help-seeking process and establishing what parents perceive to be the barriers to treatment (Boulter & Rickwood, 2013; Kazdin & Wassell, 2000). Sayal et al. (2010) utilised focus groups with 34 parents who had concerns about their child's mental health and had engaged with non-specialist community settings. Analysing the discussions within these groups found that parents’ concerns regarding the stigma attached to mental health diagnoses, and worries about their parenting being judged negatively, represented barriers to them seeking help for their children. Their findings were arguably strengthened through the use of validation groups, as this allowed interpretations to be clarified with participants, ensuring that the findings reflected the views of parents as closely as possible.

However, although specific barriers were identified, little is known about the context that caused parents to experience these issues as problematic and the meaning this held for them. Therefore, focussing on the process of therapy and exploring parental experiences at greater depth may contribute to our understanding of why these issues were experienced as problematic, enhancing opportunities to address them.

Why is it important to look at the experience of ongoing therapy rather than the experience of engagement?

As CPs our role as scientist-practitioners mean that it is important that our research reflects and contributes to current challenges in the mental health practice. As noted above, existing research has focussed on the help-seeking process (Reardon et al., 2017). This focus on help-seeking is also reflected within the existing political environment, as there is currently an emphasis upon reducing waiting times (Department of health and social care & Department of Education, 2017). However,
although challenges of initial engagement represent a key issue within children’s mental health services, dropout during the course of therapy is equally problematic. This is because if therapy is not completed, the effects are unlikely to be successfully sustained, resulting in children being re-referred and further adding to the number of people waiting for support (Children’s Commissioner, 2016; Hansen, Lambert, & Forman, 2002). For that reason, only reducing waiting times rather than exploring and supporting ongoing engagement in therapy could be viewed as a false economy. Furthermore, exploring what is happening during the process of therapy is important because it is at this point that therapists have direct contact with parents and have an opportunity to support positive outcomes.

**Why should we focus on parents of children in individual therapy rather than other formats of therapy?**

Within children’s mental health care a range of approaches to therapy are taken including individual work, family therapy and therapies which are co-facilitated by parents. Of the existing research which has explored parental experiences of ongoing therapy, there has been a greater focus on therapies in which parents were actively involved (Stapley, Target & Midgley, 2017). Sheridan, Peteron and Rosen (2010) conducted a qualitative study of the experiences of parents engaging in family therapy. They found that, for the 15 parents they interviewed, the impact of engaging in therapy varied. In some instances parents were left feeling inadequate, while others reported the value of therapy as it improved their understanding of their child. Although this draws upon a small sample which is not necessarily representative, it arguably demonstrates that parents’ experiences are likely to be complex and multifaceted and warrant further research.

However, because parents engage in family therapy as active participants, this experience is qualitatively different from that of individual therapy. This is because parents have their own experience of therapy as opposed to primarily reflecting on the meaning they make of their child requiring therapy. In contrast, parents of children who are engaging in individual therapy hold a novel position where they have a great degree of influence over attendance and engagement and yet remain external to the
therapy (Hawley & Weisz, 2005). It would therefore be of value to therapeutic practice to understand if existing findings reflect the experiences of parents of children who have engaged in individual therapy. In exploring this, we take a step towards being better placed to support parents across a wide range of therapies.

In an unpublished doctoral thesis, Clark (2016) took a first step in considering this otherwise under-researched area. Her qualitative study explored the experiences of mothers of young people under the age of 16 who were experiencing mental health difficulties. Her findings emphasised the way in which mothers attempts to make sense of their child’s difficulties involved both attributions to external issues and self-blame. Her findings described that mothers felt less alone once their child had engaged with therapy and that the therapeutic process positively impacted the parent-child relationship. Unfortunately due to the limited demographic information available it was not possible to ascertain how far the findings represent children under age 12. The value of a positive child-therapist relationship was also noted, however, less focus was placed upon the parent-therapist relationship. Given that existing research points to the importance of collaboration, this seems an important avenue to explore further.

Rationale:

Parents play a crucial role in children’s ongoing engagement in psychological therapy. Whilst existing research has provided a step towards developing our understanding of parents’ experiences, there remains considerable room to continue to explore this area. This study aimed to explore the lived experience of parents whose child had engaged in individual therapy with a particular focus on children under age 12. Despite parents being regarded as having a more active role in children’s therapy prior to age 12, this younger age group has received less attention within the existing literature. Exploring this aimed to contribute to developing our understanding of the therapeutic process when working with children and to provide a step towards improved care for a wider age group (Barnard & Kuehl, 1995). Listening to the voices of parents directly is well aligned with the client centred approach of CoP which acknowledges the client as an expert on their own experience (Mcleod, 2003). Not
only can parents offer a unique insight into the child’s world (Hawks, 2015), but in exploring the meaning this experience held for them it can support empathic engagement with parents and provide a firm base for collaboration. Therefore, the present study aimed to address the research question:

‘What are parents’ experiences of having a child in therapy?’

This study had an exploratory aim but endeavoured to describe and understand this experience in order to build upon and contribute to the evidence base around helpful approaches to working with children and supporting their caregivers.

**Method:**

**Ontological and epistemological position:**

This study was conducted from a critical realist perspective. It has been approached in line with an assumption that a single reality exists, but that that our interpretation of this single reality is impacted by our personal experiences and historical, political and cultural contexts (Bhaskar, 1993; Jenner, 2005; Ussher, 1999). As a consequence of this ontological position, critical realism holds a view that knowledge cannot be fully derived from observation and measurement as these procedures will always be in relation to existing constructs of the phenomena being researched (Jenner, 2005; Sayer, 2004). This contributed to the choice of a research methodology which allowed for interpretation and reflection upon the context of the experience.

**Rationale for choice of research methodology:**

An Interpretative Phenomenological Analysis (IPA) was utilised within the current study. IPA attempts to examine and understand the meaning people make of experiences in their life and their embodied being-in-the-world (Finlay, 2011, Merleau-Ponty, 1962). IPA was selected as the most appropriate method for investigating the present research question due to its idiographic focus on individuals’
personal experiences (Larkin & Thompson, 2012). The idiographic commitment of IPA enables a balance to be found between noting points of convergence across multiple participants’ experiences while allowing space to consider divergence, thereby retaining the depth and value of each individual's experience and voice (Smith, 2017). Given that existing research on parents’ experience of the process of their child’s therapy had focussed upon broader themes (Sayal et al., 2010), it seemed that focussing on the particular and gaining a personal rather than objective statement could both extend existing findings and potentially address this gap within existing research.

With its phenomenological underpinnings, IPA is informed by an understanding that our experience and the meaning we make cannot be separated out from the existing world (Heidegger, 1962; Sartre, 1956). It highlights the importance of developing an empathic understanding of the others experience and, as far as possible, to understand what the experience is like from their position and how they make meaning of it at cognitive, emotional and embodied levels. As IPA offers the opportunity to specifically explore not only what the experiences of parents are, but also, how they made meaning of this experience it was regarded to be an appropriate methodology to utilise in answering the present research question and contributing to extending existing research. This is because current research has placed a greater emphasis on identifying the advantages and challenges associated with being a parent of a child who is seeking or engaging in therapy (Sayal et al., 2010). However, within such studies, there was limited exploration as to why these events were experienced as positive or problematic. As a consequence, this limits the way in which practitioners might be able to apply the findings in practice. Therefore, utilising IPA to answer the present research question is viewed to have potential to make a further contribution to practice through generating greater insight into the meaning this experience held for parents and as a consequence support practitioners to be better placed to understand and support parents and their children.
IPA is particularly useful for exploring parents’ experiences of their child’s therapy as although many therapists are likely to have a tacit understanding of this phenomenon; more focussed engagement with parents’ lived experience is required to enhance our understanding (Finlay, 2011).

With its hermeneutic underpinnings and an understanding that interpretation plays an important role in bringing to light the latent elements of a phenomenon (Heidegger, 1962), the process of meaning making is central to this methodology (Smith, Flowers & Larkin, 2009). IPA requires the researcher to engage in a double hermeneutic, whereby the researcher is making sense of the participants sense-making (Smith & Osborn, 2008). This provides an opportunity to simultaneously look at how the individual experiences and makes meaning, while also allowing the researcher to take a questioning position and engage in their own meaning making process (Smith et al., 2009). This process of intersubjective meaning making allows for a greater depth of understanding, in which the sum is greater than the total of the individual parts (Finlay, 2011; Larkin & Thompson, 2012). This is valuable in relation to the research question as it seems that the complexity of parental experience calls for a method which can do justice to the rich meaning within the individual lifeworld.

It may have been possible to explore the present research question using other methodologies including Discourse Analysis (DA) and Thematic Analysis (TA). However, although TA does describe individual perceptions, it has a greater focus on identifying themes that represent many participants (Braun & Clarke, 2015). In contrast to this, it seems that IPA is able to capture multiple stories and accounts and explore commonalities across them, while retaining a focus on the unique and individual ways these shared components may be experienced. Therefore, IPA was selected rather than TA as the current research aimed to understand the experiences of parents in depth to contribute to our understanding of not only what they experience but also the meaning of this. DA was not viewed to be suitable in answering the current research question as it was not primarily concerned with how language was creating or shaping the experience of parents. Instead it aimed to develop an insight into the experiences themselves, whilst acknowledging underlying communications, which is more aligned with IPA (Smith et al., 2009).
Methodological procedures:

Participants:

Recruitment:

Purposive sampling was used to select a homogenous sample of participants who could offer an in-depth understanding of the topic (Patton, 2002). A snowballing recruitment method was used based on a number of professional contacts within non-NHS organisations. Through this method, six participants were recruited. This sample size was felt to provide a balance between gaining enough experiences to carefully consider possible themes across cases but also allow enough time to engage with each case at depth (Patton, 2002).

Inclusion and exclusion criteria:

Parents whose children had engaged in individual talking therapy (in a non-NHS setting) were invited to participate. It was stipulated that their children should have been aged between 6-12 years at the time the therapy took place. This was because parents have been found to play a more significant role in therapy of younger children (Fitzpatrick & Irannejad, 2008). Prior to age 6, children are less likely to engage in a talking therapy (Campbell & Simmonds, 2011). To support the establishment of a homogenous sample, a guideline criterion was established which specified that therapy should have taken place a maximum of 5 years prior to the participation in the current study and been completed a minimum of 6 months before the interview, to ensure any follow up appointments had been concluded. This worked to ensure that participants were reflecting back on the process. Therapeutic approach was not specified. This study was specifically interested in focussing on the experience of having a child in therapy and what this meant to the parent, rather than the effectiveness or experience of a particular approach. However, Individual therapy was specified as opposed to family/systemic therapy, as the role of parents within family/systemic therapy is qualitatively different, with parents having their own experience of therapy as opposed to primarily reflecting on the meaning they make of their child requiring therapy.
Participant demographics:

Six participants were recruited to take part in the study. All of the participants were mothers. To ensure anonymity each participant has been given a pseudonym (Elliott, Fischer, & Rennie, 1999). Table 1 offers an overview of participant demographics. The participants were all residing within the UK at the time of interview, and all of the therapy had taken place in the UK. As the participants’ children had not been given a formal diagnosis, this is not recorded in the demographic table. However, all six children were described by their parents to be experiencing anxiety, with one child also described as experiencing anorexia. The nature of the anxiety the children were experiencing varied and ranged from generalised anxiety, separation anxiety following a bereavement, anxiety primarily associated with a physical health diagnosis, anxiety focussed on school due to issues with bullying and school refusal.

Table 1: Demographic Information

<table>
<thead>
<tr>
<th>Participant</th>
<th>Gender of parent</th>
<th>Ethnicity of parent</th>
<th>Gender of child</th>
<th>Age of child at point of engagement in therapy</th>
<th>Courses of therapy discussed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abigail</td>
<td>Female</td>
<td>White British</td>
<td>Male</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>Sophie</td>
<td>Female</td>
<td>White European/Other</td>
<td>Male</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>Charis</td>
<td>Female</td>
<td>White British</td>
<td>Female</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>Lisa</td>
<td>Female</td>
<td>White British</td>
<td>Male</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>Beth</td>
<td>Female</td>
<td>White European/Other</td>
<td>Male</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Georgie</td>
<td>Female</td>
<td>White British</td>
<td>Female</td>
<td>12</td>
<td>1</td>
</tr>
</tbody>
</table>
Procedure:

Participants were initially contacted via email (Appendix 1) which included a copy of the participant information sheet (Appendix 2). When they had replied and confirmed their interest in taking part in the study any queries were addressed before arranging a time to conduct the interview.

The interviews lasted between 45–75 minutes and were conducted at the University of Surrey. Prior to the interview, participants were offered a further opportunity to read the participant information sheet, questions and queries about the study were addressed and time was dedicated to ensuring participants understood their right to withdraw and the consent forms were explained and signed. Following an initial conversation to establish rapport with the participant, the interview was guided by the interview schedule which was comprised of eight open ended questions (Appendix 4). At the end of the interview participants were again invited to ask any questions. All interviews were digitally recorded and transcribed verbatim.

Data collection:

The data was collected using individual semi-structured interviews guided by an interview schedule (Appendix 4). I developed the interview schedule in line with IPA guidelines (Smith et al., 2009) and relevant literature to ensure that it was comprised of a strategic use of questions that illuminated the research topic. A semi-structured approach offered consistency across the broad questions asked, whilst allowing flexibility to explore, at depth, idiographic detail of participants’ experiences (Rubin & Rubin, 1995). This aimed to provide a rich account of participants’ experiences and allow for an in-depth analysis (Willig, 2001).

Analytic approach:

I analysed the data using the method described by Smith et al. (2009). The first step involved transcribing the interviews and then reading and re-reading the transcripts to develop a holistic sense of participants accounts (Appendix 5). Transcripts were then analysed one at a time. Initial exploratory comments were made considering three levels. The first level aimed to note key words and interesting content. The second level considered significant uses of language, including
metaphor. Finally, comments at the conceptual level were made which required me to make tentative interpretations and move away from direct understandings of the text (Appendix 6).

I identified emerging themes through ascertaining statements which represented the different aspects of the participant’s experience and my initial interpretations. Following this, connections across themes were considered and emerging themes were clustered under superordinate headings.

The analysis involved going back to the transcript and exploring how these themes were supported by the text. The super-ordinate and sub-themes of individual transcripts were then integrated to try to identify master themes, and connections between them considered (Appendix 7). Individual transcripts were re-visited throughout the analysis to ensure that themes were grounded in the text and supervision supported me to ensure the themes represented the salient meanings within the transcripts (Bramley & Eatough, 2005; Smith, 1996b).

The resulting themes were used to produce the written analysis. Extracts were included within the written analysis as well as tables collating the raw data under the corresponding themes, to enable the coherence of my interpretations to be interrogated (Smith, 1996b) (Appendix 8).

It was important that I as the researcher remained reflective over my role in producing and facilitating the sense making of the data (Smith et al., 2009). As the primary researcher in this project, my therapeutic experience with children is likely to have impacted the way in which I engaged with this topic and, consequently, my interpretations (Ethrington, 2004). However, in remaining mindful of my own experiences and retaining a clear focus on staying with the experiences of the participants I aimed to be continually reflective about the impact of this throughout the research process. For example, during the analytic process I noticed that many of the themes which initially were noted were capturing a negative experience of the therapy. I reflected upon how my own experience might have led me to miss more positive examples and returned to the transcripts searching and attending to particular examples where parent’s reported positive experiences. However, these remained
limited within this particular sample. The possible understandings and implications of this will be further explored in the discussion.

**Ethical considerations:**

This research was conducted in accordance with the principles of the BPS ethical code of human research ethics (2010) and granted ethical approval by the University of Surrey Faculty of Health and Medical Sciences (Appendix 9). Respect for autonomy and dignity of persons was met through maintaining privacy and confidentiality, obtaining informed consent from participants and ensuring self-determination (Appendix 3). Maximising benefit and minimising harm was attained through ensuring participants were well informed, confidentiality procedures were adhered to and all data was anonymised and stored securely using password protected USB’s in accordance with University of Surrey guidelines based on the General Data Protection Regulation (2018). Participants were provided with adequate time to read the information sheet and were offered the opportunity to ask questions. Participants were informed of their right to opt out of the study and withdraw without any negative consequences. This aimed to avoid exposing participants to distress. Furthermore, participants were debriefed at the end of the interview and provided with a space for questions to be raised. As a CP researcher, I was mindful of the potentially harmful effects of contextual factors including power and worked to ensure that as far as possible this was addressed through these ethical research practices and ongoing reflexivity (Kasket, 2012).
Findings:

The following analysis explores 6 parents’ experiences of their children’s engagement in therapy. The analysis will specifically focus on and explore 3 main themes:

1. ‘I got left with everything’: Therapy as an isolating experience

2. ‘Hang on, I am his mother’: Perceived impact on parenting capacity

3. ‘Walking on a cliff edge’: Responsible but unable to help

The theme titles utilise quotes from the interviews. Although these themes are presented as discrete categories, they aim to capture the different shades and textures which were viewed to comprise the experiences of these participants. As noted by Finlay (2011) the complex nature of human experience means this analysis does not aim to provide ‘answers’ but rather aims to “capture something of the mess” (pp. 244).

To maintain anonymity, identifiable information within the extracts was changed. Some extracts have been modified to enhance readability but have been documented with symbols to note this (Appendix 10).

Table 2: Master themes:

<table>
<thead>
<tr>
<th>Theme:</th>
<th>Sub-theme:</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘I got left with everything’: Therapy as an isolating experience</td>
<td>Feeling misunderstood</td>
</tr>
<tr>
<td></td>
<td>Left alone at sea</td>
</tr>
<tr>
<td>‘Hang on, I am his mother’: Perceived impact on parenting capacity</td>
<td>Having the confidence to ‘just be mum and dad’</td>
</tr>
<tr>
<td></td>
<td>Boundaries as a saboteur</td>
</tr>
<tr>
<td>‘Walking on a cliff edge’: Responsible but unable to help</td>
<td>Helpless and hopeless</td>
</tr>
<tr>
<td></td>
<td>Did we do something wrong?</td>
</tr>
</tbody>
</table>
Theme 1: ‘I got left with everything’: Therapy as an isolating experience

This theme aimed to capture the way in which parents experienced both their child’s difficulties and the resulting therapeutic process as having an isolating impact on them. It is divided into two sub-themes which aim to offer insight into the different ways this sense of isolation was expressed within the interviews. The first sub-theme ‘feeling misunderstood’ focuses upon the way in which others’ judgements could impact parents’ freedom to share their own, and their children’s experiences. The second theme ‘Left alone at sea’ relates to how a number of parents experienced a lack of support from the services their child was engaged within.

Feeling misunderstood:

A number of participants shared that they experienced a worry that their child’s difficulties and subsequent engagement in therapy would not be understood by others in their life. It seemed a fear of this led some parents to avoid discussing their situation with friends and family and as a result appeared to leave them isolated.

Abigail’s previous experiences of how other parents had responded to her son’s difficulties led her to anticipate that sharing that her son was engaging in therapy would bring judgement from others:

“They ask you terrible things and they say terrible things, like ‘you know you never know about genes’, ‘it’s genetic isn’t it?’, and you think well this is my child you’re talking about, so they'd kind of have opinions, and I kind of feel that had I then said he’s going to therapy, people would have had it confirmed that he’s a weird difficult child, and he isn’t” (Abigail)

Expressing that it was terrible for others to relate her son’s challenges to being a genetic issue appears to demonstrate that this did not align with how Abigail understood her child’s difficulties. It seemed that in the use of the term ‘genetic’, connotations of her child’s difficulties being something internal to him and fixed challenged the way in which Abigail made sense of her child’s difficulties as being the result of the challenging situations he had experienced. Considering this in addition to the idea that others could view her child as ‘weird’, something which she felt he was not, appears to demonstrate how these discrepancies could leave Abigail
with a concern that her child would be misunderstood if she told others about the therapy. It seemed that, as a consequence of this concern, it reduced who she could share this part of her life with.

Similarly, Charis’ experience reflected a concern that her child’s engagement in therapy would not be understood:

“[Her] grandparents were like oh she’s so difficult... so I don’t feel I can share her diagnosis with, well, anyone. Because in such a small village, you say one thing and it will go around the whole village. So I just kept it sort of to myself really” (Charis)

In her account, Charis seemed to communicate that others were not compassionate in the way they understood her child’s difficulties. There appeared to be a fear that her child would be judged and misunderstood by others if her difficulties were known. As a result of this fear, it appeared she was not able to draw upon social support as a way to cope with her child’s difficulties and was left isolated through having to ‘keep it to herself’.

In contrast to the experiences of Charis and Abigail, who appeared to hold assumptions about how others would respond to them and their child’s engagement in therapy, Georgie reflected upon experiences where she felt she and her child had been explicitly rejected. Her account suggested that this was a consequence of others viewing her daughters’ difficulties negatively:

“Well I’ve had one conversation with a friend; a very good friend to Ella who has been incredibly supportive ... and her parents were getting worried about the impact on her, which I can understand, but I bumped into her mum and she was so cold towards me, so cold and said ‘how do you catch anorexia anyway?’ (laughing)” (Georgie)

Although Georgie laughed at the end of her comment, this appeared to mark her surprise at how this other mother could misunderstand her daughter’s experience, despite Georgie herself demonstrating compassion and understanding for this other parents concerns. Her description of this mother as ‘cold’ evokes a sense of distance in the interaction. While this extract does not indicate that all of Georgie’s interactions
were this way, it does highlight the potential for the child’s difficulties and subsequent therapeutic engagement to trigger a distancing from others.

It seems due to feeling others would not understand or be compassionate towards them; parents avoided sharing their child’s difficulties with others. This sub-theme highlights that while feeling misunderstood can be considered challenging in and of itself, it was particularly meaningful within parents’ experience of their children’s therapy because it contributed to a sense of isolation.

‘Left alone at sea’:

In many of the accounts shared it seemed parents felt there was a lack of appropriate support from the services they engaged with, which left them feeling alone in their struggle to manage their child’s difficulties. The lack of support provided by therapists and therapeutic services seemed to be interpreted by parents as evidence that their child’s wellbeing was not being taken seriously and that no one else understood or cared about the challenges they were facing. Lisa expressed her surprise at the lack of support available:

“He’s also very anxious, thinks he’s going to die, or the family is going to die. When you’re dealing with it as a parent you just think there would be someone that could help us” (Lisa)

There was a flat-ness in Lisa’s tone. I wondered if this might illustrate a sense of shock. The stark contrast between her experience of the severity of her child’s anxiety, and the reality she experienced of support being unavailable, appeared to leave her feeling stunned. A number of parents described how challenging it was to feel they were left alone. Charis described a sense of being abandoned by those people and services who she expected would help her:

“[The therapy service] just left us at sea. They left us to cope with it. Or they passed us on, and said oh we can’t help so we’ll pass you on to someone else.” (Charis)
Her use of metaphor evokes a sense that there was no one to offer the reassurance of firm ground. Instead, she appeared to be left alone, floating in uncertain waters. The way she described being passed from one person to another adds a different layer to the experience of instability. It seems to indicate that she felt her and her child did not belong anywhere. This lack of belonging evokes ideas of being alone. She went on to describe how she felt the system of care was not offering enough support:

“Then I feel resentful to the system because no one took charge, no one said ‘this is what she’s got’, ‘this is how we think we should deal with it’, ‘we’re going to support you’. There was no safety net. Everything just kept falling away” (Charis)

It seemed there was a desire to identify what her daughter has ‘got’, perhaps illustrating a need for certainty. This view may be unsurprising given the dominance of medicalised discourses which posit that mental health issues can be understood as something internal which can be identified, quantified and fixed. If this reflects in part how Charis made sense of her child’s difficulties, it is understandable that she would feel resentful that no one helped her in the way she expected them to. Her description of the process having no safety net captures the fear associated with the uncertainty she experienced. It seemed that her description of everything falling away could be understood as a representation of the dissolution of her assumptions that services aimed at improving children’s wellbeing would be made up of people who care.

This sub-theme offers some insight into the challenges parents experienced as a result of a lack of support. It was conveyed that it was not only the practical implications of having to manage their child’s difficulties alone which was challenging. It seemed that it was the way in which parents made sense of the lack of support offered as being indicative of a lack of care from therapists and services which generated a sense of isolation.

Parents’ experiences of their children’s engagement in therapy appeared to be multifaceted and evolving. Although a sense of isolation appeared to capture one aspect of this journey, other examples within the accounts highlighted that when connection was found this was experienced as having a positive impact on their confidence as parent. This is explored within the next theme.
Theme 2: ‘Hang on, I am his mother’: Perceived impact on parenting capacity

When they recounted their experiences of their child’s therapy, it was evident that for all six participants, their identity and role as a parent was both supported and challenged during the therapeutic encounter. This theme illustrates the varying impact the therapeutic process could have on the way parents viewed and made sense of their role as a parent through exploring two sub-themes ‘Having the confidence to ‘just be mum and dad’ and ‘Boundaries as a saboteur’.

Having the confidence to ‘just be mum and dad’:

This first sub-theme encapsulates how parents found their children’s engagement in therapy challenging but that in some ways it also strengthened their parental identity as something positive. It seemed that collaboration supported parent’s recognition that they could remain in the parenting role and that the therapist was able to offer something additional to this, rather than replacing them. Georgie described a sense of relief in not feeling she and her husband had to resolve their child’s difficulties, but instead there was value in being a parent:

“That’s been our role I think. To not be clever, but to just be mum and dad” (Georgie)

She went on to say:

“She gave us helpful strategies but also the whole experience felt quite containing” (Georgie)

Georgie’s comments appear to illustrate how through establishing a working relationship with her daughter’s therapist, she was able to appropriately support her child in a practical way through the use of strategies. However, her description of this experience as being containing seemed particularly important and may illustrate just how challenging it could feel for parents to support their child through their distress. It seemed that the therapist’s support helped to generate a feeling of safety and reassurance for Georgie and offer her an opportunity to focus positively on her role as ‘mum’ rather than trying to take on the roles of other caring professionals. It seems
that there was movement from a place where she felt she was attempting to straddle multiple identities and instead was able to focus on ‘just’ being mum. The relief this offered is further understood when we consider her wider context of also managing her relationship to her two other children. If she only had to be mum, this was more aligned with her responsibilities outside of the therapeutic context.

It seems that their children’s engagement in therapy supported parents to be able to return to being ‘just mum and dad’ as part of the responsibility of care could be shared. The relief this brought was highlighted by Abigail:

“From my point of view, there was something of a relief, it wasn’t all me? It wasn’t all on me, sorry” (Abigail)

Within this extract, Abigail’s expression of relief from having to cope with her child’s difficulties alone evokes imagery of the child’s difficulties being physically experienced in an embodied way as a weight which was on the parent. It seemed that the support provided by the therapist to her child enabled her to put down the weight of having to cope alone. However, although she corrected herself, I wondered whether she did partly feel that she may somehow be responsible for her child’s difficulties. Observing her child engage and benefit from therapy may have offered her an alternative way to make sense of her child’s difficulties and the relief she described could be in relation to the release from feeling it was ‘all me’.

The relief noted by Abigail was also reflected in Beth’s account. Beth described how communication with the therapist helped her to feel reassured and supported the development of greater resilience:

“It helped for me because you relax and you become, I become stronger from knowing that I have that support from someone and also that she says what I am doing is ok, then I find the strength to keep on going in a different way” (Beth)

In Beth’s description there is a sense of relief from carrying this burden alone. It seems that receiving encouragement and recognition of her approach contributed to her subjective sense of wellbeing and how confident she could feel as a parent. This extract also highlights the strain of the experience and that finding ways to gain
additional strength was important in being able to support her child in the way she wanted to.

This sub-theme focused on parents’ experiences of their child’s therapy as something challenging which impacted their confidence as a parent. However, it demonstrated the potential for this impact to be tempered by a supportive and collaborative therapist-parent relationship. This might offer support to the importance of parent-therapist alliance, even when parents are not directly involved in the work.

Unfortunately, while these positive experiences represented part of parents’ experiences’, other aspects of their children’s therapy appeared to negatively impact their sense of their capacity to parent.

**Boundaries as a saboteur:**

This sub-theme aimed to capture the challenges parents described as arising from the implementation of therapeutic boundaries in their children’s therapy. It seemed that many parents regarded the therapeutic boundaries as in some way sabotaging their capacity to be the parent they wanted to be and care for their child in the way they saw fit. Many parents seemed to have constructed their parental identity around having an active role in supporting their child. In line with this, parents usually took a leading role in arranging access to therapy. Parents’ accounts illustrated how the therapeutic process challenged this active supporting component of their parental role and somewhat forced them to take on a more passive stance. This is evident in Charis’ description of her thought process during the time her child was engaging in therapy:

“Well it was one of the things which I always found quite bizarre because on the whole, we were very side-lined, but we are the ones after that hour, who are taking her home for the other 23 hours of the day. So it seemed crazy to me that it was very focused on her but there was nothing for us as well” (Charis)

As the primary caregiver, it seemed she felt confused as to how she could be expected to help and support her child without any guidance. Many parents in the
current study described the way in which they were shocked by the fact that much of the therapeutic work did not involve them and was kept entirely confidential between the child and the therapist. There was a degree of frustration due to parents feeling that they were able to do more to help but that somehow the boundaries, which were designed to help their child, were preventing them from being supported effectively. This was noted by Sophie:

“I just thought, if the counsellor had been a bit more inclusive, even if she’d have said, even if with his permission had allowed us to be in the room with him, retrospectively I think it would have helped him to relax a bit more and see it was ok for him to talk about how he was feeling, and it would have helped us to help him” (Sophie)

Reflecting on her experiences it seemed she felt more could have been done by the therapist to support her child and facilitate her capacity to help. Sophie’s recognition that she would not have wanted this to happen without her son’s permission demonstrates her understanding of the importance of confidentiality, yet there appeared to be a tension between this boundary and her desire to support her child.

Lisa also commented on the boundaries of her child’s therapy and explained that although she wanted her son to have a space where he could speak freely, she also felt it would have been helpful to know how he was getting on:

“I just feel he needs someone to talk to, but also the parent needs to be involved. Not as it has been in the sense, I know you get reports at the end of it all, but I think parents should be included. Not in the way of every session, but every few, brought in, ‘what’s been happening for the past few sessions?’, ‘ok, let’s have a few more and then check back in’” (Lisa)

The to-ing and fro-ing in Lisa’s explanation of what she would have liked to be different might represent an internal battle between wanting her son to have a private space where he could receive help and perhaps also finding it difficult to not be the one who could help him. Such a tension highlighted the complexity of the mixed emotions generated by her child’s therapy, but also the multiple layers of
experience (Smith et al., 2009). Considering a further layer of her experience, and in line with a number of the other participants, it seemed that part of the challenge of being shut out was that this negatively impacted parents’ attempts to develop their understanding of their child. Lisa went on to explain why she felt being more involved with the therapy could have supported her to care for her child better:

“I want to know what’s going on in my son’s head... I mean I would understand him better, and I could care for him better knowing and understanding ‘why are you feeling like this’ ‘Why are you having these thoughts?’ ‘How can I help you?’” (Lisa)

Her description of wanting to know what was happening in her child’s head offers a parallel to her desire to know what was happening inside the therapy room, and yet both appeared to be experienced as unavailable to her. Wanting to understand her child and know him better highlights that she may view her child’s difficulties as a barrier to their relationship. It seemed that the boundaries of the therapy were regarded as generating an additional barrier to her child and generating further disconnection rather than supporting her to find answers to her questions. The philosopher Nietzsche posited that ‘He who has a why to live for can bear almost any how’ and this idea has been applied within existential psychotherapies (Frankl, 1984). This idea may shed further light on why the boundaries were experienced as so challenging by parents, as through preventing meaning making, they may also have made the struggle to support their child more difficult to bear.

This sub-theme focused on how parents experienced the therapeutic boundaries as to some extent preventing them from being able to care for their child in the best way possible. It illustrated the way in which parents struggled to manage frustrations within the therapeutic process due to feeling they had skills to contribute which were not being utilised. This seemed to be problematic because it was felt to jeopardise their child’s opportunity to overcome their difficulties. In addition to this, the boundaries seemed to be experienced as creating a barrier to parents’ wider meaning making process.
A desire to care for and protect their child was an important thread which ran throughout all of the accounts given by parents. In addition to the reported challenges to this posed by the therapeutic boundaries, at a broader level, many parents appeared to reflect upon a sense of helplessness.

Theme 3: ‘Walking on a cliff edge’: Responsible but unable to help

This theme attempts to capture the challenge parents appeared to experience as a consequence of witnessing how close their child was to the ‘edge’ of their distress, and yet feeling that they were unable to do anything to help. The first sub-theme ‘Helpless and Hopeless’ considers how this position of tension evoked a sense of being out of control which in turn impacted how far they were able to hold hope that things would change. The second sub-theme ‘Did we do something wrong?’ illustrates the way in which a number of parents described a process of questioning if they had made mistakes or were responsible for their child’s difficulties in some way.

‘Helpless and Hopeless’

As parent’s shared their experiences, it was noted that their children’s engagement in therapy led them to get in touch with feeling that they did not know how to help their child. The emotional impact of this was explicitly noted in Charis’ account:

“It was this deep sorrow, that I’ve got this child that I can’t help” (Charis)

There is something profound and final in her description of sorrow, it felt as if she held a belief that this would never change. It seems the sorrow she described may have been exacerbated due to viewing the experience as fixed and unchanging. During the interview, I as the researcher had a strong embodied response of a tightness forming in my chest as Charis spoke, making me feel like I was frozen and constricted. I wondered if my embodied experience may represent the stuck-ness experienced by Charis. This interpretation appears to be further supported within her narrative when she described the impact of feeling unable to help:
“As a parent you just feel that you are sinking into this black hole. I just felt overwhelmed, I felt terrified and overwhelmed, for me and more for her, that I didn’t know how to help” (Charis)

This extract captures a sense of futility in attempting to keep trying. Just as light is prevented from escaping a black hole, it seemed her hope was swallowed up by the overwhelming fear seemingly triggered by her child’s difficulties. Her use of the word ‘sinking’ portrayed an experience which was slow. I wondered whether, the temporal element of the experience might serve to further illuminate her sense of terror and, in a similar way to how accidents often appear to be witnessed in ‘slow-motion’, having to witness her daughters struggle grow and not be able to intervene supports an understanding that she could be left feeling hopeless. In line with this, Georgie described the process of witnessing her child in a state of distress, which she could not change, as traumatic:

“It is traumatic seeing your child that bad. Yeah so it’s been really hard and when things have improved a bit erm, you’re always wondering if, or how long is it going to last for? Is there going to be another trip up?” (Georgie)

Georgie’s use of the phrase ‘trip up’ in this extract appears to indicate that the cause of her daughters difficulties was perhaps viewed as something external which happened to the child which the parent could not control and was unable to protect the child from. If Georgie makes sense of her child’s difficulties and the therapeutic process as something which is unpredictable and could rapidly change, rather than remaining stable, we can better understand the trauma of this experience. Her description evokes a feeling of being on high alert, constantly waiting and anticipating a new problem will occur. I wondered whether a sense of remaining hyper-vigilant to the prospect that her child’s difficulties could resurface served to protect her from the distress she had experienced as a result of feeling unprepared for the challenges with which her daughter struggled.

Together these experiences seem to illustrate how one consequence of their child’s engagement in therapy was to leave parents feeling helpless and impacted their hope for change. Maier and Seligman (2016) describe the way in which difficult events which leave people feeling out of control can result in a loss of hope that things
can change, and as a consequence people give up. However through recognising that future negative events “will not be permanent, global, and uncontrollable” (pp 29) hope can be restored (Maier & Seligman, 2016). In line with this concept, it points to the importance of supporting parents to view their current struggle as temporary and encourage them to avoid focusing on what they cannot change, but instead reflect on the value of the love and care they can offer their child.

As noted within this theme, at times parents appeared to feel hopeless because they recognised that they were not able to help their child. In contrast to this, a number of parents also described times when they questioned if they should have done something differently and potentially prevented some of the distress experienced by their children.

‘Did we do something wrong?’

Questioning their responsibility and reflecting upon whether they were to blame for their children’s difficulties was a theme present in many of the accounts given by participants. A number of participants described that their child’s engagement in therapy was a trigger for feelings of regret and a degree of shame about not having been able to prevent their distress. Sophie spoke about her experiences leading up to her child’s engagement in therapy and reflected on her behavior at the time:

“I thought oh my goodness, erm I’ve been quite remiss as a parent I was taking care of everybody else thinking he was ok, but afterwards, retrospectively I felt guilty because I thought I hadn’t taken care of him properly” (Sophie)

This extract demonstrates the complexity of the context within which the parental experience exists. In trying to care for one child she felt she jeopardised another. It seems that Sophie viewed the state of her child’s wellbeing to be the measure of the quality of her parenting and this led her to question whether she could have done something differently. Sophie went on to describe how her child’s engagement in therapy triggered her to reflect upon her identity as a mother:
“As a mother you want to protect your child and you don’t want them to need counselling, because in some way you feel you have failed as a parent” (Sophie)

Sophie’s account appeared to illustrate the tension which was evoked between her conceptualisation of what her role as a mother entailed (i.e. protecting her child) and her child requiring therapy. Her understanding of this as somehow indicating she had failed, led me to wonder whether this questioning of responsibility brought about by her child’s engagement in therapy, also impacted her self-esteem.

Feelings of regret coupled with a need to justify their behaviour were present in many of the interviews. Georgie spoke about the mistakes her and her husband felt they had made in the process of their child’s care:

“We thought we were doing the right thing, actually we were making it worse, but we didn’t know, we didn’t know” (Georgie)

This extract seems to demonstrate that their child’s engagement in therapy led Georgie and her partner to develop a different understanding of what their child’s needs were. However, in recognising this, it meant that they had to acknowledge that they may previously have made mistakes. It seems that Georgie found this recognition difficult. Her repetition of ‘we didn’t know’ might reflect an attempt to reassure herself that she couldn’t have done things differently.

This sub-theme illustrates the impact children’s difficulties had on parents’ judgement of themselves, their self-esteem and their own wellbeing. However, the degree of self-criticism and responsibility seemed disproportionate when it was considered in relation to the complex context they found themselves in. It seems that when considering the parents’ experiences collectively there may be value in encouraging parents to be self-compassionate in order to limit negative impact on self-esteem (Marshall et al., 2015). This may limit the potential for parents own wellbeing to be compromised by their child’s difficulties.
Discussion:

The present study explored parents’ experiences of having a child in therapy. It aimed to describe these experiences and help develop a greater understanding of the meaning they held for parents and contribute to the evidence base around helpful approaches to working with children and supporting their caregivers. The three master themes identified are further considered here in relation to existing research. However, it is important to note the tentative position from which these links and implications are made; holding in mind that the analysis and interpretations provided here represent one of a range of possible meanings (Finlay, 2011).

Situating the findings within existing research:

The theme ‘I got left with everything’ highlighted that feeling misunderstood could lead to isolation in both emotional and practical respects. While it was noted by Sayal et al. (2010) that judgement and fear of stigma represented a barrier to engagement in therapy, the current study was able to offer further insight into the way this may also operate as a barrier to parents being able to draw upon wider social support during the course of therapy. Furthermore it captured the way in which a lack of support from therapists and services was at times interpreted by parents to mean they did not care about their child and contributed to parents feeling alone in their struggle. Understanding this can support therapists to provide suitable opportunities for communication between therapist and parent to reassure the parent that they share a primary goal to promote the child’s wellbeing. Providing this could better facilitate collaboration and, in turn, foster successful outcomes for the child (Novick & Novick, 2005). Interestingly this theme contrasts the findings of Clark (2016) who found that mothers experienced feeling less alone once their child had engaged in therapy. This contrast serves to demonstrate the idiographic nature of the experience but also reflects that the parent-therapist relationship can be regarded as an important factor in how parents’ make sense of the quality of their child’s therapy.

In their interviews, parents demonstrated the way in which their child’s engagement in therapy impacted how they made meaning of their capacity to parent. Several parents shared how the therapist’s reassurance that they were supporting their child in the best way possible allowed them to feel more confident in their role as a
parent. For some parents it seemed that the boundaries around their child’s therapy were experienced as preventing them from being able to support their child and inhibited their understanding of their child’s difficulties. This is considered important given that research has demonstrated that when parents feel shut-out it may be more challenging for them to understand the relevance of the work which can result in them removing their child from therapy (Kazdin, Holland & Crowley, 1997). However, it is also important to note that the therapy needs to remain appropriately boundaried in order for the child to experience a sense of safety in the space (Raval & Smith, 2003). This theme may serve to illustrate the value in supporting parents understanding of the purpose and value of the therapeutic boundaries as well as offering psychoeducation within the context of a strong therapist-parent relationship. Enhancing parental understanding can support parents to manage their child’s difficulties as well as supporting the parent-child relationship (Stapley, Target & Midgley, 2017). Given that parents are the ones who remain with the child after therapy is completed this is regarded as crucial in sustaining long-lasting change (Feinstein, Fielding, Udvari-Solner & Joshi, 2009).

Within parents’ experiences, the theme ‘Walking on a cliff edge’ explored how parents described feeling responsible but unable to help. This theme offered support to Sheridan, Peteron & Rosen’s (2010) findings within family therapy that parents were left feeling inadequate as a result of their child’s difficulties and demonstrate this was present for parents of children in individual therapy. In addition, it lends support to Clark (2016) who also found that parents made sense of their child’s difficulties through blaming themselves. However, the current findings develop this further by offering additional insight into the trauma of this and the impact it had on parents own wellbeing. This understanding is important because if parents’ wellbeing is suffering, they are less likely to be able to support the child (Newland, 2015). This finding demonstrates the value in therapists sharing their formulation of the challenges experienced by the child, as this might offer a more balanced and accurate way for parents to make meaning of the experience, as opposed to blaming themselves. This might allow parents to be better placed to respond to their child’s needs and promote their own wellbeing.
It was clear from the interviews that having a child in therapy could be extremely emotionally overwhelming for parents. While they may not represent the primary client within child-focused work, it seems that is possible for us as therapists to make a positive difference to their struggle and through sensitive collaboration, restore their hope.

Reflections:

Reflecting upon the findings, it is interesting to note that the themes which I identified were mostly capturing negative or difficult experiences. Despite returning to the transcripts to check this, the transcripts were predominantly focused upon the challenges parents experienced. I wondered whether this might indicate that the participants who came forward represented a self-selecting group. It might have been that parents’ whose experiences were challenging may have been more drawn to the opportunity to have a space to share their struggle and in the process make some meaning of the challenges they experienced (Myers, 2000). As participants were aware that the study hoped to contribute to informing practice, they may have felt sharing the areas which went ‘wrong’ could have a greater impact than sharing those areas which went ‘right’. However, it would have been valuable for me to have recognised this during the interview stage so that I might have been able to be curious about whether there were any other positive or useful elements.

In addition to this, although CoP takes a non-pathologising approach to working with mental health difficulties and avoids diagnosis (Strawbridge & Woolfe, 2010) it was regarded as important to consider the variation in the presentations and challenges that led these children to receive therapy and to consider if this impacted or shaped how parents experienced the process of their child engaging in therapy. As noted in the method section, all of the parents described that their child was experiencing some anxiety, however the origin and presentation of this anxiety varied. Despite these differences, the findings did not reflect that the experiences shared by parents varied greatly according to the child’s presenting difficulty. However, one child was also identified to be experiencing anorexia. In contrast to more generalised anxiety, research has highlighted the necessity of family engagement in supporting recovery from an eating disorder such as anorexia (Lock & Grange, 2013).
Interestingly, the parent of this child did appear to describe fewer instances of feeling shut out by the therapist and her experience focussed instead on the challenging impact of wider judgement and her own self-criticism. This might illustrate how the therapeutic approach can be informed by the child’s presenting difficulty and impact how parents experience their child’s therapy. However, this parent’s experience also shared many elements with the other parents. Therefore, overall, it seems that while the specifics of the challenges their children were experiencing were important to the parents, it was the broader fact that their child was in distress that appeared to dominate and shape the experiences of therapy which they described. This may serve as a reminder, in line with CoP values, that we must consider the client within their context and build a formulation about their particular history, environment and experiences in order to find effective ways to help, rather than assuming a label/diagnosis gives us a full picture of the child’s or caregiver’s experience (Strawbridge & Woolfe, 2010).

Utility of the research:

The present research highlighted how the experience of their child engaging in therapy could trigger parents’ own difficulties and evoke not only self-blame and criticism, but a questioning of their identity. The findings contribute to informing the clinical practice of CP’s working with children as they highlight how developing an understanding and remaining sensitive to the emotional impact the experience can have on parents can foster a stronger working relationship with the child’s wider system of care. While collaboration with parents has been noted as valuable (Campbell & Simmonds, 2011; Novick & Novick, 2005), the present findings provided a more in depth understanding of the meaning this process can hold for parents which enables the way in which CP’s mobilise this collaboration to be less tokenistic. Instead, it supports an appreciation of the complexity and tensions which seemed to characterise parental experiences, for example; both wanting their child to have their own therapeutic space and yet struggling when they were not a part of this. As a consequence of this understanding, CP’s, and other practitioners offering individual therapy for children, may be better placed to accurately empathise and
relate congruently to parents and tailor the collaboration in such a way which meaningfully acknowledges the parents experience. Supporting parents effectively makes a contribution to promoting the child’s engagement in therapy and successful outcomes (Novick & Novick, 2005). Therefore, the findings make an important contribution to CoP through their support of therapeutic practice with children.

Furthermore, while attention to the area is growing, research considering therapy with children has been limited from a CoP perspective (Davy & Hutchinson, 2010). Therefore these findings also provide a further step towards ensuring that CoP research reflects the lifespan approach we take to our work, and has generated additional areas for future research from a CoP perspective. The present research contributes to CoP practice remaining grounded in a broad and meaningful research base (BPS, 2015).

Evaluating the research:

This research can be evaluated against the criteria set out by Yardley (2000). Providing detailed information regarding the rationale, recruitment and interview process aimed to demonstrate transparency and coherence. In this study sensitivity to context was shown at a number of levels including the empathic approach to the interview process and remaining reflective about the negotiation of power within this context with myself perhaps being perceived as the research ‘expert’ and the participants as the experts on their experience. However, it is also demonstrated at the analytic level through the provision of verbatim quotes from the participants to allow the reader to check the interpretations being made about the experiences they shared. The guidelines for IPA set out by Smith et al. (2009) were followed and can be used to further evaluate the analysis and demonstrate commitment to rigor and methodological competence. In addition, providing links to existing research and avenues for future research aimed to evidence the impact and importance of the topic (Kasket, 2012).
Limitations:

Although IPA’s use of interpretation supported the possibility to see beyond the explicit level of what participants communicated, it is still important to note that individuals present what they want to be known about themselves (Riessman, 2003). Given the concern regarding judgement and being misunderstood noted by parents in this study, there may have been a degree of wanting to present themselves in a favourable light and protect their identity as capable parents. This may therefore be regarded as a limitation. However, it seemed that providing an open and empathic approach to the interview process supported parents to offer a genuine and reflective account of their experiences.

It is important to note that although the study intended to interview both mothers and fathers, the final sample was made up of only mothers. Therefore, the findings cannot claim to be representative of the experiences of fathers. Research has found that although fathers’ involvement in childcare has continued to rise over the last 40 years, within western society mothers remain more likely to be viewed as the primary caregiver for children (Bianchi, 2000). This might indicate that mothers are more likely to have a role in the child’s therapeutic journey and partially explain why mothers rather than fathers came forward to take part in the study (Stapley, Target & Midgely, 2017). However, additional research is necessary to understand this in addition to how this imbalance of gender within the current sample may have impacted the findings.

Future research:

Based on the above limitation, future research might aim to explore a similar research question with a more balanced sample of mothers and fathers. In exploring this further it may highlight any differences between the experiences of mothers and fathers. This could help to tailor the support that therapists can offer. In addition, within the interviews parents spoke of feeling that they had failed as a parent and ideas of what a being ‘good’ parent involved. Therefore, exploring how discursive constructs contribute to the emotional impact noted within the present study may further support our understanding of this experience.
**Conclusion:**

This research has provided insight into what it can be like for parents to have a child engaging in therapy. It has highlighted the tension which can be present between parents’ desire to ensure their child receives appropriate care and the impact that not being involved in the therapy has on their own wellbeing. This research does not suggest that the solution is to invite every parent into the therapy room, but rather that it is possible to invite parents to accompany their child on the therapeutic journey. The findings demonstrate the important role therapists can have in supporting parents to hold a positive attitude towards the work. It emphasises the need for sensitive collaboration between therapist, parent and child to enable parents to be more confident in supporting their child outside of therapy. These findings are relevant to CoP as further developing our understanding of the value of ongoing collaboration can help us to improve the quality of therapeutic intervention for children (Novick & Novick, 2005; Smith & Thew, 2017). I hope this research will help to support therapists in their work and enable parents to move from isolation to connection.
References:


General Data Protection Regulation (2018){UK} General Data Protection Regulations (GDPR).


Appendices to Year 3 empirical study:

Appendix I: Recruitment email

Dear (INSERT NAME HERE)

My name is Emma Fredman, I’m e-mailing you about a study that I’m conducting as part of my Doctorate in Psychotherapy and Counselling Psychology at the University of Surrey. The study is about Parents’ experiences of having a child in therapy. The study involves taking part in an interview regarding your experiences of going through this process. The interview will last for approximately 50 minutes. Participation is confidential and voluntary. This study has been approved by the University of Surrey Faculty of Health and Medical Sciences Ethics Committee.

If you would like to participate, or have any questions about the study please contact me via phone or email to receive more detailed information and arrange a suitable time.

Thank you for your time.

Emma Fredman
Appendix 2: Participant Information Sheet

Participant Information Sheet

What are parents’ experiences of having a child in therapy?

Introduction

I am a Counselling Psychology PsychD student and would like to invite you to take part in a research project. Before you decide you need to understand why the research is being done and what it will involve for you. Please take the time to read the following information carefully and ask questions about anything you do not understand. Talk to others about the study if you wish.

What is the purpose of the study?

This study seeks to gain an understanding of parents’ experiences of having a child in therapy. Research has demonstrated that many young people who attend therapy do not complete the work posing a risk to their wellbeing. Parents play a crucial role in children’s attendance to therapy, supporting them in both practical and emotional ways. Research has indicated that speaking to service users directly can help to improve the quality of therapeutic practice and can support successful therapeutic outcomes. When working with children, we view both parents and children as service users; therefore it is viewed as extremely important to gain insight into the views of parents. It is hoped that through discussing your experiences of having a child in therapy we can learn more about its impact on you as a parent, how you coped and how you might have benefitted from this. Overall we are interested to learn about the meaning you have made from the experience so that therapists might be better placed to support other parents going through this process and have a better understanding of the difficulties and the areas which were viewed as useful. Out of this I hope to write up the research for my Professional Doctorate in Counselling Psychology at the University of Surrey.

Why have I been invited to take part in the study?

You have been invited to take part in this study because you are a parent whose child has attended individual psychotherapy/ a talking therapy.

To be eligible to take part in the study, you must meet the following criteria:

- Your child must have been aged between 6-12 years at the time they took part in therapy
- The therapy must have ended at least 6 months ago and a maximum of 5 years ago
- The therapy should have been individual rather than family therapy
Do I have to take part?

No, you do not have to participate. There will be no adverse consequences in terms of your legal rights, that is, if you decide not to participate or withdraw at a later stage. You can withdraw your participation at any time. You can request for your data to be withdrawn until August 2018 without giving a reason and without prejudice.

If you withdraw from the study this will mean the following for your participation and data*: Identifiable data already collected will be withdrawn from the study. Anonymous data already collected will be used because we cannot trace the latter information back to you. No further data would be collected from you.

What will my involvement require?

If you agree to take part, we will then ask you to sign a consent form. If you do decide to take part you will be given this information sheet to keep and a copy of your signed consent form. The research will last 5 months but your involvement would only be a 45 – 60 minute interview on one agreed day.

What will I have to do?

I would like to interview you for approximately an hour regarding your experiences of your child being in therapy and the impact this had on you and the meaning you have made of this experience. The interview will be recorded and then I will transcribe the interview. The transcription will then be looked at individually and then in relation to other transcriptions.

What will happen to data that I provide?

Research data are stored securely for at least 10 years following their last access and project data (related to the administration of the project, e.g. your consent form) for at least 6 years in line with the University of Surrey policies.

Personal data will be handled in accordance with the (UK) General Data Protection Regulations (GDPR) 2018.

What are the possible disadvantages or risks of taking part?

During the course of the interview you may find that speaking about your experiences makes you aware of things which feel difficult or brings things up that are upsetting for you. Although there will be a chance to talk about this after the interview, it may be most useful for me to provide you with details of where you can find appropriate support if you would like to discuss any topics or issues that arise in more depth. If at any point you no longer feel comfortable taking part, the interview can be paused or terminated completely if necessary. There will be no negative consequences of this.

What are the possible benefits of taking part?

The participants involved may benefit from the research as through sharing their experiences of their child taking part in therapy as it can help to ensure that we learn how best to support parents and young people during this process.
What happens when the research study stops?

The researcher will use the data collected to write up a research report which will be used as part of the fulfilment of her PsychD in counselling psychology.

What if there is a problem?

Any complaint or concern about any aspect of the way you have been dealt with during the course of the study will be addressed; please contact Emma Fredman, Principal Investigator via e.fredman@surrey.ac.uk in the first instance or my Supervisor Cristina Harangea via c.harangea@surrey.ac.uk. You may also contact someone who is independent of the research team, e.g. Head of School, please see address below. If you remain unhappy you can file a complaint using the complaint procedure, e.g. Clinical Research Centre.

School of Psychology Address:

School of Psychology
AD Building
University of Surrey
Guildford
GU2 7XH

School of Psychology tel: +44 (0) 1483 689 436

The University of Surrey holds insurance policies which apply to this study. If you experience harm or injury as a result of taking part in this study, you will be eligible to claim compensation. This does not affect your legal rights to seek compensation.

If you are harmed due to someone's negligence, then you may have grounds for legal action. Regardless of this, if you wish to complain, or have any concerns about any aspect of the way you have been treated during the course of this study then you should follow the instructions given above.

Will my taking part in the study be kept confidential?

Yes. Your details will be held in complete confidence and we will follow ethical and legal practice in relation to all study procedures. Personal data [name, contact details, audio/video recordings] will be handled in accordance with the (UK) General Data Protection Regulations (GDPR) 2018 so that unauthorised individuals will not have access to them.

The data you provide will be anonymised and your personal data will be stored securely and separately from those anonymised data. You will not be identified in any reports/publications resulting from this research and those reading them will not know who has contributed to it. With your permission we would like to use anonymous verbatim quotations from audio recordings in reports.
In certain exceptional circumstances where you or others may be at significant risk of harm, the researcher may need to report this to an appropriate authority, in accordance with the {UK} General Data Protection Regulations (GDPR) 2018. This would usually be discussed with you first.

Examples of those exceptional circumstances when confidential information may have to be disclosed are:
- The researcher believes you are at serious risk of harm, either from yourself or others
- The researcher suspects a child may be at risk of harm
- You pose a serious risk of harm to, or threaten or abuse others
- As a statutory requirement e.g. reporting certain infectious diseases
- Under a court order requiring the University to divulge information
- We are passed information relating to an act of terrorism

**Full contact details of researcher and supervisor**

Researcher: Emma Fredman  
Email: e.fredman@surrey.ac.uk  
Supervisor: Cristina Harnagea  
Email: c.harnagea@surrey.ac.uk

**Who is organising and funding the research?**

This research is organised by the University of Surrey and is un-funded.

**Who has reviewed the project?**

This research has been looked at by an independent group of people, called an Ethics Committee, to protect your interests. This study has been reviewed by and received a favourable ethical opinion from University of Surrey faculty of Health and Medical Sciences Ethics Committee.
Appendix 3: Consent Form

Consent Form

What are parent’s experiences of having a child in therapy?

Please initial each box

- I have read and understood the Information Sheet provided. I have been given a full explanation by the investigators of the nature, purpose, location and likely duration of the study, and of what I will be expected to do.

- I have been advised about any disadvantages/risks/discomfort/possible ill-effects* on my health and well-being which may result. I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given as a result.

- I agree to comply with the requirements of the study as outlined to me to the best of my abilities.

- I agree for my anonymised data to be used for this study / future research that will have received all relevant legal, professional and ethical approvals*.

- I give consent to my interviews with the researcher to be audio recorded

- I give consent to anonymous verbatim quotations being used in reports

- I understand that all project data will be held for at least 6 years and all research data for at least 10 years in accordance with University policy and that my personal data is held and processed in the strictest confidence, and in accordance with the {UK} General Data Protection Regulations May 2018

- I understand that I am free to withdraw from the study at any time without needing to justify my decision, without prejudice and without my legal rights being affected.

- I understand that I can request for my data to be withdrawn until August 2018 and that following my request personal data will be destroyed

- I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate time to consider my participation.
Name of participant (BLOCK CAPITALS)
......................................................................................
Signed
......................................................................................
Date
......................................................................................

{Please add a signature and date space if a witness is required}

Name of researcher/person* taking consent
......................................................................................
(BLOCK CAPITALS)
Signed
......................................................................................
Date
......................................................................................
Appendix 4: Interview Schedule

Interview Schedule:

Introductory question: What attracted you to taking part in this research project?

Prompt=

- What did you consider when you were deciding whether to take part?

1. Could you tell me a bit about the circumstances around how your child came to engage in therapy? / Could you give me a brief history of what led to your child engaging in therapy?

Prompt =

- How was it determined that the child needed help? (Where, when, context?)
- What was this process like for you as a parent? (meaning and significance?)

2. How do you feel about the fact your child required therapy? Have you always felt that way?

3. What is your perception of the difficulties your child was experiencing?

Prompt=

- Did your view or understanding of the difficulty change during the course of therapy?
- If so, what did it mean for you as a parent to change your understanding? (made it easier or harder)

4. How did you experience the therapeutic relationship between your child and their therapist?

5. What was your relationship with your child’s therapist like?

Prompt =

- Do you have a sense of what contributed to this?
- How might this have been different?

6. How did you feel while your child was in therapy? (Physically, emotionally, mentally?)

Prompt =

- Could you tell me about how/ if your experience of your own wellbeing changed while your child was in therapy?
- How do you understand/ make sense of these experiences and changes?

7. Has having a child in therapy changed how you view yourself?

Prompt =

- If so, what is different from before? Which areas have changed?
8. How have you personally, or you as a family, coped with your child’s difficulties during their engagement with therapy?

Prompt =

- Has the experience of your day to day life changed in anyway?
- What has your experience of your other relationships been like while your child was in therapy?
- Do you feel it has changed how other people see you and/or your family?
- What do these changes mean to you?

Concluding/summary question: Is there anything else we haven’t spoken about that you feel might be important for me to know about your experience of having your child in therapy?

General Prompts =

- Can you tell me more about that?
- How did you feel about that?
- What is the significance of that to you?
Appendix 5: Example Transcript of Interview - Extract

Words in **Bold** indicate the researcher speaking, word not in bold indicate the participant speaking.

**Interview with ‘Sophie’**

I wonder if you could tell me a bit about the context in which your child came to engage in therapy?

So it came about because my father-in-law died and at the time I thought that because, I was paying so much attention to my husband to be honest, and my two older children interestingly, because he was younger I thought he won’t be that affected by it or as affected by it because he didn’t know him as long so erm but then I became aware that he was getting very anxious. He wanted to know where I was going and when I would be back, and if I was a minute late he would be in terrible distress erm he yeah just basically needed to know my every whereabouts. Interestingly more me than his dad, I don’t know why, but I suppose he was younger and I was his primary caregiver so, his dad was around don’t get me wrong, but yeah it got to the point where if I was going out, he needed to know exactly where I was going and if I said I was going to be back 11 and I was back at ten past 11 he would be very distressed erm so we figured we needed to address this anxiety that he had to make him feel better

Great, and so how did you then find somebody for him to then go and see?

So I spoke to erm somebody that I knew that was a counsellor and she suggested, she actually mentioned that Organisation A had a children’s’ service which I didn’t know at the time because I’d also made a few phone calls, I’d been on the BACP website and, someone had told me about that and erm, but what I was, the message that was loud and clear on the BACP website was that not all therapists would take on children, because he was so little, he was below a certain age, they needed special insurance, or the place where the therapy was going to take place had to be safe so to speak. So in the end it was just easier to go to Organisation A because they were all set up and also they were cheaper, so that was another factor at the time, and they gave a special rate for kids, so that’s how we kind of chose where he was going to go but I didn’t get the opportunity to meet the therapist beforehand, she was just the person who was recommended to deal with children, so, erm, so I didn’t really see her till the day that I took my son.

Yeah, I wonder how you found that process of trying to seek someone to support him with that anxiety? What was that like for you as a parent?

I suppose as a parent I just needed to make sure I did the best I could to find the right therapist for him because obviously, I needed it, I wanted it to be a good experience for him so to speak. Erm but actually having spoken to, as I said, having spoken to one counsellor who was very informative and whose judgement I really trusted, so when she said Organisation A had a good children’s service erm after that I stopped looking at the BACP website, and just made an appointment there, so actually because I trusted their judgement, actually in the end it was quite an easy process.
Ok that's great, thank you. And you already mentioned a little bit about you know how your sons’ awareness of where you were heightened and you described it as anxiety, but I wonder if you could tell me any more about your perception was of the difficulties or challenges you felt he was experiencing at that time?

Erm I think, he was quite, if I look back he was sort of quite withdrawn and erm it was just yeah erm, yeah he was withdrawn but it was just this constant anxiety about, well about me but also about other members of his family, you know even his sisters, if they went out, he wanted to know where they were, and were they safe, I mean at the time he was quite little but they were teenagers so they were all over the place, you know, so he used to kind of worry for them as well. Erm mainly for me but he wanted to know where they were and if they were going to be ok, erm and it took us a while to make the correlation between his anxiety and the bereavement because, as I said, really with hindsight, we just assumed he would be ok, and at the time I didn’t really understand bereavement too much, erm so I figured it was going to be trickier for his elder siblings because they had known the deceased, who was then his grandad, longer. So I figured it would be alright for him and wasn’t really a problem but actually in his little quiet way he was just absorbing everything, not saying anything. And it just took us maybe a year or so just to work out what on earth was going because I suppose, looking back his thought processes were well if grandad could die suddenly, because it was a sudden death, then the same could happen to my parents or other members of the family, because he wanted to know, oh yeah that was the other thing, because when his grandad died, his grandmother was sort of quite elderly and my parents were quite elderly, so if the phone rang he’d want to know who it was, what the conversation was, was everybody ok,

Yeah

You know basically was there potentially another bereavement on its way, yeah it was kind of quite hard for him really

And I wonder what it was like for you during that time?

Initially I found it, I thought, I found I got quite annoyed, he just wants to know too much information but afterwards (laughing) when this kept going on I thought oh my goodness, erm I’ve been quite remiss as a parent I was taking care of everybody else thinking he was ok, but afterwards, retrospectively I felt guilty because I thought I hadn’t taken care of him properly, basically.
Appendix 6: Example of Coding

209 he wouldn't allow himself to show emotion in there so I don't know that really, she was able to extract exactly what was going on in his
210 head, mainly because he wouldn't allow himself to relax and tell her
211 what he was feeling.
212
213 Right.
214
215 Especially after his sister told him, after the negative comments
216 they made, I think they really ruined his whole counselling
217 experience.
218
219 The other thing I wanted to ask you a bit more about was your
220 experience of your relationship with the therapist and how I
221 wonder what it would have meant to you if she could have given
222 you the encouraging smile or even to have met as a family as you
223 described?
224
225 I think the whole thing would have been a lot, I think, a lot nicer, I
226 don't think I'm trying to think back it might have said anything negative
227 in front of my son, I'm hoping I didn't say anything of what I was
228 thinking in front of him, or making out loud. I really can't
229 remember if I did or not. He could probably tell from my body
230 language that I wasn't too pleased with the way she treated me.
231
232 Even so whether he picked up on that I don't know. I just felt she
233 could've just been a bit warmer, a little more encouraging,
234 knowing that you are giving the most precious thing in the world to a
235 counsellor to help your child, even it was hard, just felt it out of control
236 because I was out of control, but I just found her very cold. Just
237 very reasonable, so if you... well, I hope she's not displacing, I hope
238 she's not like that with him, even, which I don't think she wasn't I think
239 looking at him...
she was sick, but I don't know that she was the looking back. If you can't fix it right now, just have good therapists are you

That's the thought you were leaving at the time?

Yet she was working for Organisation A, so I thought if you're working for a big organisation like Organisation A you must be good otherwise they wouldn't take you on, so

I wonder if we could go back to what you said about feeling a bit out of control and what that was for you in this context?

Arid terrible, because you're in a child whose, you're 100% arm and psychic, I've got it, it's hard actually. I was disordered to know what they thought about, and I know I had to curb my curiosity, but I literally could not tell you to this day what they talked about. My son will not talk about it, will not mention it. Now at the age, he's a little bit older now, actually I might ask him one day if it was a positive experience or not. I suspect not actually because he didn't see the whole counselling through and he wanted to stop. And there was, and I encouraged him, despite my feeling about the counsellor I wanted him to carry on with it, because I really wanted him to have a positive experience of it and see the benefits of it but he wanted to stop, so because he wanted stop, I was then forced to, well if he wasn't going willingly, it wasn't helpful for anybody

I wonder how you felt about the fact he wanted to stop?

Disappointed because I didn't think that we actually solved anything, I think in fact because of what his sisters had said, I think that was the

You also sort of mentioned despite you having certain views about the therapist, you still wanted to encourage him to keep going?

Yeah absolutely. Yeah I just felt erm, think for kids, in particular if you need help as a youngster, if you can, if you're lucky enough to find a counsellor that you have a great rapport with, I think it can facilitate your life because it means, if in the future you're struggling with anything, you think, you, I had a really positive counselling experience, I'm struggling in my life now, and I think I'm going to go back to a counsellor, maybe not the same one, but I figure for him if he had had a positive experience, I mean as he goes into teenage hood, if he needs a bit of extra help, and sometimes as parents we're not able to help them or they need someone who isn't as close to them, erm, they think ok there's somewhere else I can go, and he's been offered, he had an issue at school, and he was offered counselling at school but he won't go, and now I'm talking to you if I'm remembering, he said I don't need it, I'm not mental, I don't need it. So obviously that comment that his sisters made all those years ago really resonated with him which is a massive shame.

I wonder what it was like for you to have those feelings and yet still encourage him to keep going? To have the difference? What was that like?
I suppose always at the forefront of my mind was that I wanted to do whatever I needed to do for his benefit and if it meant I had to swallow my pride if this woman annoyed me and just deal with it (laughs) and just deal with it, that was my problem, not his family, but you know. Some parents might possibly have said I don't like this therapist and I don't want my child to see them, but no, I thought I've got to shut up my feelings, listen to them and deal with them, so that he could have a good experience, so that she could help him and his problems at the time, his anxiety.

You also mentioned that the child having a good relationship with the counsellor was important because as a parent you may not always be able to help, even if you wondered if you could say anymore about that experience of you feeling it was something you couldn't help him with?

No, I just thought, if the counsellor had been a bit more inclusive, even if she'd have said, even if with his permission had allowed us to be in the room with him, retrospectively I think it would have helped him to relax a bit more and see it was okay for him to talk about how he was feeling, and it would have helped us to help him, because then the conversation you have at home isn't the same you have in a therapeutic room, because obviously the counsellors experience and ways of extracting info, which it just wouldn't happen at home, so it was a real shame, the whole experience was just a real shame.

I wonder what it's like to have that feeling of not being able to help?
Appendix 7: Individual Sub-themes clustered under Master Themes

Orange: Abigail
Yellow: Sophie
Green: Charis
Blue: Lisa
Pink: Beth
Purple: Georgie

Theme 1: ‘I got left with everything’: Therapy as an isolating experience
## Theme 2: ‘Hang on, I am his mother’: Perceived impact on parenting capacity

### Subordinate theme: Who’s the parent here? – the balance or conflict between feeling supported to feeling robbed of the parenting role entirely

#### Theme: Robbed of parenting role:

- Battle to show who cares the most
- Battle to show who knows the most
- Threat of therapist
- Therapist sabotaging parents’ capacity to protect child
- Taking control away from parent
- Threatened by therapist-child relationship
- Therapist withholding information reducing parents’ capacity to help
- Therapy threatening their identity as a parent
- (Parent also looking to be parented?)
- Therapy as a trigger for self-reflection on parental role
- Is their role important?
- Uncertainty of where they fit
- Feeling excluded from the work

#### Theme: Relief of support:

- Gratitude for support
- Child’s difficulties as a burden
- Therapy offering a release and relief
- Protecting family life

#### Theme: Ambivalence to therapy:

- Parent questioning value and ability of therapist
- Parents role as protector
- Uncertainty of therapeutic process
- Challenge in acknowledging value in therapist-child relationship
- Questioning value of therapy
- Questioning child’s capacity to engage

### Subordinate theme: Therapy contributing to parental isolation/rejection

#### Theme: Rejection/Isolation

- Transparency vs. exclusion
- Sense of exclusion or rejection from therapy reinforcing parental self-blame

### Subordinate theme: The solitary waiting room

#### Theme: Rejected and excluded by therapist

- Rejected rather than invited into relationship
- Lack of collaboration
- Parental voice silenced during therapy
- Therapy as a lonely experience
- Lack of communication
- Parental needs minimised
- Therapy triggering changes in support system

#### Theme: Child’s difficulties as a reflection of parenting capacity:

- Therapy triggering parent to question their capacity to care for child
- Impact on parent view of self on a more personal/individual level
- Feeling responsible for child’s issues arising
- Concern of judgement in their parenting capacity and child as bad

### Subordinate theme: Oscillation between hope and hopelessness

#### Theme: Hope driven by love/positive experiences (actually only serve to make the less even greater)

- Relief from sole responsibility
- Therapist offering relief from parental blame
- Child experiences experienced as a burden and therapy offering relief from this
<table>
<thead>
<tr>
<th>Themes: Loss of Parental Identity</th>
</tr>
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<tbody>
<tr>
<td>Subthemes:</td>
</tr>
<tr>
<td>Individual identity lost due to focus on child</td>
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<table>
<thead>
<tr>
<th>Themes: Hope of understanding — and its impact on child's wellbeing and distress of parent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subthemes:</td>
</tr>
<tr>
<td>Therapy as a key step towards understanding their child</td>
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<tr>
<td>Understanding child as a way to improve their care</td>
</tr>
<tr>
<td>Commitment and engagement driven by desire to understand</td>
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<tr>
<td>Meaning of therapy unclear to parent (lack of communication)</td>
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<table>
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<tr>
<th>Themes: Providing containment</th>
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<tbody>
<tr>
<td>Subthemes:</td>
</tr>
<tr>
<td>Building confidence in parenting role</td>
</tr>
<tr>
<td>Normalising difficulties and response</td>
</tr>
<tr>
<td>Offering support and reducing isolation</td>
</tr>
<tr>
<td>Providing understanding</td>
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<tr>
<td>Child's difficulties impacting parent's emotional wellbeing</td>
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<table>
<thead>
<tr>
<th>Themes: Therapy as part of a wider system of care and context</th>
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<tbody>
<tr>
<td>Subthemes:</td>
</tr>
<tr>
<td>Therapy as a parent of a more complex system of care</td>
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<tr>
<td>Value of additional professional in supporting therapeutic engagement</td>
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<table>
<thead>
<tr>
<th>Themes: Therapy offering hope/ normalisatios</th>
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<tbody>
<tr>
<td>Subthemes:</td>
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<tr>
<td>Offering reassurance</td>
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<td>Not feeling alone</td>
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<tr>
<th>Themes: High levels of emotional distress/hedychondria</th>
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<tr>
<td>Subthemes:</td>
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<tr>
<td>Coping with uncertainty</td>
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<tr>
<th>Themes: Limited freedom</th>
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<tbody>
<tr>
<td>Subthemes:</td>
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<tr>
<td>Containment</td>
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<td>Not so isolated</td>
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<td>Responsibility shared</td>
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<tr>
<th>Themes: Therapeutic intervention as damaging</th>
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<tbody>
<tr>
<td>Subthemes:</td>
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<tr>
<td>Therapy as causing further distress</td>
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<td>Therapy as a hindrance</td>
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<tr>
<th>Themes: Struggle to the potential of exclusion vs supplements</th>
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<tbody>
<tr>
<td>Subthemes:</td>
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<tr>
<td>Exclusion undermining parents' capacity to help</td>
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<tr>
<td>Struggle in making meaning of rejection</td>
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<tr>
<td>Superficial support / parental needs unmet and unmet</td>
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<tr>
<th>Themes: Value of collaboration</th>
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<tr>
<td>Subthemes:</td>
</tr>
<tr>
<td>Improving parental confidence</td>
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<tr>
<td>Helping parents sustain hope</td>
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</tbody>
</table>
Theme 3: ‘Walking on a cliff edge’: Responsible but unable to help
Appendix 8: Theme tables with sample quotes across all participants

Theme 1: ‘I got left with everything’: Therapy as an isolating experience

Sub-theme 1: Feeling misunderstood

<table>
<thead>
<tr>
<th>Participant</th>
<th>Sample Quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Abigail:</strong></td>
<td>“People are actually just are terrible, they ask you terrible things and they say terrible things, like ‘you know you never know about genes’, ‘it’s genetic isn’t it?' and you think well this is my child you’re talking about, so they’d kind of have opinions, and I kind of feel that had I then said he’s going to therapy, people would have had it confirmed that he’s a weird difficult child, and he isn’t”</td>
</tr>
<tr>
<td></td>
<td>“I told my closest friend... I didn’t tell anyone else ... I didn’t want to feel any more different at the time”</td>
</tr>
<tr>
<td></td>
<td>“I felt stigmatized”</td>
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<td></td>
<td>“I felt different from the other mums, and I was different anyway.”</td>
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<tr>
<td></td>
<td>“I just felt different”</td>
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<tr>
<td><strong>Sophie:</strong></td>
<td>“They’d say to him oh what do you need counselling for, oh only mental people need counselling, so then it’s put this really negative perception of counselling in his head, so then it all went downhill from there really”</td>
</tr>
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<td></td>
<td>“Once his sisters, on the second session, after they got the wind of what was happening, and he had this perception he was mental, I don’t think then he embraced the counselling in a very positive way so that was a real real shame, so if I could go back again, I would encourage him to let his sisters know, and I would certainly sit with the girls and say your brother needs counselling, he’s not coping very well, he’s very anxious, blah blah blah, rather than it come out in the way it did, and he had such negative comments from his sisters, I think it just tainted the whole experience for him”</td>
</tr>
<tr>
<td></td>
<td>“I know you have to have boundaries but it felt like she was saying ‘I know better than you’”</td>
</tr>
<tr>
<td><strong>Charis:</strong></td>
<td>“[Her] grandparents were like oh she’s so difficult... so I don’t feel I can share her diagnosis with, well, anyone. Because in such a small village, you say one thing and it will go around the whole village. So I just kept it sort of to myself really. And then I think, I should probably just have counselling for it for myself, to deal with how I’m feeling (crying)”</td>
</tr>
<tr>
<td><strong>Beth:</strong></td>
<td>“I remember, erm, my mother she had written it in her diary, that she was so sad, and it was so terrible, and in many respects it was”</td>
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<tr>
<td><strong>Georgie:</strong></td>
<td>“Well I’ve had one conversation with a friend; a very good friend to Ella who has been incredibly supportive ... and her parents were getting worried about the impact on her, which I can understand, but I bumped into her mum and she was so cold towards me, so cold and said ‘how do you catch anorexia anyway?’ (laughing)”</td>
</tr>
<tr>
<td></td>
<td>“She said well ‘yes how do you catch anorexia anyway?’ Erm, and kind of made it clear that she didn’t really want her daughter to be so involved”</td>
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<td></td>
<td>“Then other people who have avoided contact”</td>
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<td></td>
<td>“Yes and you sort of feel by sort of friendships, the parents of ELLAs friends and the school, you feel a bit ostracized sometimes (whispered tone) oh ELLA’s got mental health problems. And I think some people have definitely avoided contact”</td>
</tr>
</tbody>
</table>
“There have been certain friends who’ve really stood out as really being there and then other people who haven’t, and then other people who have avoided contact because they don’t want their daughter to, it’s my fantasy but they don’t want their daughter to spend time with ELLA because of the impact on their daughter”

“I think as a parent, you think perhaps they (the therapist) feel the problem is because of you”

“(impersonating therapist) I’m going to keep ELLA to myself, keep all the information to myself, and I’m only going to tell the school, because the problem is with the parent, and we’re going to try to sort it all out here”

“I mean obviously I don’t know what she was thinking, I don’t know what she was thinking about me as the parent, and that’s my fantasy of what she was thinking about me because of the lack of sharing of information”

**Sub-theme 2: Left alone at sea**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Sample Quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charis:</td>
<td>“[The therapy service] just left us at sea. They left us to cope with it. Or they passed us on, and said oh we can’t help so we’ll pass you on to someone else.”</td>
</tr>
<tr>
<td></td>
<td>“I was just so gutted and I was angry, I was really angry actually. It was like, you can have this person but you can’t have them. He’s going to help you but he’s not going to help you.”</td>
</tr>
<tr>
<td></td>
<td>“The whole process was like beating my head against a brick wall. Just another door slammed”</td>
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<td></td>
<td>“Then I feel resentful to the system because no one took charge, no one said ‘this is what she’s got’, ‘this is how we think we should deal with it’, ‘we’re going to support you’, there was no safety net. Everything just kept falling away.”</td>
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<tr>
<td></td>
<td>“She was kind of just floating around in the system, and no one knew what to do with her.”</td>
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<tr>
<td></td>
<td>“We are going to support you, and we are not going to give up on you. Because they just gave up”</td>
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<td></td>
<td>“That felt quite scary actually, that I realised that she needed more than what I was ever going to be offered. That I felt really scared for her, and I felt scared for me”</td>
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<tr>
<td></td>
<td>“That’s terrifying as a parent, and at that point I thought oh my god, she needs more”</td>
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<td></td>
<td>“The realisation that she needed more than pastoral care or a bit of counselling, it had gone way past that, and as a parent you just feel that you are sinking into this black hole. I just felt overwhelmed, I felt terrified and overwhelmed, for me and more for her, that I didn’t know how to help”</td>
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<td></td>
<td>“I felt like we were at sea, all floating around, and everyone was floating around at sea and no one put any connections together. No one communicated with each other, no one put connections together and said but why is this child school refusing?”</td>
</tr>
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<td></td>
<td>“If someone had said, put the connections together and invested more time, because no one person, invested any decent amount of time, it was like well you just 6 weeks, well you just get once a term. And then they were like well you have to pay for it then.”</td>
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<tr>
<td></td>
<td>“They just gave up”</td>
</tr>
<tr>
<td></td>
<td>“I felt that they weren’t meeting me halfway, so if I could get her halfway, they’d meet me halfway, but I was having to get her to the halfway mark and then getting her to them as well.”</td>
</tr>
<tr>
<td></td>
<td>“It was just like oh this hasn’t worked, and that was the end of it.”</td>
</tr>
<tr>
<td></td>
<td>“I got left with everything (tearful)”</td>
</tr>
</tbody>
</table>
“I shouldered 90% because my husband was like well obviously the way I dealt with it was wrong so he backed off, and my son was 14. 15 you can’t expect a boy that age to help, no one else was there, I was literally shouldering and carrying it on my own”

“So as a parent, well my husband at that point backed off, he didn’t know what to do, and I was left”

“Be prepared to invest the amount of time a child needs, not just you’ve got 8 weeks of sessions. I mean what do we do at the end of the 8 weeks?”

“One of the counsellors was left saying I can’t work with this child, I can’t do anything”

“I don’t think the counsellors knew what to do with her”

“I didn’t have anyone to talk to to say just hold on, this will work”

“I feel I’ve let her down. But no actually they’ve let me down (crying) the system has let me down.”

“There was that missing link, there was that missing, they didn’t quite seem to get that if I was a happy mum, if we help you as well, you will be better for her, we’ll help her but we’ll also just bring you in.”

“Maybe there is a group where parents can go and share their experiences confidentially, and just know that, oh you’re going through that, because that’s the thing, I felt totally on my own, I just felt so alone”

Lisa:

“It would be good if there was someone that could ... be there, to be able to speak to or to say try this!”

“He’s also very anxious, thinks he’s going to die, or the family is going to die. When you’re dealing with it as a parent you just think there would be someone that could help us”

“It’s absolutely ludicrous that there’s no mental health for children, its huge now it becoming bigger and bigger and bigger, and it’s absolutely disgusting that they can’t provide these children with any therapy. I’ve looked to go private and it’s going to cost me in the region of £5000, money I do not have (laughing) but if that’s the help he needs.”

“I’ve basically done it myself”

Beth:

“I think, it is very tiring and also I felt that you wanted to know were we doing something very wrong, or we needed help and guidance. How to deal with the situations”

Georgie:

“So we went to see ELLAs head teacher at the very end of the term when she was deteriorating and just before we were seeing the psychotherapist, to see how the school could help and oh she was horrendous ... Absolutely horrendous she was more concerned about the impact of ELLA on her other children and her nurse rather than ELLA”

“It really felt like we were put through a sausage machine, and it was a formula and it wasn’t personal”
‘Hang on, I am his mother’: Perceived impact on parenting capacity

**Sub-theme 1: Having the confidence to ‘just be mum and dad’**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Sample Quotes</th>
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<tbody>
<tr>
<td>Abigail</td>
<td>“It was the right thing for him at that time and it was and it kind of made it it’s made me feel a bit this sounds weird but a better mother for it”</td>
</tr>
<tr>
<td></td>
<td>“From my point of view, there was something of a relief, it wasn’t all me? It wasn’t all on me, sorry”</td>
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<tr>
<td></td>
<td>“I think I felt it was good because in large part I could devolve that part (laughter) somebody else was dealing with his problems, it was quite a relief that there was somebody there”</td>
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<td></td>
<td>“I think it was for me personally it was really important because it was getting quite overwhelming and it was something outside the school and I mean I can’t describe how it was at that time, my whole life was dominated either by medical appointments for him, social work”</td>
</tr>
<tr>
<td>Sophie</td>
<td>“Sometimes as parents we’re not able to help them or they need someone who isn’t as close to them”</td>
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<td></td>
<td>“At the time I was trying to understand why he was behaving like this and where it was all coming from so to be honest I was hoping the counsellor would solve a problem, because obviously if he felt better, then life in the household would be better”</td>
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<tr>
<td>Charis</td>
<td>“And then we paid huge huge amounts of money for a psychologist. Who did help actually, and she diagnosed high functioning Asperger’s in girls and erm but my daughter doesn’t accept that diagnosis and she talked to me and she was great and I felt quite supported by her. But then, so I should because I was paying £130 for an hour.”</td>
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<td></td>
<td>“He connected with my daughter, he connected with me. I felt the first session with him I felt you get it; he was really supportive of me”</td>
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<td></td>
<td>“For that 18 month period when she saw her I felt, like someone was on my side”</td>
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<td></td>
<td>“She just made me feel like it wasn’t all my fault and that there is light at the end of the tunnel and you can move forward”</td>
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<td></td>
<td>“It gave me hope, that he was really going to help us, I just felt this complete flood of relief, and that ok I can hand her over, I can just sort of take some of the responsibility off of me, it was like, right you’re on my side (tearful).”</td>
</tr>
<tr>
<td></td>
<td>“It was quite comforting, I was more at peace, because I just had this inner turmoil”</td>
</tr>
<tr>
<td>Beth</td>
<td>“She just reassured us this is quite normal reaction and what we were doing were, was good and it’s just a matter of keep on going, and it will get better”</td>
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<td></td>
<td>“I think it was just nice for us to have met up with someone who had the knowledge and could speak to our son and see him and see us, how we were and how we think about things and for us to be reassured that however hard, there are no quick solutions but keep on going and what we’re doing is the right thing.”</td>
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<tr>
<td></td>
<td>“It helped for me because you relax and you become, I become stronger from knowing that I have that support from someone and also that she says what I am doing is ok, then I find the strength to keep on going in a different way”</td>
</tr>
<tr>
<td>Georgie</td>
<td>“[Therapist said that] When she eats you don’t say well done, you just take the plate away, eating is a normal behaviour, we all do it, you don’t praise a normal thing that you’d expect someone to do, so she was quite helpful really. But luckily, I mean we had a couple of flare ups the first two times with ELLA, but then she settled down and she just got on with it.”</td>
</tr>
</tbody>
</table>
“She gave us helpful strategies but also but the whole experience felt quite containing”

“So it turned out that she had also had anorexia herself and been an inpatient. So I think she was very solid in her sense of how she approaches the work. There was no panic.”

“It was all very relaxed and very personal and she had real experience based on her personal on her own struggles and she knew what it felt like sitting there”

“That’s been our role I think. To not be clever, but to just be mum and dad”

**Sub-theme 2: Boundaries as a saboteur**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Sample Quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Abigail:</strong></td>
<td>“I don’t remember her actually telling me anything that had come up and some things that were important did come up because he would talk about I don’t know we talked about the monster or something like that which had meaning for him erm, but she didn’t, I wonder what that would have meant to you to have that update you spoke about? I think it would have made it feel more complete? I don’t know if that makes sense? Could you say a little more about it? I think it would have helped to join up all the dots”</td>
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<td></td>
<td>“Part of that I found a bit difficult because I was the parent and if things were going on I’d like to have known but I didn’t and he was only 9 and a very young 9 more like 5 or 6 emotionally”</td>
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<tr>
<td></td>
<td>“Hang on, I am his mother”</td>
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<td></td>
<td>“This teacher would give me an update on anything that had come up and anything she might have been curious about, and this was entirely different, it was very boundaried, very separate and I didn’t know, so at the time I think it you know I’ve got the benefit of time now, so yes but I think at the time I felt a little bit shut out and I might have wanted to know more, or to say oh yes that’s this, but I had no say in it, but it was entirely between her”</td>
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<td></td>
<td>“It made me a little bit shut out I think is the word, but, yeah and uneasy... The shut out-ness and uneasiness were not for me it was because I hoped that he was being fully understood, so it was about things that I could have clarified”</td>
</tr>
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<td></td>
<td>“I think I may have even said is it possible to have a review meeting and she said no we don’t do that, and it was like arghh, and she would say ‘we like to keep this between therapist and the child’ and this was based on trust (Laughter)”</td>
</tr>
<tr>
<td></td>
<td>“This is someone I am trusting my child to and I’d like them to be a bit caring, to me too.”</td>
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<td></td>
<td>“The home school link worker but she wasn’t a trained therapist but she was brilliant and she made me feel very included and did everything the therapist didn’t, I came in, she called me in, and just said I wanted to let you now, this beautiful drawing, she actually loved my child, and believed him so I get relationship with her, so it was quite interesting this thing that he had, the therapy, that I was quite shut out of it”</td>
</tr>
<tr>
<td><strong>Sophie:</strong></td>
<td>“Maybe she’s not there to reassure me but I just felt we could’ve , if we’d have had a session together the 3 or 4 of us together, it might have changed my sons experience as well, as much as mine”</td>
</tr>
<tr>
<td></td>
<td>“I just thought, if the counsellor had been a bit more inclusive, even if she’d have said, even if with his permission had allowed us to be in the room with him, retrospectively”</td>
</tr>
</tbody>
</table>
I think it would have helped him to relax a bit more and see it was ok to for him to talk about how he was feeling, and it would have helped us to help him”

“I accept that the counsellor had to, I suppose my son had to feel that he could say whatever he wanted to the counsellor, and feel safe, but, I don’t know what I would have liked even, would be for her to suggest that we had a family session with him, so that we. Without her breaking confidentially, to help us help him, but none of that was offered.”

“I know you have to maintain confidentiality but he was quite young, and I just figure that suggestions should have been made to do some family therapy with him, it didn’t happen, I felt really frustrated with the counsellor and I just really didn’t hit it off with her”

“Because he would never talk about what happened in the room, I had no idea what they talked about, if it was positive, you know particularly after the first session, whether it was a positive or negative experience, he just kept saying, I don’t need to know, I don’t need to tell you anything, erm, so I actually to this day do not know what they talked about or how he actually felt about the counselling”

“‘I know you have to have boundaries but it felt like she was saying ‘I know better than you’”

“I suppose while he was in there, because I’d have to wait for him, because he was a minor, I’d wait outside for him, so on the other hand there were moments of hopefulness, I hope when he comes out he’s feel healthy and like he’s unloaded something maybe and feel lighter in his mood and his demeanour, so that was one, on the other hand id also feel out of control, because we didn’t know anything that was being said in that room, what was being said, what wasn’t being said because I felt a bit of animosity towards the counsellor, because I felt a bit venomous towards her so that probably didn’t help, erm but really the bottom line was, I think during the sessions, I always hoped more that he would have the courage to really tell her how he was feeling to allow himself to completely relax in her company, but he never did, he told me that, I can’t cry in front of her”

“I’d also feel out of control, because we didn’t know anything that was being said in that room, what was being said, what wasn’t being said”

“It was awful, because the trouble was erm, you know as kids, when they’re under 16, you can go to the doctor with them, but suddenly he’s in this counselling session, and I had no idea what was going on”

“I just got the impression that my son took her saying you don’t have to talk about it quite literally and felt he couldn’t talk about it”

**Charis:**

“Well it was one of the things which I always found quite bizarre because on the whole, we were very side-lined, but we are the ones after that hour, who are taking her home for the other 23 hours of the day. So it seemed crazy to me that it was very focused on her but there was nothing for us as well”

“There was that missing link, there was that missing, they didn’t quite seem to get that if I was a happy mum, if we help you as well, you will be better for her, we’ll help her but we’ll also just bring you in.”

“Because I was on my own with all these thoughts in my head, I kept thinking I’m doing it wrong, ... that’s the one thing she didn’t need the inconsistency. Even now she needs consistency, everything staying the same and everything to be calm and that was the one thing that lacked. I had all these thoughts going round in my head, I can’t process these thoughts, I don’t know which avenue to go down, so I was just ping ponging around”

**Lisa:**

“When she told me I wouldn’t be in the room I did feel quite awkward about it, because I thought that’s my son, and he’s 8 years old! And I want to know what he’s
talking about and she said it's private, its confidentiality, and I cannot be in the room. I found that odd

“I just feel he needs someone to talk to, but also the parent needs to be involved. Not as it has been in the sense, I know you get reports at the end of it all, but I think parents should be included. Not in the way of every session, but every few, brought in, ‘what’s been happening for the past few sessions?’, ‘ok, let’s have a few more and then check back in’”

“You feel like you can’t help him”

“She would only tell me if he said something which would cause him to be harmed or anything like that but I just felt that being 8, I should have been allowed in room.”

“I was outside the room so I could hear muffled voices. I couldn’t quite work out what they were saying but I wanted to know what they were talking about. She wouldn’t tell me either.”

“I want to know what’s going on in my sons head... I mean I would understand him better, and I could care for him better knowing and understanding ‘why are you feeling like this’ ‘Why are you having these thoughts?’ ‘How can I help you?’”

Georgie: “I think as a parent, you think perhaps they [the therapist] feel the problem is because of you”

“(impersonating therapist) ‘I’m going to keep ELLA to myself, keep all the information to myself, and I’m only going to tell the school, because the problem is with the parent, and we’re going to try to sort it all out here’”

“I mean obviously I don’t know what she was thinking, I don’t know what she was thinking about me as the parent, and that’s my fantasy of what she was thinking about me because of the lack of sharing of Information”

“She told the school nurse that, would you tell ELLA’s parents that I am not allowed to have any contact with them, that she had signed some professional agreement, which as a trained music therapist myself I thought, but there’s also a safeguarding issue here, and if you feel a child’s behavior is to themselves damaging, you’ve got to tell the parents”

“Particularly when I began to feel that ELLA wasn’t doing very well and the nurse had spoken to me. But she even refused to return a phone call.”

Theme 3: ‘Walking on a cliff edge’: Responsible but unable to help

Sub-theme 1: Helpless and hopeless

<table>
<thead>
<tr>
<th>Participant</th>
<th>Sample Quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abigail</td>
<td>“It’s making me feel emotional now because it’s really awful having a child, he would hit himself and say I’m bad I’m bad I’m wrong I’m bad and you cannot actually do anything about that, you can’t tell them how much they’re loved”</td>
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<td></td>
<td>“So it was somebody else helping, because I didn’t feel able to help with this aspect, I was his mother too, I couldn’t help with working through all these things, however much we try to”</td>
</tr>
<tr>
<td>Sophie</td>
<td>“it’s awful because you know your child is hurting, and it’s hard to know how to help them”</td>
</tr>
</tbody>
</table>
|             | “I think when they struggle emotionally its heaps heaps harder because it take a lot
longer to repair it, if indeed you can repair it, you can’t always repair it”

“He didn’t see the whole counselling through and he wanted to stop and there was, and I encouraged him, despite my feeling about the counsellor I wanted him to carry on with it, because I really wanted him to have a positive experience of it and see the benefits of it, but he wanted to stop, so because he wanted stop, I was then forced to, well if he wasn’t going willingly, it wasn’t helpful for anybody”

“I mean it was probably more frustration than anything else, I really had tremendous hope that the counselling would help him and so I was really frustrated and disappointed that he didn’t feel that. I’m not saying it was the counsellors’ fault; it’s just that if he wasn’t really engaging 100% then she couldn’t really help”

“I just felt she could’ve just been a little bit warmer, a little more encouraging, knowing that you are giving the most precious thing in the world to a counsellor to help our child”

“I felt ok, I mean I felt, obviously it was a massive worry, it did feel like there was a weight there, if your kids aren’t happy it’s hard for you as a parent to feel happy,”

“Well I mean to me, the best day is, my best day is when the kids come in and they’re happy and content, and they’re at one, there’s nothing worse than you know, when your kids hurts, when your child hurts, you hurt 100 times more, if they’re really struggling emotionally, it’s very very hard”

Charis: “I just felt overwhelmed, I felt terrified and overwhelmed, for me and more for her, that I didn’t know how to help”

“You can see her eyes shutting down, and the world closes in, and then you can’t get to her.”

“I still, literally to this day I still, we still don’t know how to deal with her”

“It’s frustrating not being able to help her”

“It was this deep sorrow, that I’ve got this child that I can’t help”

“I felt so sad for her, I felt sorry for her, I thought I can’t help you; I need someone professional to help you”

“So at that point she just said I’ll deal with it on my own. She was like, stop talking about it, stop going on about it stop trying to fix me and put all these people to help me, because they don’t help. And she was right. I just felt a bit bereft, a bit lost. So at that point I thought, I don’t know who to turn to, I literally don’t know”

“As a parent, I just felt, I felt probably most of those years, hopeless”

“It’s affected my mental health definitely. I mean I know I had mental health issues before with post-natal depression but yeah I feel, defeated, (crying)”

“I just remember that sick churning feeling, and I had a lot of physical symptoms, like high blood pressure, and panic attacks and heart palpitations so I felt sometimes I couldn’t breathe”

“I felt terrified, I felt most of my days feeling terrified for her.”

Lisa: “You feel like you can’t help him”

“I don’t know really, I just felt down, that you want to give your child the best possible start”

“Well you feel like you’re failing him. You really do feel like you’re failing him”

“It’s upsetting; I mean you think he’s such a good looking little chap, why does he even think that about himself?”

Beth: “Well we were worried about how he was feeling himself, if it had to do with the diabetes or if it was a reaction to all of that or, we found it difficult to know sometimes in situations, how to deal with them, and erm what sort of erm limits to put or, yeah”

Georgie: “I honestly don’t know what’s made it work. And we don’t actually know if definitely has worked, we’re still walking on a cliff edge.”
“It is traumatic seeing your child that bad. Yeah so it’s been really hard and when things have improved a bit erm, you’re always wondering if, or how long is it going to last for? Is there going to be another trip up?”

“I feel stuck, I feel totally in limbo, waiting for something to happen, so it’s yeah, exhausting.”

“A lot of uncertainty. We’ve both, I’m sure we’ve both been depressed since January, at times worse than others, but we definitely have. But you have to kind of just keep going. Because you have to don’t you?”

“But it’s completely taken us over and I know my husband’s health has suffered and my health has been ok but I like I say I’ve definitely felt depressed at times and definitely anxious”

**Sub-theme 2: Did we do something wrong?**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Sample Quotes</th>
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<tbody>
<tr>
<td><strong>Sophie:</strong></td>
<td>“When he was having his therapy, he was quite embarrassed about it and he wouldn’t allow me to tell his two sisters that he was going to therapy, so we had to pretend that he was going to rugby training...I didn’t want that to happen I wanted to be quite open about the whole thing, but he felt really embarrassed that he really needed help” and then “my daughters only found out by accident, I think that was a big mistake actually because I think by colluding with him, and not telling his sisters, I think it probably enforced in his mind, that it was a big dirty secret and it wasn’t a big dirty secret at all, I think it was actually quite brave to go, to even contemplate going so, and you know you live and learn”</td>
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<td></td>
<td>“I don’t think my maternal receptors were working very well at the time”</td>
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<td></td>
<td>“It took us a while to make the correlation between his anxiety and the bereavement because, as I said, really with hindsight, we just assumed he would be ok”</td>
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<td></td>
<td>“So I figured it would be alright for him and wasn’t really a problem but actually in his little quiet way he was just absorbing everything, not saying anything”</td>
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<td></td>
<td>“I thought oh my goodness, erm I’ve been quite remiss as a parent I was taking care of everybody else thinking he was ok, but afterwards, retrospectively I felt guilty because I thought I hadn’t taken care of him properly, basically”</td>
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<td></td>
<td>“Well the thing is as a parent you just want to protect your kids, and at the time I felt I hadn’t protected him well enough at all, I hadn’t given him any tools to cope with it all”</td>
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<td></td>
<td>“I was actually worried more about the two girls and my husband, because I thought he, the little one wouldn’t be affected by the bereavement as much, which, looking back at it (laughing) was such a dumb thing to think but there you are”</td>
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<td></td>
<td>“It was erm it wasn’t my finest hour”</td>
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<td></td>
<td>“So I was cross with them, but also cross with myself because, because I just think as a family it just wasn’t handled very well, so I think that was the problem really.”</td>
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<td></td>
<td>“I’m trying to think back if I might have said anything negative in front of my son, I’m hoping I didn’t say anything of what I was thinking in front of him, or muttering out loud, I really can’t remember if I did or not. He could probably tell from my body language that she wasn’t best pleased with the way she treated me.”</td>
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<tr>
<td></td>
<td>“I didn’t feel responsible that he needed it, I did feel a bit responsible that I didn’t pick up on the clues that he was suffering about his grandad dying”</td>
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</tbody>
</table>
| | “As a mother you want to protect you child, and you don’t want them to need
counselling, because I someway you feel you have failed as a parent”

| **Charis:** | “She went to CAMHS for I think about 6 sessions, erm,  
*On her own or?*  
No with me, but it didn’t work. And they said it’s not working because they want all  
the family there”  
“I feel I’ve let her down” |
| **Lisa:** | “It kind of hit me really hard, I took it like personally, as if it was me”  
“Well you feel like you’re failing him. You really do feel like you’re failing him” |
| **Beth:** | “I think, it is very tiring and also I felt that you wanted to know were we doing  
something very wrong, or?” |
| **Georgie:** | “We were invited to a parents group, which actually was a complete disaster for us,  
because all the parents in this group had their children at home eating, and at this  
point our daughter was in hospital with a tube, not eating anything, and we were  
struggling to get her to eat”  
“We thought we were doing the right thing, actually we were making it worse, but  
we didn’t know, we didn’t know” |
Appendix 9: Ethical Approval

RE: Ethics Application - signing the form for approval - Ethics Reference FT-PSY-612-18

Earl JE Mrs (FHMS Faculty Admin)

Wed 20/06/2018 09:37

: Fredman EE Miss (PGR - Psychology) <e.fredman@surrey.ac.uk>
:
:: Harnagea CE Dr (Psychology) <c.harnagea@surrey.ac.uk>

Dear Emma

Thank you for submitting your ethics study Webform submission application form, checklist and summary to the Faculty of Health and Medical Sciences Ethics Committee via the Fast Track procedure. I am pleased to confirm that your project, as stated in your application, is considered to be low risk and does not therefore raise any issues that would necessitate a full ethical review and you are therefore able to proceed with your research.

Please keep your original application, checklist form and summary with the reference given above together with a copy of this email, as no copies are kept by the ethics committee.

If there are any significant changes to your project which require further scrutiny, please contact the Ethics Committee before proceeding with your Project.

Many thanks and good luck with the study

With best wishes

Julie

Julie Earl
Administrator Faculty of Health and Medical Sciences Ethics Committee
Duke of Kent Building (16DXos) (Tuesdays, Wednesdays & Thursdays, 9-5.15)
Tel: +44 (0) 1483 689175
Email: jearl@surrey.ac.uk
Web: surrey.ac.uk
Senate House, University of Surrey, Guildford, Surrey, GU2 7XH, UK

From: Fredman EE Miss (PGR - Psychology)
Sent: 20 June 2018 07:49

https://outlook.office.com/ios?fileevent=surrey.ac.uk
Appendix 10: Table depicting symbols used in transcript and extracts

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Meaning</th>
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<tbody>
<tr>
<td>“”</td>
<td>Quotation marks to depict the beginning and end of a quote</td>
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<tr>
<td>‘’</td>
<td>Quotation marks to illustrate a quote within a quote</td>
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<tr>
<td>(.)</td>
<td>Pauses and silences</td>
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<tr>
<td>…</td>
<td>Dialogue trailing off (at the end or middle of a sentence) or picking back up (at the beginning of a sentence)</td>
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<tr>
<td>(parenthesis)</td>
<td>Non-verbal cues</td>
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<tr>
<td>[ ]</td>
<td>Words added by me to ensure readability</td>
</tr>
</tbody>
</table>
Appendix 11: Counselling Psychology Review Journal Guidelines

*Counselling Psychology Review* is the Division of Counselling Psychology’s quarterly peer-reviewed research publication. It brings together high quality research pertinent to the work of counselling psychologists.

It primarily focuses upon work being undertaken in the UK but it is also likely to be of interest to international colleagues and those in related therapeutic disciplines. The content is pluralist in nature, with its focus being on excellent work rather than methodological or paradigmatic preference, and submissions are invited in the following areas:

- papers reporting original empirical investigations (qualitative, quantitative or mixed methods);
- case studies, provided these are presented within a research frame;
- theoretical papers, provided that these provide original insights that are rigorously based in the empirical and/or theoretical literature;
- systematic review articles;
- methodological papers related to the work of counselling psychologists.

For more information about the peer review process for this publication please contact the Editor.

**Notes for Contributors**

1. **Length:**
Papers should normally be no more than 5000 words (including abstract, reference list, tables and figures), although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

2. **Manuscript requirements:**
- The front page (which will be removed prior to anonymous review) should give the author(s)’s name, current professional/training affiliation and contact details. One author should be identified as the author responsible for correspondence. A statement should be included to state that the paper has not been published elsewhere and is not
under consideration elsewhere. Contact details will be published if the paper is accepted.

- Apart from the front page, the document should be free of information identifying the author(s).

- Authors should follow the Society’s guidelines for the use of non-sexist language and all references must be presented in the Society’s style, which is similar to APA style. For an electronic copy of the Society’s Style Guide, go to the Publications page of www.bps.org.uk and then click on Policy and guidelines/General guidelines and policy documents and choose Society Editorial Style Guide from the list of documents).

- For articles containing original research, a structured abstract of up to 250 words should be included with the headings: Background/Aims/Objectives, Methodology/Methods, Results/Findings, Discussion/Conclusions. Review articles should use these headings: Purpose, Methods, Results/Findings, Discussion/Conclusions.

- Approximately five keywords should be provided for each paper.

- Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc., for which they do not own copyright.

- Graphs, diagrams, etc., must have titles.

- Submissions should be sent as email attachments. Word document attachments should be saved under an abbreviated title of your submission. Include no author names in the title. Please add ‘CPR Submission’ in the email subject bar. Please expect an email acknowledgment of your submission.

- Proofs of accepted papers will be sent to authors as email attachments for minor corrections only. These will need to be returned promptly.

3. **Submissions and enquiries should be e-mailed to:**

Dr Terry Hanley. Email: terry.hanley@manchester.ac.uk