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Parental and grandparental stories of parent work in child psychotherapy, with families affected by mental health difficulties: a psychoanalytically informed narrative inquiry.

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A Psychoanalytically Informed Narrative Inquiry

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Thesis submitted in partial fulfilment of the degree of
Doctorate in Child and Adolescent Psychoanalytic Psychotherapy

Robert Gordon University, School of Social Studies & Human Development Scotland

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ABSTRACT

Parental and Grandparental Stories of Parent work in Child Psychotherapy, with Families Affected by Mental Health Difficulties - A Psychoanalytically Informed Narrative Inquiry

Thesis submitted in partial fulfilment of the degree of Doctorate in Child and Adolescent Psychoanalytic Psychotherapy -Nikki Eriksen BA (Hons), MSc

This study presents narratives about the experience of parent work undertaken separately, but alongside Child Psychotherapy, with parents and carers in a specialist Child and Adolescent Mental Health service (hereafter abbreviated to CAMHS) service for families impacted by severe and enduring mental health difficulties. Beginning with a thorough review, scoping the existing literature on parent work in Child Psychotherapy, studies included span a range of Child Psychotherapy research approaches. Prevalent themes in the literature are classified, with direct and diverse parental experiences of and perspectives on this work identified as a significant gap. In particular, the experiences of parents facing mental health challenges are under-represented. This study generated direct accounts of parent work with a sample of three parents and carers: One parent with severe anxiety and depression, another with complex post -traumatic stress disorder and one grandparental kinship carer, whose daughter had severe mental health difficulties. Narratives were generated Using Free Association Narrative Interviewing (Hollway and Jefferson, 2013), combined with a Narrative Inquiry approach, which allowed for further discussion of meanings of interview transcripts to be undertaken with each participant, facilitating co-composition with the researcher in the process of telling their stories (Clandinin 2016). A process of psychoanalytical reflection and dialogue on resulting research texts was applied in supervision, considering the unconscious aspects of meaning and communication arising, utilising the psychoanalytic method of reflection developed through infant observation, as a method of research (Rustin 2012).

Themes within each individual narrative, as well as across all three participant narratives are identified, adopting a rigorous psychoanalytic observational approach, arriving at significant findings in relation to delivery of parent work: The distressing mental impact and trauma of experiences endured prior to entry into parent work within the specialist service; vagueness in terms of memory of the original setting up and understanding of parameters of parent work; feelings of exclusion, disconnection and discomfort linked with long periods between review meetings; anxiety and feelings of loss linked to changes in parent worker; epistemic mistrust and the (gradual) development of trust; appreciation of containment of strong emotions in the work; greater capacity for mentalizing becoming internalised and compassionate, non-judgemental attitudes being highly valued. Where participants expressed feelings of complaint, these focused on practical issues to do with travel and access, poor facilities in the clinical environment, and a lack of clarity about goals and aims in the work. An unanticipated outcome of the research was the degree of enthusiasm elicited by the study, with participants engaging thoroughly and finding a voice through the process and production of personal narratives. Consideration is given to how the quality of the experience of parent work could be improved for parents, both within the service context of the particular study, as well as more widely. This is the first study to present direct experiences of the parent work which is carried out separately but in parallel with child psychotherapy, exploring first person, in- depth narrative accounts of this work; recommendations are made for further participatory research.

Keywords: parent work; child psychotherapy; F.A.N.I.; psychoanalytic; narrative inquiry; mental illness

GLOSSARY OF PSYCHOANALYTIC OR OTHER SPECIALIST CLINICAL TERMS

Clinical audit: An assessment of an aspect of health service delivery against a predetermined standard or measure of good practice.

Counter transference: When an analyst infers that her own state of mind may be reflecting unconscious communications of the patient (Rustin, 2019, p. 66).

Double counter transference: Where there are either dual-therapists and the impact of the communications from the patient/s on both is referred to, alternatively where there is a single therapist and what is being described is the complexity of unconscious communication received from the parent and also from the child.

Intrapsychic: Internal psychological process, for example experiences of conflicts within the self, or of dreaming or phantasy occurring within the mind.

Mentalizing: The capacity to understand one's own and others' behaviour in terms of underlying mental states and intentions, a human capacity intrinsic to affect regulation and productive social relationships, with a crucial impact on parenting.

Oedipal: Refers to aspects of relationships evoking earliest unconscious feelings around rivalry, and competition concerning the attention and love of the maternal or paternal objects. Also, a developmental stage which, if successfully worked through, supports separation from the object and establishment of a separate sense of self.

Parent Work: Generic term referring collectively to the sessions of support work, offered to parents, as individuals or as a couple, and to carers where they are the main guardian, alongside and in parallel with the treatment of the child in Child Psychotherapy. Delivered in a variety of formats and in diverse public and private clinical contexts, to support parents and carers to keep their child in mind and think about their difficulties in the context of their relationship with them.

Transference: The unconscious emotional response of the patient to the therapist, reflective of their previous experiences and expectations of relationships, particularly and usually those of attachment or dependency.

Triangular Space: Metaphor for the concept developed by Britton (1998) and symbolising the potential for an internal space for self-awareness and reflection in an infant, occupying what is also called the 'third position' created through an experience of being observed and thought about by two others (usually parents).

Note on Terminology and Language

The language of the clinical service was used in referring to 'mental health difficulties' in the title for this thesis. However, participants' right to define themselves is understood to be important; 'having anxiety' or 'feeling really depressed' was more often how parents and carers described their difficulties, whether or not they had a specific diagnosis.

CHAPTER ONE
INTRODUCTION: SITUATING THE RESEARCH STUDY

1.1 Policy and National Context

As Jarvis (2005) has stated, parent work across modalities in Child and Adolescent Mental Health service (hereafter abbreviated to CAMHS) in the UK is the 'Zeitgeist', with guidelines for managers (National Institute for Clinical Excellence, 2018) recommending parent work be delivered in parallel with a number of mental health interventions with young people, including Child Psychotherapy. It is important to define what is referred to by the generic term 'parent work' early on. Generally, when referring to the parent work that is offered separately from, but in parallel to child psychotherapy for the child, this is supportive work with the overall aim of helping parents and carers to keep their child in mind and think about their difficulties in the context of their relationship with them. Practitioners usually aim to be led by the concerns and preoccupations of the parents and carers engaged in this work, an approach consistent with the non-directive approach of child psychotherapy.

In practice this parent work, which may be delivered in the UK, US, Europe and around the world, by a psychotherapist or other supporting professional, varies tremendously in frequency, style, focus and model of delivery. It is often carried out by professionals from a range of backgrounds, not only child psychotherapists. In contemporary UK CAMHS, a clinical psychologist, applied psychologist, family therapist, mental health nurse, counsellor or child psychotherapist, may be providing this parent work. Their diverse models and approaches to thinking about family relationships, reflecting different training and experiences, will determine what actually happens and how it is discussed. The depth and quality of the parent work provided will also be influenced, and at times considerably limited by, the prevailing culture, priorities and staff time available within the many overstretched public health service settings in which Child Psychotherapy is delivered. There can therefore be no single, easily defined, homogenous definition of the practice and theory of this 'parent work' due to the complexity of this field. As Whitefield and Midgely (2015) have pointed out, a psychodynamically informed approach to parent work is highly valued, particularly when delivered by those trained in Child Psychotherapy; yet even within this field there is a considerable variety of views on the theory and practice of parent work. The aims, focus, level, approach to thinking about the influence of the parental past, and questions as to whether or when to interpret transference in the work, are some of the issues on which there is a great deal of variance, and will be explored and further evidenced by the literature review. The parent work explored in the research study presented here therefore captures the flavour and experience of a sample of this work in a particular context.

The setting for this study was the researcher's workplace in a 'Tier 3', that is specialist service, within a Child and Adolescent Mental Health service in Scotland. This service accepts referrals specifically for children impacted by 'severe and enduring' parental mental health difficulties and is the only service of its kind in Scotland.

The focus of the study is an exploration of parents' or carers' experiences of the parental support work offered to them within this service while their child undergoes psychotherapy.

In Scotland, changes to children's mental health services are underpinned by the national framework shaping all Children's Services, 'Getting it Right for Every Child' (2006). This considers the child's needs firmly in the context of their family relationships and wider community, including schools and public health settings, and there is a continuing policy focus on improving accessible support for children and parents across child and adolescent services (The Scottish Government's Mental Health Strategy 2017-2027).

The 'Taskforce on Children and Young People's Mental Health Delivery Plan' executive summary also stated the following to be urgent priorities in December 2018:

- More effective support for the families of children and young people experiencing poor mental health.
- Better data and intelligence routinely available to everyone working in the service so they can identify gaps in services and also the impact their work is having.

This taskforce aims for a 'rights based' approach, with the UN Convention on the Rights of the Child (1989), stating children's right to 'the best possible health', a key component of this being the provision of good quality healthcare. Changes to services are, according to the taskforce strategy, to be greater informed by 'what matters to me', and strive to reflect what children, young people and their families value as outcomes and experiences, and increased awareness of 'Adverse Childhood Experiences' ('ACES') are to be integrated into joint service planning and delivery. 'ACES' refers to difficult or challenging life circumstances or experiences such as bereavement, poverty, illness, divorce, or other familial adverse experience, the impact of which, particularly where experienced in a cumulative way or in combination, may lead to considerable negative impact on children's development and later their adult mental health status (Felitti and Anda, 2003). Growing up in a family where there is parental mental ill-health has been identified as one of these 'ACES'.

The review of the literature, which constitutes chapter two of this thesis, highlighted a gap in the available literature about the experiences of parents in general, from their perspective, including those with mental health difficulties, who engage in parental work in Child Psychotherapy. The main research study presented in chapter three of this thesis, therefore aimed to address this gap, eliciting parental narratives about experiences of parent work in a specific service context where parental mental ill-health is identified as impacting on the children and young people who are referred.

1.2 Evolution From Local Service Audit to Study Design

'Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change.' (NICE 2002)

Prior to embarking on the study, the researcher undertook a clinical audit and evaluation of parent work within the service, gathering information from practitioners about their approach to the delivery of the parent work offered while children were in Child Psychotherapy. This clinical audit performed the important function of scoping and contextualising the research study presented later in this thesis. By identifying areas for improvement, then designing a research study which could further inform how to make these, the audit was able to lend an action research aspect to the research study locally, with the findings leading to quality improvements in parent work here.

The broad aim of the parent work offered within the specialist service where the study was conducted, is to offer an intervention to those parents with mental health difficulties, and sometimes other carers (where the parent is not well enough to be the primary carer of the child), in order to support them in their understanding of the infant or child from an emotional perspective. The service also states within the operational policy aims and objectives that it is a community-based team 'promoting a de-stigmatising environment where families can access mental health supports.'

To establish a standard by which to evaluate the status of current service provision with this group of parents, the 'Competency Framework' published by the Association of Child Psychotherapists (2017) was examined for relevant definitions of quality. The quality standards selected as most relevant, were those focused on working with diversity and on outcomes in work with parents (see Appendix 1.2). Both of these areas had also been identified by the literature review, as relatively neglected areas in child psychotherapy research. Given the particular vulnerability of this parent population, those affected by severe and enduring mental health difficulties, and the stated service aim and ethos of promoting de-stigmatisation, addressing issues around diversity, and considering parental views about outcomes in the work, seemed imperative.

The following questions were formulated as a focus for exploration by the audit:

- What methods are in use in the parallel parental work intervention currently to gauge parents' expectations and experiences of this aspect of the work (as distinct from the direct work with the child)?
- How are the needs of this particular parent population integrated into the delivery of the parallel parent work within this service?

Four practitioners, two of whom were child psychotherapists, and two mental health clinicians (one of these with a family therapy training) who were working with parents whose children were being seen for Child Psychotherapy within the service at the time of the audit, were asked a series of questions (see also Appendix 1.2) to establish some simple qualitative data, a baseline from which to audit the current standard of practice being achieved in relation to the above. The focus was on how the service engaged with parents' experiences and their evaluation of this aspect of the service, in order to identify potential gaps or issues with this.

Key findings from audit interviews

None of the child psychotherapists or mental health practitioners whose views were sought for the audit reported using formal outcome tools or standardised measures for evaluating the parent work.

Nor did the professional participants refer to seeking direct feedback from parents evaluating the parent work at the more meta-evaluative level of service satisfaction or satisfaction with the parent work. One practitioner stated that being asked about it for audit was making them think about the child's psychotherapy termly review meetings, implying that it was now occurring to her that there could be an opportunity for this during these regular meetings.

The inter-dependence and links between parental and child or young person's mental health and the reinforcing positive or vicious cycle between the adult's mental health and sense of themselves as a parent was emphasised by practitioners as an observable feature of the work.

In terms of working flexibility to meet the needs of this group of parents in a non-stigmatising way, there was good indication that the Association of Child Psychotherapists quality standards were being aimed at in terms of the reported flexibility and positive and caring attitudes demonstrated towards parents and carers.

There was, however, little evidence of explicit and direct seeking of parental feedback or any indication that such a process had been thought about, and this reflected a prevailing view that progress was monitored implicitly through ongoing dialogue and conversation within parent sessions.

Outcome

The researcher's interpretation of this brief snapshot of qualitative data obtained from colleagues was fed back to the head of service and discussed with the practitioners who had participated.

A recommendation was then made by the researcher and agreed with the team, that it would be desirable to develop some improvements to practice and to seek to integrate increased parental feedback and evaluation into service delivery. The findings of the audit had confirmed that a gap existed in current practice in parent work within the service, which was consistent with the broader gap which had been highlighted by the literature review. An action plan was outlined, setting out a timeframe within which to complete the 'audit cycle' (NICE, 2002) and make improvements, thus making the audit part of a process of 'action research' (Rapoport, 1970).

1.3 Aims and Objectives

An area for improvement had been identified from the clinical audit and dialogue with practitioners. It was hoped that by exploring more direct feedback from parents about their experience of this work, some improvements in the delivery of this intervention might be achieved. The Child Psychotherapy team was unanimous that further exploration and research gathering such parental experiences would be desirable and informative in terms of service improvement and development.

This practical and clinical focus, as well as the academic aim of bridging the knowledge gap identified by the literature review then informed the aims and objectives, and choice of research question and design for the present study. By eliciting experiences of parental work, reflecting on the emotional impact and meaning of these, making links with and adding to the existing observations and theories in the parent work literature, the aim was to inform changes and improvements in service provision locally. In addition, to share the results of the study more widely, making a useful contribution to broader thinking and debate about the practice of parent work in Child Psychotherapy. Faulkner (2012, p. 47) suggests that studies involving such 'service user' involvement can help ensure research remains more relevant to clinical practice.

CHAPTER TWO

PARENT WORK IN CHILD AND ADOLESCENT PSYCHOANALYTIC PSYCHOTHERAPY: A NARRATIVE REVIEW OF THE LITERATURE

2.1 Background and Objectives of Literature Review

Several of the authors of the articles included in this review (Holmes, 2018; Rustin, 2018; Whitefield and Midgley, 2015; Novick and Novick, 2013) have identified the need for more research in the relatively neglected area of parent work. There has been a consistent move away from the outmoded view, at one time prevalent in Child Psychotherapy during the earlier part of the 20th century, that parent work was necessary perhaps, but somehow marginal to or even potentially intruding on the intervention with children.

The general trend has been moving in the direction of work with parents being regarded as more desirable and complementary, even essential to the goals of Child Psychotherapy. Szapocznik (1989), for example, has provided some evidence that Child Psychotherapy without parent or family work could be detrimental. Fonagy and Target (1996), in their large retrospective study of cases conducted at the Anna Freud Centre into predictors of outcome on treatment, also found a variety of suggested correlations between parental involvement and improved treatment outcome, including parents receiving analytically informed guidance alongside the child's treatment.

The literature review presented here evolved over time, beginning life as a scoping review in 2018, before finally emerging in 2022 in its current form as a narrative review; it may be helpful to explain this evolution in some detail. The final review reflects a somewhat hybrid approach, retaining some elements that evidence the rigour and methodical steps followed through the systematic searching and mapping processes adopted during the original scoping stage, but ultimately presenting within a narrative framework, a mostly descriptive style of presentation and synthesis of the main themes in the existing literature on parent work.

The initial decision to undertake a scoping review of parallel parent work interventions in child psychoanalytic psychotherapy, mapping all of the issues and themes emerging from this literature to provide a complete overview, including a focus on gaps in the literature, merits further explanation. It was reached after preliminary searches and discussion with academic supervisors confirmed that there was unlikely to be sufficient evidence in the area of parallel parent interventions in Child Psychotherapy to formulate a traditional, narrower systematic review question examining evidence-based literature in this area. Scoping reviews however have proved controversial; there has been debate as to the specific characteristics of them as a genre or member of the large family of types of systematic review. Colquhoun *et al.* (2014) however suggest that it is a:

> Form of knowledge synthesis that addresses an exploratory research question aimed at mapping key concepts, types of evidence, and gaps in research related to a defined area or field by systematic searching, selecting and synthesizing existing knowledge.

A stepped approach to the scoping of the literature was followed as shown in the table below:

Identify search questions and domains
Find the relevant studies
Select relevant studies
Chart the data
Collate, summarize and report the results
(Optional) Consult stakeholders

Table 1: Stepped approach recommended by Arksey and O'Malley (2005)

There is debate concerning the level of evaluation that should be included in a scoping review, with Arksey and O'Malley (2005) omitting this aspect from the steps. The researcher, however, was keen to explore research methods informing Child Psychotherapy literature critically, and so evaluation was added as a further step. Marcel Dijkers (2015) has asked rhetorically, and persuasively:

> If a scoping study is undertaken to map the research in a particular area, specifically to identify the gaps in research, how useful is such an exercise if the quality of that research is not addressed?

The literature review presented here is therefore complex, ambitious in scope and reach: it covers identification of strengths, weaknesses, prevalent themes and areas for suggested development, through the analysis of demographic and thematic data, as well as quality appraisal, and narrative synthesis, of the articles included. Thoroughly exploring this corpus of literature, existing theories and themes as well as gaps, made it possible for the researcher to design a study which could build on this and undertake research which would represent a novel and useful addition to it. This approach of gradually building upon the existing research knowledge has been identified by Midgely (2017) as key to strengthening quality and broadening the evidence basis for the practice of Child Psychotherapy.

2.2 Identification of Literature

Search Strategy

The articles selected for discussion were identified applying a rigorous search process, involving initial screening of over 1300 abstracts of articles as they arose during searches, selecting whether they were relevant to parent work in Child Psychotherapy. This formed a list of 71 full text relevant papers retrieved for initial inclusion, which were then read closely and analysed, with further decisions made for final inclusion or exclusion for the review depending on the degree to which they matched criteria.

A total of 27 articles are included, 23 of which were identified for the period up to 2018 (when the main searches were first completed), with a further four articles added after the search processes were repeated in 2021. Parent work in this context was defined as the parental support undertaken with parents or carers, separately but simultaneously, alongside their child or adolescent, while they were having Child Psychotherapy.

The 'Population Concept Context' framework was used to decide on key search domains, developed by applying the terms: Population (Child and Adolescent); Concept (Parallel Parent Work); and Context (Child Psychotherapy). This is a procedure recommended in the Reviewers Manual for Scoping Reviews (Joanna Briggs Institute, 2015), which was identified as being a relevant framework given the breadth of this review. Databases yielding most relevant results were selected for advanced searches (see Appendix 2.2 for an example of the search record).

This search strategy was repeated across several databases three times in total between 2017 and August 2021 in order to keep the review up to date with any new articles published during that time.

The main target journal was hand searched, reading the contents pages and relevant abstracts online for every issue of the British Journal of Child Psychotherapy from when it began in 1963 to 2018, a process repeated once again in the third and final search for the period 2018 to 2021.

Inclusion and Exclusion Criteria

Articles were selected for inclusion where they contained descriptions of parent work with parents and carers (foster, adoptive and/or kinship) running parallel to Child Psychotherapy, or they used empirical data from qualitative research to explore such work. The studies were required to include at least some detailed description of clinical work with parents or carers and could not be wholly theoretical, abstract or conceptual, or to merely reference occasional contact with parents. These were broad inclusion criteria to meet the aim of reviewing all available psychoanalytical literature on parent work in child and adolescent psychotherapy. Parent-infant dyadic work (where children and parents are worked with together in the same room) was excluded; the latter approach is distinctive and has been the focus of a systematic review study already carried out elsewhere. For a complete list of inclusion and exclusion criteria see Appendix

2.2.

2.3 Analysis of Literature

Memo 1: Data Extraction and Memo 2: Quality Appraisal Tool

Two separate tools were applied during the process of reviewing each article in turn: Memo one covering the main features of the intervention's model of delivery and summarising key themes and/or findings; and Memo two, a quality assessment checklist. These memos (see Appendix 2.3) were used to extract and analyse the data from each article selected for full text paper sourcing.

There was a considerable scale and complexity to the data extraction and quality appraisal task of such a large and broad range of studies. The quality appraisal checklist was designed broadly, keeping a record of different types of articles, noting various points of relative merit and de-merit. The concept of what counts as Child Psychotherapy research is as yet, rather vague in this field, with at times somewhat polarised positions being maintained by prominent figures in the profession. The word 'research' is used to signify different things in different contexts in the world of Child Psychotherapy and for this review of the literature, an inclusive and broad framework appreciating diverse approaches was adopted. This was informed by Desmarais' (2007, p. 292) view of 'epistemological pluralism', whereby when making judgements about the relative trustworthiness of the different types of knowledge generated by different psychoanalytic authors and researchers, connections between the differing approaches and the knowledge generated can be appreciated rather than one type of research being viewed as primary or higher up on a scale of validity. Different types of research and knowledge are regarded in this approach as more or less helpful 'tools for thinking' (Desmarais, 2007, p. 293) about the clinical situation, varying in applicability and relevance, according to context.

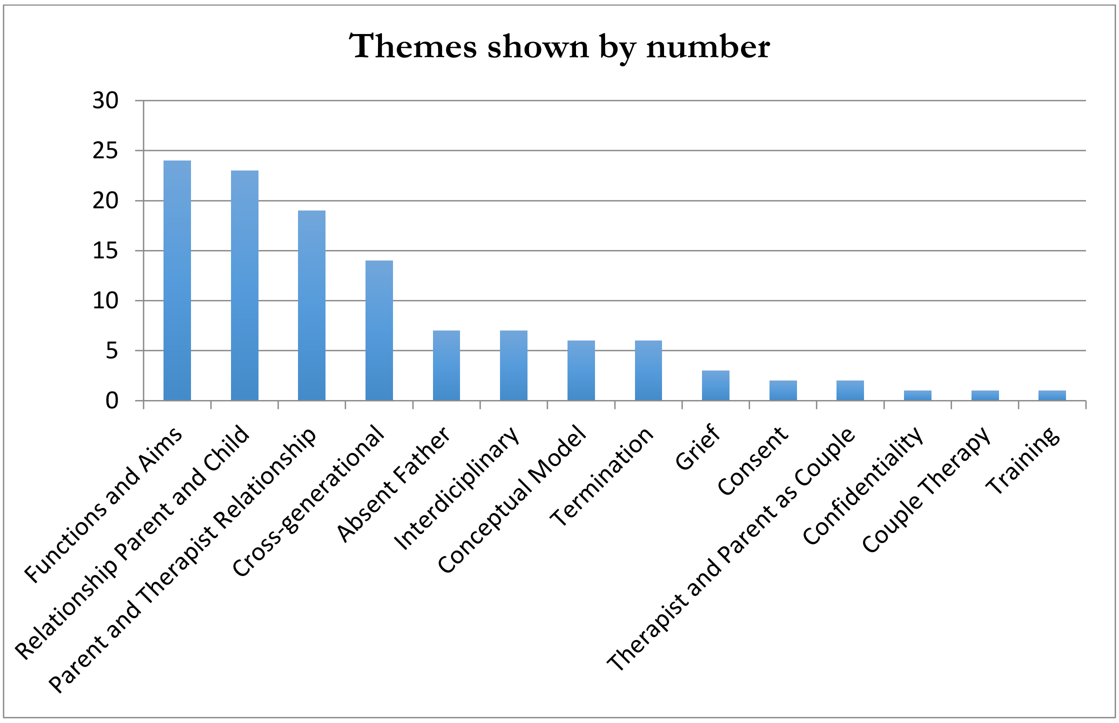
The memos used to appraise each article included in this review were designed to record a range of features or research types as they arose, including noting, where applicable, the empirical basis for each article to help evaluate quality. This is an aspect prioritised by Fonagy (2003) who has made the plea for the profession to incorporate and work to empirical standards or risk remaining regarded as producing research of an inferior quality. It has been noted that there has been, at least until recently, a reluctance on the part of psychoanalytical practitioners to embrace such empirical approaches (Midgely, 2001, p. 232).

Questions relating to ethical quality, descriptions of demographics of patient populations referred to and the presence or absence of patient feedback or participation, were also included in the quality appraisal tool. The latter is of especial relevance to work relating to young people who have been shown to value being listened to and being 'heard' (Midgely, 2011, p. 240) and whose parents and carers could also helpfully be more involved in research, and whose perspectives are needed in order to evaluate and monitor outcomes in Child Psychotherapy as all child mental health services (Urwin, 2007, p. 136).

2.4 Qualitative Themes

The full list of themes from all the data extraction memos and quality appraisal checklists from the searches completed to 2018 were collated into summary charts. Charts of diverse emergent themes counted and clustered under themed headings during the scoping review are shown in Appendix 2.4.

The bar chart below shows how many times a theme was counted in total, arising throughout the articles. For example, 'Functions and Aims' was a theme identified in 24 of the articles, and 'Consent' in 2.



The included articles discussed below are now grouped and discussed under headings judged by the researcher as most representative of their main focus and content, beginning with the most prevalent themes. The headings vary slightly in name from those charted above, with additional themes added relating to work with grandparents and those describing work with unwell parents and families affected by trauma for example added at a later date. The re-reading of articles during the latter stages of the review, for the purpose of summarising and synthesis thematic content in narrative form, sometimes lead to a slight change in the interpretation and hence naming of a theme. Three themes 'Interdisciplinary', ‘Training’ and ‘Grief’, are not discussed in what follows, because although they arose within articles, they were not considered the *main* focus of any individual article.

Functions and Aims of Parent Work

A flexible approach to working with parents, highlighting the need for the therapist to adapt to the parent’s need as opposed to the parent adapting to a preconceived classical psychoanalytic model, is argued for by Lanyado (1996), who states that in clinical practice such ‘applications’ and ‘adaptations’ of treatments are often made and that an ‘open discussion’ of them is overdue (Lanyado, 1996, p. 442). A case example is used to illustrate this point, where the practitioner author worked with a family affected by trauma, due to the sudden and tragic death of the youngest daughter, at aged two. Lanyado describes how an initial focus on the aim of creating an emotionally holding context, built the foundations upon which the work with the whole family could proceed, with the strong alliance built enabling more challenging work with the parent when the need arose. In this way, later on in the work, when the mother expressed direct anger towards the psychotherapist during a parent work session, interpretation of the transference was, according to Lanyado, made possible, due to the previously well-established holding environment.

Providing an overview of clinical practices and aims in work with parents by child psychotherapists, Rustin (2018) describes four varieties of approach along a spectrum. The first is where the gaining of support of parents to protect and sustain the child’s therapy is the main aim. The second is where the parents are looking for support with their parental functioning, and the third is where the explicit aim of the work is change in family functioning, agreed by the parents as part of the treatment as a whole. The fourth approach is individual psychotherapy for one or both parents, to which the parents have committed themselves as parents in their own right, even though what brings them into contact with psychotherapy initially is concern for their child. Rustin describes how, as the work evolves, a different aim than the one originally intended may be appropriate, and that signalling this to the parents, enabling consent for a change in technique, keeps the therapist clear about their responsibilities. Rustin cautions that where work is carried out with parents who have been very deprived or have mental health issues, keeping the level of involvement reduced may sometimes be wise, as working with deeper conflicts may lead to undermining of parental capacities and breakdown. The study selects from a small number of clinical case examples to draw these conclusions and conceptualise four levels of parent work, which might evolve in practice.

The above articles point to the complexity and ethical sensitivity of the work with parents, as well as the need for attuned and individualised approaches. In terms of how these studies might be regarded in terms of ‘research’, in the more formal restrictive sense of descriptive studies carried out using widely accepted empirical methodologies, these articles may fall short. However, their validity can be seen in their applicability as conceptual and descriptive clinical writing. The authors make theoretical and practical recommendations relevant and useful in practice, derived from long and extensive clinical experience as practitioners, with this knowledge shared through reference to clinical examples. The majority of the studies included in this literature review can be seen to belong in this category which the reviewer classifies as 'Type A: Learning from Experience, with reference to case examples.'

In a similar vein, Novick and Novick, in Dowling et al. (2013) promote a framework of different levels, in this case a dual-goal approach to parent work with parents of adolescents. The emphasis is on life-long interdependency between parent and child, changing and adapting at different stages in the life cycle, as opposed to regarding the key task of adolescence as separation, historically the more traditional psychoanalytic view. Dowling *et al.* (2013), document an interview with them about this dual-goal model, the first more pragmatic aim being to support the child's treatment and make it effective, and the second, to be transformative of the parent-child relationship. Novick and Novick cite success with this model, stating that both parents and adolescents appreciate and support the approach. However, as with the previous articles discussed so far, this claim relies for its validity on the practitioner's reference to examples and assertions from clinical practice. There is no explicit reference to the empirical process arrived at for this, as if the implicit assumption is that clinical observations and experience are regarded as sufficient for the general purpose of professional knowledge sharing.

Another study asserts a key aim of parental work as being to work with the issue of enmeshment between parent and child. Gvion and Bar (2014) reflect on their preferred model of the same therapist working with parent and child but at separate times (as opposed to there being a different therapist for each) and emphasise what they see as an important opportunity afforded by this. The case is made that when the child knows that the parent works, as it were behind closed doors, with their therapist, and, similarly, at other times the parent experiences being on the outside of the therapeutic relationship, behind the closed door of the child's therapeutic space with the therapist, both have an opportunity to experience enlarged triangular space. This is a largely theoretical article, about a preferred model for achieving a particular aim in parent work, with limited case illustration from clinical work. The authors are making links with Britton's (1998) concept of the triangular spaces created by the connections between two parents and their child, applying this concept and extending it to the area of parental therapy, summing up 'Three people take part in the therapeutic situation: the parent, the therapist and the child, and each observes the connection between the other two and can gain from this connection.' (Gvion and Bar, 2014, p. 61). Once again, there is an absence in this article of any more empirical verification or measurement of the stated outcome, the authors relying heavily on their own assessment about the efficacy of this. In this way, once more, while it may be of theoretical interest to practitioners, the article lacks the rigour which might be afforded by a more empirical approach, for example, a measurable test or comparison in support of its claims.

The literature discussed thus far highlights not only how diverse therapists' views about the aims of parent work may be but also point to a diversity of theoretical positions informing thinking around which models are best suited to achieving those different aims.

In one study, an interesting historical interpretation is given of the tendency in the profession for marginalisation of parent work, with Goodman (2017) suggesting that the prioritising of the child's psychic life over external influences, in the first half of the twentieth century in child psychoanalysis, is one explanation. Goodman states the influence on her of the Novicks' approach (referred to also above in Dowling, 2013), and outlines her adoption of their same therapist and dual-goal system, arguing the positive outcome of this being the ability to attend closely to the dynamics of the multiple therapeutic alliances. Goodman draws on a case example to share clinical experience of parents being enabled by the concurrent work to modify their parenting as they began to appreciate how their son's mind worked. The analyst helped them see how external factors, including some parental behaviours, were increasing his internal anxieties, and the son was supported both by this work and his individual work to develop more ability to regulate his feelings. Goodman's paper and case example read persuasively as a practical and also theoretical justification for this way of working. In terms of research validity, this is another example of a ' Type A' study, authored by a practitioner sharing their perspective and learning from professional experience, with a mixture of focus on theoretical and clinical issues observed in practice.

Another study is an exception within this cluster by practitioners on the functions and aims of parent work, in that it utilises a brief qualitative method, with the author interviewing 7 child psychotherapists in his team to explore their perception of aims in parent work which they had undertaken over the previous year. This is an example of a handful of studies in the review which are here classified as 'Type B', that is 'Small scale qualitative practitioner enquiry'. Holmes (2018) interviewed psychotherapists about parent work, applying a thematic analysis to the data arising, identifying practitioners' main aims from this as follows: Increasing empathy with the child; decreasing enmeshment; and containing anxiety. Holmes found that therapists also tailored their aims to the individual parent's levels of psychological functioning and level they felt they were able to benefit from. Linking to issues raised in his literature review about the variable levels of work and need to adjust as the work develops, Holmes argues for parent work aims to be made explicit in Child Psychotherapy training and practice, stating this could help describe the work and the challenges of it more accurately, of benefit not only to therapists and those involved in training, but also enabling greater transparency with parents themselves at the point they are embarking on parent work. This paper was exceptional of the studies on the theme of aims, in that the author attempted to establish and name the demographics of the parents the therapists worked with, although it is the therapists in the study who are asked to define this, rather than parents being approached directly to self-define. This produced an interesting result: Most parents were defined by the therapists as not having a mental health diagnosis (67%); however, the therapists thought that the *majority* of the parents may in fact have had an *undiagnosed* mental illness (72%). Holmes highlights a limitation of his study being the lack of opportunity to consult with parents themselves, acknowledging, 'It would have been interesting to also speak to the parents under consideration about their impressions of the aims of parent work' (Holmes, 2018, p. 272).

Despite this review of several studies exploring varying perspectives on aims in parent work, it remains unknown what parents' and carers' views and understanding are of aims in this work. There are many references to changing and variable aims being a source of technical complexity and challenge, involving moving through different levels of work in unpredictable and varied emotional territory in parent work described in practice, yet how this is experienced from the parent's point of view remains unexplored. There is also an important emerging question raised in the last study (Holmes, 2018) about how potentially very high numbers of parents may be regarded as facing mental health issues, yet somehow whose self-identification remains unvoiced, and whose perspectives have not so far been explored.

Relationship between Parent and Child

In a descriptive account of case material from the first year of treatment, Braithwaite and Edgcumbe's (1967) study reports on analytic and interpretative once-weekly work, with a mother and daughter separately, which it is asserted, averted the crisis of severe and worsening separation anxiety which the child presented at the beginning of treatment. In this single case study example, the authors state that crucial information about the mother's loss of another baby when the child in treatment was 18 months old, and her subsequent depression, came to light through the parent treatment. This information was then applied to support the child to work through feelings of worthlessness and rejection as these emerged as themes in the child's transference relationship with the analyst.

The article communicates vividly a key point resonating with a frequent observation in psychoanalytic work, about the profound impact of unmourned loss of an infant or child, and is also in agreement with other authors in the review in arguing that parent work carried out by the same therapist can in some circumstances be a helpful model. However, in common with all but one of the studies discussed so far, the author is sharing a descriptive account of their own work.

While there can be validity and relevance in such accounts of clinical experience, if they are to communicate an increased trustworthiness in their reporting style, psychoanalytic practitioners and researchers could aim for standards of presentation and reflection in their writing about clinical experience. Ideally this writing should demonstrate qualities including being able to hold a position of uncertainty and openness to a range of possibilities, maintaining a psychoanalytically rigorous, informed, curious, questioning and reflexive stance, the characteristics of what Hindle (2009) has termed a 'research state of mind' (Hindle, 2009, p. 327).

The tone used to describe the work in Braithwaite and Edgcumbe's writing however, conveys an assumed position of 'expert' judgemental theoretical certainty throughout, and this undermines, for the current reviewer, the trustworthiness which such a descriptive clinical paper depends on for some validity. This study also falls short of ethical standards, further undermining trustworthiness, when the author shares, without qualification, a subjective and very negative view of the appearance of the mother 'spoiled by unskilful make-up and unflattering spectacles.' (p. 35). The reviewer is aware that these criticisms may seem irrelevant when directed at an article written more than 50 years ago. However, it is relevant to hold in mind, that historically the 'expert' position has been regarded by some in the profession as tenable, and the profession has been criticised for this. Relying on practitioner observation and judgement without demonstrating capacity for transparency or reflexivity about the methodology used to arrive at conclusions, or the limitations of this, adds little to the establishment of more robust knowledge and learning about the processes and outcomes of parent work in Child Psychotherapy.

One study focuses on ways that overcoming parental unresolved Oedipal issues in parent work helps to support the work and developments within the child. Miller (2004) shares her observations of issues in several families where she worked with both parents as a couple, and where the presenting problem was initially located very much as residing in the child. One of her cases focuses on the parallel work carried out separately with the parents, and Miller describes through case material, the process by which during this parent work the couple began to be able to reflect with the therapist and recognise their fluctuating states of mind. At times, the couple are seen as able to think together about their child in a helpful way and at others to became more self-pitying and prone to outbursts of aggression. While the paper brings to life with some vivid description, an important aspect of working with couples in parent work, the study was felt by the reviewer to lack clarity in places, to the point this became a barrier to accessing the necessary understanding of the complex learning points which the author was attempting to share.

Another study describes a clinical case where the parent therapist and child therapist are the same person and identifies a novel theoretical concept of them being enabled to act in this therapeutic role as a kind of 'translator'. This is reported as helping to make the child's world comprehensible, with the therapist becoming part of the family system, accessing intrapsychic material about the child's inner world as well as interpersonal data from the family. In this study, Nilsson (2019), also reiterates and corroborates

Klauber's (1998) concept (discussed later in this review) of parental emotions of guilt and shame being reactivated in the parent work, where the therapist may become identified with the trauma of the diagnosis itself by talking about it. A theme of parallel processes is observed and discussed, with an idea mooted that the network and environment begin to hold the child in mind, assisted by the therapist being able to hold the parents in mind. An outcome reported in this case example is that parents were enabled by this to focus more on their child's needs. Nilsson (2019) uses descriptions arising from close observation and recording of individual case work with parents and a young child with autism. This is an example of a more contemporary study whereby a practitioner shares learning from experience in classic psychoanalytic 'case-study' style, improved in this case by the greater trustworthiness of the material arising from the sharing of reflections based on observational material, including clinical vignettes and sections of clinical notes.

These three studies above suggest different ways that work with parents can help to shift dynamics and negative attributions projected onto a child within a family and thus relationships are improved. Once again, an implicit theme can be seen weaving throughout these studies, concerning the delicate nature of the work, the skill and experience required in delivering parent work given the challenges involved in effecting positive change, and the complex interactions with parental experience, emotions and family dynamics.

Therapists' Relationships with Parents including Transference and Counter Transference

In an early study on the complexity when working with the so-called 'double counter transference', Kohn (1976) discusses the simultaneous analysis of a mother and her son, where he operates as the same analyst for both. Kohn discusses some perceived advantages of this way of working, but concludes that in this case study the outcome has too much focus on the relationship between the mother and son and less on each individual's analysis and development. Kohn locates the difficulty being that by being in the role of 'expert' to the mother as well as interpreter of the transference towards him he was unable to work effectively: 'The more I interpreted the transference, the less help I gave her as the therapist of her child. The more help I gave her as the therapist of her child, the less help I gave her as her own therapist.' (1976, p. 497). Kohn does not dismiss this approach outright, however, and suggests that reflecting on the failure of this individual case is as helpful as reflecting on other success, and is open to the idea that perhaps just as much can be learned from 'a purposeful controlled contamination' as from keeping the transference field 'uncontaminated'. Here again with an older study, there are at times jarring ethical contrasts with contemporary practice, with the effect of rather undermining what otherwise might be considered points of contemporary relevance. For example, despite the mother's disclosing repeated physical attacks on her son, the writer does not invoke what the modern researcher or practitioner would regard as essential child protection measures, instead focusing only on addressing the *meaning* of mother's attacks, not intervening to prevent the harm to the child. However, the case study reads as an honest and detailed exploration of the tensions which can arise when working as the same therapist with parent and child and in this sense shares some additional useful learning from experience, once again emphasising the complexity of relationship dynamics and difficulties with holding sometimes multiple therapeutic roles, which may arise in parent work.

Another study addresses the complexity of the psychodynamic field when mother and child are treated by different analysts simultaneously to their children receiving treatment, describing two case examples to report on the effect of the mother's 'split transference' reaction. Buirski and Buirski (1980) generalise what they regard as an important technical issue arising from these two case studies where, as a result of the uncovering taking place in their own analysis, the mothers defended by splitting off negative affects from their own analyst and displacing them onto the analyst of their child. The authors suggest that mis-recognition of the split transference and misunderstandings can easily arise as a technical difficulty in this model of parent working, leading to premature cutting off of either or both strands of the treatment. As mentioned, this study is regarded by the reviewer as one that is useful in highlighting another nuance of the complexity and challenge arising in work with parents, and the assertions are presented as grounded in deep reflection and engagement with more than one set of case material. Many of the studies included in this review have considered the positive and negative aspects of working as the same practitioner with parent and child or with two different therapists working in parallel. A question arises, as yet unanswered, as to which model might be preferable in different contemporary public and private mental health services and contexts.

In one study, Bion's (1961) concept of basic assumption and working group functioning is adopted as a theoretical framework for understanding particular clinical experiences of transference and counter transference in work described with parents. Brady (2011) cites examples of working with both parents and the child separately (although sometimes bringing parents and child together as well), where the defensive organisation in the child can be understood as a representation and projection of the larger dynamics in parents or family group. The study aims to contribute to what Brady highlights as the very difficult work of conceptualising unconscious family dynamics in analytic child treatment. The argument is that through the analyst sharing their understanding of the family functioning with parents, which can be difficult and initially met with some resistance, the clearest opportunity can be given to allow them to perceive the nature of the analytic work the analyst is struggling to achieve with their child.

This is another example of a single practitioner observational study with detailed examples given from clinical work. Brady stands out so far in the articles discussed in this review, for acknowledging the significance of different demographics, and demonstrating an awareness of issues of diversity, stating that the families mentioned in the examples were from 'conventional' two-parent families. Brady acknowledges a limitation in this and suggests it would be helpful to observe differing patterns of family dynamics in more diverse family structures. The review of the literature so far has highlighted that issues of difference and diversity are not always given such acknowledgment and that this would be a desirable development in further studies.

Another study on the complex theme of relationships with parents in parent work argues that paying attention to the field of transference and counter transference, such as noticing who the therapist or the parent worker may represent in the parent's own history, is of key importance. Christiorgos and Giannakopoulos (2015) describe ways that parental presence influences both the setting and therapist's function from the very beginning, and that changes in children's behaviours result in alterations in pre-existing family dynamics, leading to reactions and feelings in the parents.

Increasing frequency of parent sessions, it is argued, can help to work through feelings linked to this and therefore support ongoing developments and changes in the child's therapy and family functioning. The authors give clinical examples of when parents are not able to work through these feelings in their own parallel work, here described as 'treatment', leading to these reactions reaching extreme levels, including cancelling or being repeatedly late for sessions, and also termination of treatment. An example is given of a mother, who previously had been listening in to her child's treatment at the keyhole of the treatment room, but was then able to work through unresolved issues in her relationship with her own mother, related to control, in her own parallel 'treatment'. The authors describe a period of intense internal reflection about the mother's own childhood, painful for her, but beneficial for the child who, it is argued, could then come to sessions relieved of his mother's unresolved dependency needs that had been projected onto him. This study conveys the potentially transformative impact of parent work when it is carried out at sufficient depth and frequency. It is another example of practitioners sharing learning from experience, and the careful description of such a breakthrough in clinical work with parents, arising from paying therapeutic attention to issues of transference, would be of relevance and interest to many professionals within this area of work. However, in terms of broader validity as a research study, once more, this study does not the generally higher standards of transparency of methodology, including a discussion of the source of the observational data, which would rate it more highly.

There is an exception in this cluster of studies on this theme, with one reporting on a small-scale practitioner lead, qualitative study, using questionnaires, as well as observational case material. O'Dwyer (2021) produced this clinical research while working with a small sample of parents in an in-patient setting, where their children were suffering with eating disorders. The study identified what are described as 'eating disorder states of mind' in parents who, it is argued, in a parallel way to their children, demonstrate ambivalence about help, finding it hard to take this in, as well as exhibiting a splitting-off of difficult feelings, with idealisation of some aspects of services and denigration of others. The focus is on the transference relationship with parents, with the author identifying a process whereby talking about feelings of aggression with the parent therapist made it more possible for parents to open up to thinking in a more integrated and authentic way. O' Dwyer observed the parents in her sample to move into a more 'depressive' position with less splitting, as the work progressed, often reflecting a parallel process of developments internally and externally with the child.

This cluster of studies on the relationship between therapist and parent (or carer) in parent work, once again, highlights the complexity and technical challenges in this work, especially the importance of reflecting on the relationship between the work with the parent and developments within the child (and vice versa). The literature often cites the need for interpretative work about the transference in parent work in order to work through difficulties which threaten the working relationship or impede treatment with the child. There is a clear sense of how difficult it can be to identify, respond to and work through the subtle issues arising, with the literature suggesting plenty of potential for conflict and impasse with parents.

Working with Parents' Historical Emotional Issues and Trans-generational Issues

In a small-scale qualitative study focused on how therapists work with parents' historical emotional issues, Whitefield and Midgely (2015), process interview material gathered from five different therapists using Interpretative Phenomenological Analysis. The resulting overarching themes identified were as follows: 'parent work not therapy: working with different parameters'; 'negotiating permission to work on the parents' childhood'; 'linking together and separating out the parents' history from the child's difficulties'; and 'making use of the parent work relationship'. The authors argue the need for transference work to be delivered in an altered way when working with parents, and found that greater confidence in working with parents, especially in an interpretative way, was shown by the more experienced child psychotherapists in the study. The results of this study reflected, captured, gathered and articulated many overarching issues concerning the general importance and delicate emotional nature of approaching trans-generational issues in parental, work which were also referred to in other studies in this review, including Lanyado (1996), Klauber (1998), and Sutton and Hughes (2005).

Whitefield and Midgely demonstrate reflexivity and acknowledge the limitations of their study, in particular the limited generalisability of the findings due to their small sample size. The authors emphasise that no interviews with parents were undertaken and suggest this would be helpful in future, in particular suggesting it would be useful to understand how parents experience the process of discussing or exploring their own childhood issues in parent work. The study meets conventions of quality for this type of research in that it is coherent, with the methods clearly described and fitting the purpose. Along with O' Dwyer (2021) and Holmes (2018) in this review, this paper represents a positive example of contemporary child psychotherapist practitioner-researchers utilising interviewing as a qualitative method for gathering up perspectives from a number of child psychotherapists, and summarising their findings using established methods of data analysis.

The reviewer also noted that this was the second study in the review to emphasise that parental perspectives were not obtained, and to recommend this as a valuable area for development and exploration in future research.

Studies Providing Meta Overview and Historical Analysis, and/or an Overarching Conceptual View of Parent Work

One study argues that concurrent work with parents in psychotherapy is as challenging, complex and important as the work with the child, and that it should be properly designated with its own title. Sutton and Hughes (2007) assert that the term 'psychotherapy of parenthood' captures this and that the rigour applied to this aspect of the work has declined. Along with other authors already discussed in this review, the authors delineate different levels of this work, including emphasising the importance of the therapist attending to their own counter transference at all levels of work, even if not actually verbalising interpretations of this. The authors also emphasise that a clear description for parents of the possible range of involvement allows the work to proceed on the basis of 'reasonable, informed consent and partnership' (Sutton and Hughes, 2007, p. 185).

In another study written from clinical experience, Marks (2020), refers to case examples to argue that child psychotherapists could explore more substantial work with parents at the outset, before therapy with the child begins, and so develop insight and build a stronger therapeutic alliance and shift unhelpful family dynamics. There are general implications suggested for the assessment and start-up period of work during what is termed the 'emergency' phase. Working with the same therapist for parent and child work is, once again in this paper, considered to have some advantages, with the observation stated that parents may otherwise experience the communications regarding their child's therapy as remote and hard to engage with. This study argues that the profession should ask the questions: How do we listen to the cries of the parent? How do we offer a therapeutic space for the parent as patient? The argument is put that consent for different levels of therapeutic work with parents may need to be renegotiated over time. Marks states, 'my language with the parents remained ordinary, goal oriented and practical' and the case is made, in a similar spirit to Lanyado's (2019) invitation for a more contemporary approach, for use of everyday language and the recommendation of a teamwork approach with parents.

These studies once again add to a growing sense of a consistent overarching theme expressed throughout the literature concerning the necessity for greater engagement with the needs of parents, renegotiation of consent for different levels of work, and for the overall approach, including language used with parents, to be more transparent in order to build a strong alliance and genuine partnership. As Marks makes her plea to find a way to listen to the cries of the parent *within* parent work, an echo of this theme can be discerned emerging from within this literature review, about the need to establish space for parental voices in future research.

Importance of Fathers Recognised

A plethora of studies made reference to the importance of fathers in parental work, and this combined with a sense of the impact of their marginalisation or absence from parent work, was a significant theme throughout the literature.

One of these argues that in cases where parents are seeking a diagnosis of Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder, what needs to be examined and understood instead to help the parents, is the link between their child's feelings - particularly of sadness, aloneness and helplessness - and their behaviours. Widener (1998) argues, using reference to case examples arising in her clinical experience as her basis for this, that both parents and especially fathers' active roles in this work has been most beneficial.

Another study focuses on a number of cases of children growing up in single parent families. Beginning with a theoretical focus, Edwards (1999) speculates on the internal impact on children who have not had the benefit of working through Oedipal issues, such as jealousy and envy, in relation to an ordinary experience of exclusion from the parental couple. Edwards suggests these children may be deficient in the capacity to make links and think about relationships and struggle to develop a sense of internal space. The author then moves on to consider the positive impact of parent work may have in this, with reference to two case examples from clinical practice. The author describes one of the mothers as being especially helped by the idea of the child's therapist and the parental therapist working together as a strong couple and, from this, being able to develop strengths and insights, unravelling the problematic relationship this mother had with her own parents. Both mothers are described as previously having denied the importance of a two-person relationship in bringing up a child, and the work with the parent therapist is seen as having allowed for the development of a substitute experience of an internal creative couple. This was another example of a paper written by a practitioner sharing their learning from clinical experience, applying psychoanalytical theory and reflection to practice and so further developing this theory about one beneficial aspect of the mechanisms and dynamics at work in parent work.

In another study, Ludlam (2005) compares approaches to parent work which address the couple as parents and those which focus on their couple relationship, arguing for combining these approaches and offering both. Ludlam highlights the need to be conscious of pulls towards Oedipal dynamics, including splitting off feelings of painful loss, which may be projected into the child, or pairing with one parent, avoiding unwanted feelings of exclusion as a therapist outside of the parental couple. Ludlam references a case example to support this argument, where a family had adopted a son, aged 6, who after settling into his placement with them, began to show highly disruptive behaviours. At first the couple were extremely guarded with the parental therapist, coming with a list of issues they wanted fixing. The therapist felt they were anxious about a repeat of the exposing process they had been through while being vetted for adoption, and so carefully worked up to addressing issues to do with their own relationship. However, once she was able to identify and work with them about their feelings of loss and inadequacy as a couple, which due to their not having been able to conceive naturally, they became more able to withstand their son's testing of the security of his new family, and came to understand how their state of mind was contributing to and reinforcing his fears of rejection.

The study makes a number of convincing sophisticated technical connections and asserts hypotheses about better ways of working. A weakness is that, as with many of the studies by a single practitioner sharing their learning from experience with reference to case examples, the material is presented in highly summarised form, with little direct reference to original observational session material which might more strongly evidence the assertions made. However, in terms of usefulness of clinical application, this, like many of the other theoretical/practical studies, is intended by the author to be a concept which can be usefully kept in mind, helping a practitioner to be alert to this as one of many possible issues which may be relevant to a given clinical situation. This study represents a positive example of the value of a study which while it provides technical descriptions of particular issues which have been seen to arise, making a theoretical case about this, leaves the ultimate 'testing' of the theory and judgements about its usefulness, or validity, to other practitioners to considering in their own practice.

Finally, Novick and Novick (2013) note that, although most now accept the importance of parent work in general, much parent work is still predominantly with mothers. They point out that although many practical reasons for not engaging with fathers are cited, there can be other less conscious factors involving 'fears and fantasies of paternal power and retaliation' (Novick and Novick, 2013, p. 129) and that both male and female therapists may be subject to such worries. Once again in this study, the authors rely on their professional experiences for the validity of their claims, observing that in many of the cases presented in this study, progress eventually depended on the participation of the fathers, their involvement often leading to turning points.

Consent

A single study, the only one to focus entirely on this as a main theme, reflects on the possible impact and ethical issues raised when a parent withdraws consent for any parallel parent work. Daws (1986) considers ethical dilemmas arising in clinical practice, especially in relation to the dynamics of ongoing consent, and draws on case material where a parent communicated her doubts about the therapy to her child, and also posed the direct and challenging question to the author as to whether she was hypnotising her child, after a session where the child had reported falling asleep for a few minutes. Daws argues that the function of such questions is to remind the professional, 'I am the parent, and I have a right to ask questions and be answered.' This study was one of few to clearly name so explicitly an ethical tension which can arise in relation to parent work and also to make such an imaginative leap, making the case for the importance of parental perspectives and respecting their right to information and understanding. From Daws' examples and long clinical experience, the reviewer believes she shares a valuable insight. Again, rather than using a formal research study method to explore the issue of consent, a particular and memorable example is shared, a form of professional knowledge, the validity of which may be judged according to how applicable it is found to be in practice, and which the current reviewer found compelling.

Parental Mental Health and The Impact of Family Trauma

Parental mental illness and/or impaired parental mental health was an overarching theme implicit and woven into several references to parental states of mind throughout the studies, rather than being addressed explicitly or directly as an issue. Only a few studies specifically named mental illness in mother or father, although many referred to trauma in a parent as the contributory or most significant issue in the family history. Studies instead tended to sum up with general statements about the background demographics of parents, for example Trowell (2011) referred to 'generally acrimonious couples or single parents' as the trend in her study of adolescents with depression (2011, p. 150), although this study did reference generally very high levels of emotional stress and adversity affecting families. Holmes (2018) was exceptional in the attempt to think directly and ask questions about the demographic and mental health status of the 26 parents worked with by the therapists in his study, where 68% were mothers, 12% both parents and one case where father only was worked with (4%), with therapists in this study estimating that a majority of parents (72%) had an undiagnosed mental health issue.

In one study, a detailed account of simultaneous but separate work with an 11-year-old boy and his mother, both of whom have multiple symptoms of severe and pervasive anxiety is considered. Hellman *et al.* (1960) select this one for discussion from two undertaken under the umbrella of what is described as 'The Research Project on Simultaneous Analyses at the Hampstead Child Therapy Clinic', although no reference is given to a larger write up of this project being available. The discussion makes for uncomfortable reading, not least because, (as seen earlier in another an older study) despite the revelation during the parent work of what would now be classed categorically as child sexual abuse, there is no child protection action taken, and the author seems unaware that this would even be a possibility. Instead, the mother's behaviour is seen as harmful but understood as pathological due to her own complex childhood and history of sexualised behaviour with her brother, and so this is addressed within her analysis, and she is described as developing a genuine guilt and sense of responsibility about the harm done. In this it is dated and limited in terms of relevance to contemporary research, being so out of step from modern practice and professional standards, but historically it is of interest, however, to see this evolution in children's legal protection and safe-guarding practice in parent work in Child Psychotherapy. There are some interesting details and a persuasive formulation formed about the intersection between mother's defences and her intrusive projections into her son and their negative impact. However, the reader is assumed to be prepared to accept the author's expert formulation uncritically, based on classical psychoanalytic theory, without any empirical evidence for her assertions being shared from case material. This paper reflects the historical trend, identified earlier in this review, where a psychoanalytical author communicates an assumption and apparently un reflexive position of certainty in relation to their professional judgements, adopting an 'expert' tone and position.

Davis and Osherson (1977) describe an extraordinary case of working concurrently with a mother with a 'multiple-personality' at the same time as her son was seen for Child Psychotherapy. They describe how the mother did not disclose the severity of her mental health difficulties until sometime into treatment, then quite suddenly introduced to the parent therapist two 'additional personalities', with a confidentiality agreement having to be negotiated about what would be shared between the analyst and each of the three different personalities as they presented themselves at different sessions. The mother, seen twice weekly, broke off treatment after 70 sessions, giving the reason that one of her more dominant personalities would not allow it to continue. As a result, the treatment with the child ended prematurely. During the treatment, mother and son were seen during one session together, when the mother insisted she wanted to tell her child about her different personalities, thinking it would help him understand his different experiences of his mother better. The therapists advised against it, thinking it would be too traumatic, but in fact both were surprised when the child seemed able to take this in and to be relieved by this new understanding. This paper was in some respects dated, written in 1977 and using language and labelling such as 'multiple-personality woman', which sounds rather pejorative in a modern context. However, the openness in describing the challenges of working with a severely mentally unwell parent is helpful. The shared material is extreme, but also resonates with the current researcher's observations of the severity of challenges arising when working clinically with a parent population whose severe fluctuations in state of mind can make for sudden and unexpected ethical challenges, as well as moments of conflict or tension between parent and practitioner. The authors report observing the apparent benefit to the child of the explanation of mother's illness; in this the study is ahead of its time and more in line with current multi-disciplinary practice globally, in recommending working with the children of parents with mental illness in considering frank and open conversations about mental illness to be a source of relief of anxiety for children (Falkov, 2017). In this way the study suggests how there can still be a value in literature that is on the one hand dated, but on the other still links with contemporary practice nearly half a century later.

In a study on the significance of trauma in working with parents, particularly focused on parents of children with autism, or who are atypical or highly disturbed, Klauber (1998) is critical of the tendency she observes, particularly in the U.S. up until the mid-20th century, to confuse the effects of the child's difficulties (both on the child themselves and on the family), with its causes, leading to a negative attitude towards parents. Klauber takes an empathic compassionate attitude towards parents, thinking about their experience and considering the traumatic impacts of diagnosis, and the trauma of either extreme concerns tending to be raised by professionals or, conversely, parental concerns being minimised. Klauber takes the impact on parental and family functioning of such chronic and severe anxiety seriously, suggesting that professionals, including child psychotherapists, should be trauma-informed in their approach to parents, recognising how highly sensitive they are likely be to feelings of judgement by professionals, summing this up powerfully 'Seeking help from professionals may be experienced as a minefield filled with the fear of judgement and criticism, with dreadful stirrings of the memory of noticing something was wrong.' (Klauber, 1998, p. 89). Klauber draws on details of a case example of a five-year-old boy whose whole family had become organised around their view of his autism, but through long term parent work were able to make connections between their own childhood experiences of loss and disorientation, to understand how some of their patterns of behaviour were stifling developments in their son. Klauber further argues that the same principles can be applied to *all* work with parents in Child Psychotherapy, saying that there is always an element of trauma and always, often unconsciously, a fear of the professional.

It can be seen how studies in this review suggest a theme about some particular ethical challenges of undertaking research with parents experiencing significant mental health challenges, but in the contemporary literature there can be discerned a reticence, reflecting a difficulty perhaps in naming such a sensitive issue about parental identity. The literature reveals also, however, a need to continue to explore this, carefully opening up the potential for parents to participate in the research conversation, while at the same time respecting their rights to self-definition and dignity as subjects involved in research. The ethical challenges of this work may suggest a clue as to why parental mental ill health seems somewhat hidden in the research literature, and it is understood that there may be a tendency for clinicians to focus on successful work rather than that which is fraught, and where therapeutic relationships frequently break down in practice. The review raises the question of whether it is possible that there exists an unconscious self-censoring, or avoidance of this subject in studies for publication, perhaps a lack of confidence in broaching and naming the sensitive issue of parents' own mental health in work with parents.

Work with Grandparents

In another study which shares learning from experience, Lanyado (2019) focuses on cases involving grandparents with kinship care parental responsibility for their grandchildren. Lanyado explores material drawn from a range of supervisees' work and some from her own, examining the motivation behind the devotion and commitment shown to their grandchildren's development, as well as examining how grandparents themselves benefit from the work undertaken to support them alongside the child's psychotherapy. Lanyado is another writer in this review who acknowledges and wishes to redress the historic lack of attention to non-nuclear family structures, pointing out that 'parental grandparents' are more prevalent in clinical work than previously, and haven't so far attracted sufficient clinical attention.

One of her case examples is of a grandparent with kinship guardianship due to severe parental mental illness. Lanyado posits the idea that their greater maturity and reflective capacity about emotions and life in general can mean this group makes good use of (grand)parent support work, leading to impressive insight and breaking of cycles, repairing of the internal and external traumas and relationship problems of the past. An enlarged capacity for mourning and healing and learning from mistakes is observed by Lanyado from her work with this demographic group. Lanyado also acknowledges particular practical and emotional challenges, stating that in her work with them it was important that practical as well as emotional supports were offered by her clinic. Helping with changes in the external environment was seen to have contributed significantly to the deepening of a therapeutic alliance and building of trust. The paper was novel in its attention to a group thus far generally under-represented in the literature, and suggests this would be a significant population to hold in mind in future.

Measurement of Outcomes of Parent Work

Outcomes were referred to throughout the studies in the limited sense that examples were cited of diverse benefits to parents, young people and children from the parental intervention. These outcomes were based on clinical judgement, however, rather than an attempt being made to measure these more objectively, or include parents as active partners in feeding back about this, or there being a focus on empirical measurement or analysis of cited outcomes. An exception in this regard, and also the only study in the review in the category of a large-scale psychoanalytic study using mixed methods, was a study by Trowell, Rhode, Miles and Sherwood (2003). It was the only study included in the review which would be seen as potentially attaining findings achieving external validity as it was undertaken as part of a randomised control trial.

The study focused on a comparison of short-term psychoanalytic psychotherapy (30 sessions) with separate concurrent parent work (15 sessions), compared with family therapy with adolescents with depression, across three centres in Europe. The therapists worked hard to engage both parents in the parent work carried out as part of the study, and note that in many cases a father had previously been closely involved in the child's early life, but then been lost due to marital breakdown or other change in circumstance.

This study focuses on the UK sample which was part of the larger three country study and describes the parent work as multi-faceted, in that it included parents in the treatment process, by thinking about the child, the treatment and about issues of parenting. This is reported as including thinking about attachment issues within the family, both positive and negative experiences of this, about the parents' own issues where these impinged on the child and, where appropriate, included thinking about historical factors within the family. It was noted that issues of loss were frequently in the parents' own histories and issues about ending had to be carefully handled when, within the safe relationship with the parent worker, painful issues had begun to be raised. An early finding reported from the study from the measurement of expressed emotions in the parent child dyads, was that work with the parent led to a healthier, less demanding emotional environment for the young people. However, this study is described as a work in progress with as yet inconclusive findings and is linked to the larger IMPACT study.

Termination and Ending as Issues

Termination and ending of parent work as an issue with serious implications and impact for families was identified in the literature. Daws (1986), Trowell (2003) and Novick and Novick (2013) were key studies mentioning how hard ending the therapeutic relationship could be, often linked to the many losses, and feelings of loneliness and isolation which had been experienced in parents' own lives. This is a significant issue to be considered in parent work, which most child psychotherapists would recognise as problematic, given the currently high turnover of clinical staff in CAMHS settings. Once more these authors are sharing perspectives and learning from their professional experience, and there remains an unanswered research question begging, concerning parental experiences of endings in parent work.

2.5 Types of Study Identified

Type A

By far the largest number of articles, 23 of the 27 included in this review, belonged in a category the reviewer has defined as Type A**:** 'Learning from experience', with reference to case examples. The strengths of these types of papers lies in their ability to share knowledge, concepts or skills in one situation which can be applied and related to by the profession more generally. As has been described, there were examples of the 'Learning from experience' type which stood out as providing exceptional originality or conceptual meta-analysis of value and relevance to the profession, in terms of their contribution to professional learning in parent work, such as the papers included by Rustin (2018), Klauber (1998) and Lanyado (2019).

These papers have professional relevance and occupy a central position in the training of child psychotherapists. Covering a huge range of particular therapeutic challenges and themes, they illustrate a plethora of clinical issues arising. Their validity may be tested in practice, depending on the degree to which they are seen to resonate with a sense of 'truth' in clinical contexts. They rate highly in the reviewer's assessment, in their possession of the quality of 'relatability', a term coined by Bassey (1981) cited in Bell (2010, p. 9) from the comparable context of case study research in education. These are rated more highly where they demonstrate a clarity of written style and transparency about the processes of observation used to arrive at hypotheses and conclusions. Responses and value judgements about Type A studies are likely to be highly subjective however. For example, for the current reviewer, a study most resonant with experiences in the clinic was Trudy Klauber's (1998), in which she explores the idea that all parents presenting children for treatment can be understood to be affected by features of post-traumatic stress. This study resonated with the current writer's experiences in the clinic and attitude towards compassionate ways of relating to parents. Such well known and often cited studies may be referred to as 'seminal' and their writers, experienced Child Psychotherapists and often leaders in the field, have a highly regarded status within the profession. Nevertheless, viewed critically, and according to more widely accepted standards in psychological research external to this profession, they may be judged insufficiently 'scientific', 'empirical' or not 'objective' or be dismissed as being too theoretically or conceptually driven (see Fonagy, 2013). There can be a conspicuous absence of attempts in many Type A studies to measure changes which are asserted empirically, leading to the accusation of a complacent reliance on subjective professional judgement. The current review highlighted scant reference to management of ethical issues in relation to sharing of the case material and almost never mention validation of material by the patient or parent, or awareness that this could be a helpful approach to incorporate.

Midgely (2017), a leading exponent calling for developments in contemporary Child Psychotherapy research, makes a criticism, in his updated narrative review of the evidence base, about most of such observationally based studies, which is their tendency not to build on each other's findings.

'Furthermore, studies often did not reference each other, build on each other and they tended not to be designed in such a way that allowed meaningful comparison of findings, restricting the development of cumulative knowledge about the evidence base for this type of treatment for children and adolescents.' Midgley (2017, p. 309).

It was noted that this was true of most of the Type A studies included this review.

Type B

Small-Scale Qualitative Practitioner Enquiry studies were classified as Type B, and identified as exhibiting higher empirical standards and features of both internal and external validity, according to the criteria on the quality appraisal checklist. Three studies - Whitefield and Midgley (2015), Holmes (2018) and O'Dwyer (2021) - are highlighted as good examples. Holmes (2018) is noteworthy of the most recent of the three studies in the category and was a good example of the strengths of this type of study, in that the findings summarised therapists' views on the aims of parent work and confirmed many of the aims which multiple Type A studies had covered in a more disparate way. Type B studies contribute to a research knowledge base for the profession in this way, gathering multiple perspectives and identifying more methodically further research which can be developed from findings. These more empirical studies have a different kind of validity. They make very limited claims to generalisability, as the sample sizes are often small, but are more 'general', and the advantage of these types of study is their ability to explore multiple views and summarise them. Whitefield and Midgely's (2015) small-scale qualitative study on the subject of how therapists work with parent's historical emotional issues is a particularly well executed example of a study in this category.

Type C

Only one study was identified as belonging in a category classified as Large-Scale Using Mixed Methods. A study by Trowell, Rhode, Miles and Sherwood (2003) was unique in the review in that it attempts to measure outcomes in parallel parent interventions in Child Psychotherapy. It was the only paper which reached all of the standards on the quality checklist and so can be seen as potentially attaining findings with external validity. However, this study is described as a work in progress with as yet inconclusive findings as it is linked to the much larger IMPACT study.

2.6 Identified Gaps in Knowledge and Recommendations for Future Research

Studies describing work with parents from different demographic populations, such as with parents suffering from mental illness, with fathers, with kinship carers and grandparental carers, and with parents of children from a variety of cultural backgrounds, were under-represented in the literature. Parental voices in the literature, expressive of their views and experiences, and considering what meaning they make of the parent work, were conspicuously absent. Measurement of outcomes in the work with parents was also scarce, reflecting a broader challenge about the complexity of outcome measurement generally in Child Psychotherapy. In this way the review identified a number of lesser-developed themes and potentially useful areas to target for future research as follows:

- Studies engaging with a wider range of issues arising with parents under-represented or from more diverse backgrounds, and demographic groups including fathers, kinship carers and parents with mental health issues.
- Further exploration of innovation and accessible modes of delivery of parent work in response to real-life clinical limitations and individual need.
- Attention to, and incorporation of, outcome monitoring and measurement and or goal setting in parent work.
- Agreement of aims and role clarification in work with parents.

From the included papers from the final 2018-2021 search, the researcher noted signs emerging of a step-change in the tone, quality and methodological approaches informing these papers. There was greater attention paid to discussing ethics, sampling, confidentiality and acknowledging sources of data. This represents a significant shift and sign that child psychotherapists, while valuing and holding on to the value of shared learning from experience, are also embracing and engaging with a modern academic interdisciplinary qualitative research culture. Desirable standards to aim for in the designing of future studies are suggested:

- Research with participant feedback, with immediate relevance in most clinical contexts.
- 'Type B' small-scale qualitative research studies are a feasible, pragmatic model for practitioner-led, clinic-based research.
- A more rigorous approach, acknowledging wider empirical external standards of validity (Fonagy, 2003) can be incorporated into Type A papers to attain higher standards. While these may not be classed as generalisable, they can aspire to achieve higher standards of transparency regarding process.
- Literature reviews using rigorous approaches and research providing overviews or meta-analysis of themes and research, including systematic reviews, are desirable in order to make links between existing studies and avoid duplication (see Midgely *et al.,* 2011, 2017).
- Innovative methods can be developed in qualitative research (Smith, 2015). A variety of approaches, established and more novel, can be integrated with psychoanalytical research. For example observation material and reflection on unconscious psychological factors impacting on meanings obtained, as in the methods used in 'psycho-social research' (Hollway, 2004, 2013).
- Participatory methods of research can be used with parents in order to incorporate their lived experience, paying due regard to ethical issues with parents who may be under immense emotional strain and/or coping with their own longstanding mental health issues.

Concluding reflections:

There was a complexity to the challenge of this literature review, which represented an ambitious and broad scoping of the large body of parent work literature published in journals, available in English, since records began. The reviewer aimed for a rigorous high quality review to be of value, not only as a basis for the research project presented in this thesis, but also as a reliable resource to inspire and add value to other Child Psychotherapy researchers, signposting innovative directions for more parent work research. For this reason the review began as a scoping review, evolving over time and further developing as the research journey continued. Given that the main research study presented in this thesis utilised a narrative methodology, it was decided that it would be more consistent to present it in the style of a 'narrative review', with less detailing of process and a more descriptive presentation. Arguably this choice renders the review more accessible and appealing to Child Psychotherapists, conveying more of the meaningful descriptive and emotional context surrounding themes as they arise in each of the included articles.

The strength of this review lies in its ambition to provide a far reaching synthesis of the main themes of the existing literature on parent work in psychoanalytic Child Psychotherapy, as well as an evaluation of quality. The reviewer acknowledges inevitable omissions arising from the attempt to independently review such a broad field, with the necessary exclusion of books and articles not meeting inclusion criteria.

Current Research Question

A clear gap in the research emerged from this literature review concerning the dearth of involvement of parents in child psychotherapy research about parent work. A research aim was therefore identified of exploring parents and carers' direct experiences of engaging in parent work at the same time as their child receives Child Psychotherapy. Three research questions were formulated in relation to this aim, and pertinent to the researcher's clinical setting and mental health policy context:

1. How can parents and carers, in families affected by severe mental health issues, best be engaged in speaking directly about their experiences and perceptions of this work?
2. What do parents and carers in families affected by severe and enduring mental health difficulties tell us about their experience of this work?
3. What can be added to understanding, knowledge and practice in this area?

CHAPTER THREE
MAIN RESEARCH STUDY METHODS AND METHODOLOGY

Parental and Grandparental Stories of Parent Work in Child Psychotherapy, with Families Affected by Mental Health Difficulties - A Psychoanalytically Informed Narrative Inquiry

3.1 Design

As this was exploratory research, concerning how parents or carers affected by mental health difficulties experience parent work alongside their child's psychotherapy, a qualitative design, termed 'psycho-social' research, was employed. It is a phenomenological approach, although not traditional, because it incorporates a particular focus on unconscious aspects of meaning, and places emphasis and value on the specificity of individual experience, psychologically as well as socially, in terms of the individual's particular social context. This approach was pioneered by Hollway and Jefferson (2013), and further extended in research on maternal identity change (Hollway, 2015). The approach has been informed by narrative inquiry as well as psychoanalytical epistemologies (explained in more detail below). This design was consistent with the researcher's overriding aim of representing parents' and carers' perspectives and experiences in a direct way, interpreting the meaning and wider implications of these narratives, while retaining as far as possible a sense of personal authenticity, emotional connectedness and narrative impact.

The idea of a 'research puzzle' as elaborated by Clandinin (2016), aptly describes the sense of curiosity, and theoretical, ethical and practical purpose which had emerged from the issues raised by the results of the literature review, outcome of the clinical audit, and the researcher's observations of parental stories 'naturally' emerging in the waiting room and clinic, during the everyday life of the clinic. A sense of the importance of stories, as a way in which people process and make sense of their experiences, and know about each other and the world around them, had often been observed in the clinic setting. The researcher noticed the way parents and carers made use of the waiting room space to share personal stories and experiences, discussing how and why they were there and bringing their child to the service, and sometimes this was communicated directly with comments such as 'we've just been sharing life stories for the past hour!' when returning children being seen for Child Psychotherapy to the waiting room. This ordinary sharing had the feeling of fulfilling a social but also emotional function and provided a solution to a research puzzle centred on the responsibilities and challenges of engaging in research with an under-represented group of parents in an ethically responsible way. The choice of design was consistent with the desire to apply an ordinary and accessible research approach, facilitating the retelling of such stories of personal experience, and most suitable for encouraging and enabling 'service user involvement' in research with this population (Faulkner, 2012, p. 39). Parents with mental health difficulties, may be thought of as vulnerable participants and can easily feel disempowered, made anxious, or in other ways feel alienated by more conventional academic research approaches (Faulkner, 2012).

Recruitment

Procedure

The researcher described the protocol and aims of the study to the team leader and professionals who were delivering the parent work to parents or carers within the service. The researcher was also a trainee child psychotherapist within the team, and therefore needed to tactfully explain to these colleagues, that careful attention would be paid to maintain a boundary between research and clinical work. At first, naturally supportive and well-meaning colleagues mentioned that they could think of 'good participants', and it was necessary to explain that an un biased and inclusive approach to inviting participants into the study was going to be vital to its integrity and validity. Reassurance was given that the confidentiality and anonymity of both participants and colleagues whose work with parents was on-going and was the subject of the study would need to be maintained rigorously throughout, including later on also when it came to sharing of findings.

The professional already known to the parent or carer then made an initial invitation, on behalf of the researcher, telling them briefly about the study. The researcher then contacted potential participants by telephone, if they had expressed initial interest and let the professional know they agreed to the researcher calling them to arrange sharing of more detailed information. It was important that participants were not parents with whom the researcher had worked as a clinician, either involved in delivering parent work to them or as child psychotherapist to their child. This would not only have presented an unacceptable ethical conflict, with the risk of the research relationship interfering with clinical relationships and outcomes, but would have undoubtedly impeded the openness and honesty with which participants were willing to explore their experiences and feelings about the work.

Individual introductory meetings were then arranged with the researcher and each participant, during which the aim and process of the inquiry was described in full, with participant and supporting information forms given (see Appendix 3.1). These meetings with the researcher were arranged to take place at the clinic or at participants' homes, according to preference. It was explained there was time to decide (up to two weeks) with no obligation or impact on treatment if they did not wish to proceed, and processes which would be followed to ensure anonymity and confidentiality throughout the research were explained. At this meeting it was also explained that if, after some time to reflect, they wished to proceed, the study consent form (see also Appendix 3.1) would be discussed and signed prior to beginning the first scheduled interview.

Participants

Approximately 50 parents and carers were actively engaged with the specialist service CAMHS service at the time the study began in January 2021, somewhat smaller numbers than would usually be the case as at this time full-service capacity had been curtailed for nearly a year by the advent of COVID-19. Child Psychotherapy, and the parent work delivered alongside it, is also just one of several interventions which are offered within this service, and is a highly specialist intervention, delivered only to a small number of children and young people at any given time. At the time of the study five parents and carers of children or young people were identified by the team's co-ordinator as potentially eligible.

Eligibility

Criteria for inclusion in the study were that the participant would be a parent or carer of a child receiving Child Psychotherapy within the specialist service and also had to have been engaged in ongoing parent support work in parallel with, but separately from, the Child Psychotherapy work with their child.

The researcher explained to the professionals involved in this initial recruitment process the importance of an inclusive and democratic approach when deciding which parents or carers to invite into the study, in order to guard against 'selection bias'. Participants were only excluded from invitation into the study where there was an ethical justification for this, such as they were currently known to be particularly vulnerable or under stress, so even invitation to involvement in the study was considered inappropriate by the team leader and as adding unhelpfully to existing pressures, or if a current child protection issue had been identified.

Sample Size

Of the maximum five potential parents or carers originally considered as meeting the criteria of having parent work while their child engaged in Child Psychotherapy at the time of the study, two were excluded from initial invitation into the research. One had recently been severely ill with COVID-19, leading at this time to extreme pressure on their family functioning. Another was understood not to have engaged in parent work during their child's attendance for Child Psychotherapy after all, because they had only attended termly review meetings for the child and not engaged in separate parent work.

Three participants was regarded as an appropriate, meaningful and feasible number, given the researcher's highly specialist clinical and service context, and the depth of qualitative research process being undertaken with two in -depth interviews and follow up meetings for further discussion planned with each one. In a related research field, educational case study research, designs generally aim to obtain a similar amount of qualitative data, from between 3 and 5 case studies. Concerning the validity of the knowledge thus obtained, Bassey has stated that it is preferable to use the term 'relatability' rather than 'generalizability' in (Bassey 1991,p.9). In this argument the merits of a case study are judged by the extent to which the details are sufficient and appropriate for a professional working in a similar situation, to relate his decision making to that described in the case study (Bassey 1991). In traditional psychoanalytic case study, the focus historically has often been on only one case at a time, and the writing up of a single case study for the qualifying paper remains central to the training process of Child Psychotherapists, being regarded as the gold standard for the degree of in-depth reflection and learning required. The aim was for depth more than breadth of qualitative data, and therefore to engage a relatively small number of participants in a high quality, in-depth research process, maintaining the most exacting standards of care and ethical engagement with vulnerable participants.

Characteristics

Due to referral criteria for the service, the participating parents had a severe or enduring mental health difficulty or, as in the case of the kinship carer, their own grown-up child had suffered from such severe mental health issues (leading to this grandparent assuming kinship care responsibility).

After considering issues relating to ethics and vulnerability, three of the five potential participants were recruited and took part in the study (see table below) including one who asked for an additional supporter, her mother-in-law, to join her for most of her interviews or meetings. All participants were female and the main carer for the child, although one was married and her husband, father of the child, lived in the family home.

Gender	Age	Relationship to child	Sole parent / carer	Mental health difficulty	Time engaged in parent work
F	50s	Grandmother Kinship carer	Y	None	7 years, frequency variable
F	40s	Mother Carer	N	Anxiety / Depression	3 years, frequency variable
F	30s	Mother	Y	Anxiety / Post Traumatic Stress Disorder	One year, frequency regular once weekly

Participant Information Table

3.2 Ethics

In addition to the particular ethical procedures and precautions outlined below, the researcher tried to go above and beyond and demonstrate a high degree of care and attention to the needs and dignity of each individual, throughout the process of the study and research relationship.

Institutional Permissions

Ethical permissions were granted prior to embarking on the study by Robert Gordon University as well as the South West Scotland Ethics Committee, according to strict requirements ordinarily required for research undertaken in NHS settings (see Appendix 3.2). Permissions may have been granted considerably earlier, however, all research ethics applications within the NHS were closed down in Scotland with immediate effect, with the advent of COVID-19 in April 2020. Once the necessary institutional channels reopened, the original ethical proposals were adjusted, integrating procedures for infection control measures and risk management, adding in provision to meet with participants online, if the participant's health status required this or they preferred and/or wear a face-mask while interviewing as per COVID-19 guidelines. By December 2020, all the additional health and safety precautions had been checked and NHS ethics permission were granted, with permission for face-to-face interviewing to take place where appropriate, safe and agreed to by participants.

Consent, Confidentiality and Protection from Distress

Participants' names and contact details were obtained from the team leader and stored on the researcher's encrypted NHS mobile phone, after consent had been given for participation, with transcripts, field notes and reflections stored on the researcher's encrypted NHS laptop.

During the discussion of the detailed participant information and supporting information leaflets during the initial meeting with the researcher, it was explained that the researcher would be writing up transcriptions of the interviews, and these would be shared with the participant themselves, who it was hoped would play an active role in checking, verifying and reviewing the content. It was explained that pseudonyms would be used and the participant would be invited to choose those they preferred for use in the final research text. It was discussed with the participant that the research text and their personal narrative would be regarded as highly personal with such precautions requiring to be taken in order to protect the identity and confidentiality of the children, families and professionals involved.

It was explained that anonymised transcripts and research texts could be shared with the psychoanalytic and other academic research supervisors, for the purpose of supporting joint analytic and academic reflection on the content.

During the consent process the researcher explained that an alternative method to transcription could be used if the participant preferred not to have their voice recorded, the researcher instead using the psychoanalytical approach of writing up observations from memory immediately after interviews.

It was also explained that participants' narrative accounts would be further represented in formal academic contexts by making use of extracts, rather than whole unedited narratives, in this thesis and possibly later publication in the Journal for Child Psychotherapy or other professional publication, if the participant gave permission. All three participants had the opportunity to discuss and ask questions and all gave their consent, expressing their wishes to be informed about any later publications beyond the academic thesis. Participants' right to withdraw at any time form the study was emphasised and made explicit, with attention drawn to the optional nature of participation. Consent forms were discussed and signed prior to beginning the first interviews.

It is generally considered good practice to ensure that there is time and space at the end of potentially emotive interviews for debriefing and any distress to reduce (Thompson and Chambers, 2012). This was provided for in the planning and carrying out of the interviews, sometimes with agreement made for a follow up phone call or text to see whether the participant wanted an opportunity to further debrief. It was explained that if the process of the interviews was upsetting, the researcher would check if the participant would like the opportunity for this further follow-up discussion afterwards, either with herself or with the worker who the participant had the existing relationship within the service.

Closing meetings were planned with each participant, when the research with them had been completed and during this a copy of their narrative given to them to keep if they had said they would like this. The closing meetings marked the formal drawing to an end of the relationship between the researcher and participants formed during the study. Given the clinical context this was considered ethically appropriate, and important for maintaining a sense of boundary around the researcher/participant relationship and marking a clear point of entry and exit from the study.

3.3 Data Collection

'Free Association Narrative Interviewing'

After the introductory and consent meeting, two subsequently planned interviews were carried out at a place of the participant's choosing. These were followed by two more follow-up meetings to discuss their transcripts with them.

Interview schedules were drafted, adopting Hollway's psychoanalytically informed 'Free Association Narrative Interviewing' method (Hollway and Jefferson, 2013). This method of interviewing was selected in preference to methods of semi-structured interviewing frequently utilised in qualitative designs such as Interpretative Phenomenological Analysis or Thematic Analysis. The 'F.A.N.I' method adopted, through its two-staged approach of interviewing, enhances the opportunity for the participant to drive and shape their own narrative, which allows their thoughts and preoccupations to emerge in a self-directed manner, with as little interference as possible from the researcher.

The first 'interview' is led by one opening question from the researcher, barely more than an invitation to the participant to begin the story from the beginning, and the second interview again takes its lead from the preoccupations and themes that emerged from the participant during the first. With minimal leading questions from the researcher, the narrative is construed as emerging in a similar way to the free association at the heart of the theory and practice of psychoanalysis.

This method of collecting interview data is theoretically more consistent with a psychoanalytic view of the unconscious; other methods may give cognisance to the importance of participant and researcher subjectivity but lack this added dimension of the unconscious aspects of subjectivity. The F.A.N.I method was also more consistent within the researcher's later psychoanalytically informed approach to the analysis of the data, which was to include a focus on unconscious aspects of meaning and the research relationship.

The emphasis on the retention of the personal meaning of individual participants' narratives was also considered an overriding aim, considered more relevant and instructive than the identification of more abstracted codes for themes and sub-themes across a larger sample. An additional benefit was the way this method of interviewing allowed a naturalistic and informal approach, with the participant really feeling that what was valued was the telling of the participant's story rather than an emphasis on answering questions.

Two of these interviews were scheduled, the first asking simply for the participant to recount their back story, of how they initially came to have contact with the service and into the parent work. This first interview was designed to allow for rapport and trust and facilitating the beginning of a narrative telling, largely led by the participant.

The second interview addressed themes that had emerged from the first one, in order to prompt further exploration and elaboration on so far unexplored aspects of the participant's experiences of parent work, which might be significant. The content of each of the first interviews was reviewed and reflected on by the researcher and with the psychoanalytic supervisor, with questions constructed individually for each participant. This prompted and further developed a narrative telling of experiences of the parent work during the second interview.

The schedules which guided the drafting of first and second interviews are shown in Appendix 3.3 as well as the individualised schedules guiding second interviews. All interviews were carried out using an informal approach to questioning that attempted to prompt naturalistic narrative telling of experience, using a conversational tone and relaxed delivery. All three participants consented to audio recordings being made using a Dictaphone.

3.4 Data Analysis

Field Texts and the Narrative Retelling Approach

Because texts resulting from meetings with participants are composed or co-composed by participant and researchers in narrative inquiry approaches, the term ‘field text’ is preferred instead of ‘data’ by the pioneers of this approach, Connolly and Clandinin (2000 cited in Clandinin, 2016, p. 46) and this terminology is adopted by the researcher here.

Initial impressionistic emotional responses and thoughts were noted and recorded after interviews, enriching reflexivity and additional meanings that might be explored in relation to these, in subsequent reflection and dialogue with the psychoanalytic supervisor.

Verbatim transcriptions of the interviews, were taken back to participants and discussed over the course of one or two planned meetings, as ‘interim field texts’ (Clandinin, 2016), rather than being assumed to be final and fixed. These follow-up meetings afforded an opportunity for the researcher to check with participants that words, phrases, or sections of the interview transcript had been understood and grasped by the researcher in terms of the participant’s intended meaning.

In this way, the follow up meetings afforded an opportunity for further co-construction and creativity (terms explored further below in epistemology and ontology), that is, collaborative thinking about the narratives: the participant, on seeing and hearing their story reflected back, shared with the researcher an extension to their original thought or was able to clarify or modify an original feeling or statement.

A further benefit of this kind of checking with the participant is to enhance the sense of equality in the relationship with the participant, putting the participant at the centre of the process. It cannot be overstated how much these vulnerable parents may easily feel under pressure to ‘get it right’ or worse, feel under interrogation by an academic researcher adopting an ‘expert’ position, undermining their confidence and ability to give voice to their own opinions and thoughts.

The original protocol design had suggested one meeting for this part of the process but, in the event, additional meetings were arranged with two of the participants. This was because of, in one case, the amount of time they had available at a time without their child and, in the other, due to the length of narrative generated by the participant who proved to be a particularly ‘natural’ storyteller, given to rich digression and additional spontaneous reflection. A drawback to this approach of checking meaning and validity in this way with each participant is how time consuming it can be, increasing the emotional demand on both participant and researcher who have to retain this engagement over time.

For participants with sometimes overwhelming caring responsibilities this meant that in practice the research process could become quite protracted, spanning many months. The overall time spent together engaging in such intimate personal narratives also inevitably meant that the research relationship grew in investment and intensity, leading to feelings of loss when it came to an end. This was familiar territory to the researcher, to some extent, who is engaged in similarly intense relationships in ordinary clinical work but for the participants the ending of such a research relationship could feel quite an unusual and unanticipated loss. Once again, the small sample size was important to ensuring that the researcher was able to pay careful attention to the needs of each participant and maintain communication and the sense of continuity and individual purpose with each one.

The field texts (the individual full texts of the narratives produced after this process of meeting and verifying) were then given to participants who wanted their own copy. In the event, all three participants were very active in the discussion of the interview transcripts and expressed their wish for their own copies of the field texts produced. Personal copies were given to the participants at individual closing meetings.

These field texts were then edited for the purposes of retelling and analysis, with individual themes identified in each participant’s narrative presented first in some detail (see next section), followed by discussion of researcher reflexivity about the process with each participant. Major themes were analysed within each narrative, considering their relation to and knowledge added to the wider literature, before finally a summary and comparison of some common or overriding themes identified across the three narratives was arrived at.

Table summarising process of data collection and analysis

Introduction and consent meeting.
Initial interview - story of entry to the parent work (audio recorded).
Process notes of first interview reviewed and reflected on with the psychoanalytic academic supervisor, drafting individual questions in preparation for 2nd interview, thinking about emotional meanings, participant's relationship with researcher.
Second interview - exploration and elaboration of aspects of parent work (audio recorded).
First follow-up meeting - sharing verbatim transcript, clarifying meaning, checking for understanding.
Second follow-up meeting - further checking, choice of language/pseudonyms for anonymised field text, participant's thoughts and reflections.
Sharing of anonymised field text with psychoanalytic academic supervisor, reflecting on themes, language, discussing emotional meaning, alternative interpretations, possible unconscious aspects of meaning, the significance to each participant of their involvement. Researcher further examining each narrative, identifying themes and issues, adding psychoanalytic reflection to the process, extracting and summarising sections for purpose of retelling and sharing findings.
Closing meeting - ending of research process, giving the participant a typed copy, agreeing follow-up contact if narratives published.

3.5 Epistemology and Ontology

The researcher maintains what has been described by Cresswell (2009) as an advocacy based and participatory worldview which, going beyond social constructivism, regards research as a practice which can address the needs of marginalized individuals in society, and address issues of social justice (Cresswell 2009, p. 9). In addition , influenced by an academic and clinical training in the psychoanalytic paradigm, the researcher's epistemological viewpoint regards subjectivity and inter-subjectivity as primary ways of knowing. These views are also influenced by pragmatism, a worldview and approach enabling flexibility and 'freedom of choice' (Cresswell 2009, p. 11), resulting here in the selected approach not only taking account of the inner world of the mind, but also considering aspects of the external world context for the research problem under examination.

At the heart of Hollway and Jefferson's (2013) psycho-social approach, lies a psychoanalytically informed view of ways of knowing and being, in which there is a significant ontological difference, that is view of truth, arising from a belief in the importance of the contribution of the unconscious, as well as conscious mind, to human experience and knowledge. This belief requires significant differences of approach. For example, in psycho-social research, the psychoanalytic view of the unconscious leads to the idea of the 'defended subject' (Hollway and Jefferson, 2013, pp. 17-19), developed from the psychoanalyst Melanie's Klein's original concept that the self is forged out of unconscious defences against anxiety (Klein, 1988, cited in Hollway and Jefferson, 2013). From this the 'Free Association Narrative Interview' method has developed, the method adopted by the researcher for the current study, based on a critique of the assumption that interviewees are sufficiently transparent to themselves to provide adequately full accounts (Hollway and Jefferson, 2013, p. 3).

The psychoanalytical research perspective also pays close attention to the emotionality of interactions. Rustin, a pioneer in the field of psychoanalytic research, explains another reason for this difference of approach to more traditional research practices, is that this form of research is 'indissolubly linked to the responsibilities of clinical practice' (Rustin, 2019, p. 66) so that the psychoanalytic researcher prioritises remaining in contact with the emotionality of the research experience.

These psychoanalytical ideas of ways of knowing informed the researcher's enhanced application of reflexivity and subjectivity as illustrated in the methods described above and running throughout the research design and process of data collection and analysis. For example, the method of using field notes and reflective discussion with a psychoanalytically trained supervisor to review the content of the interview transcripts reflected the importance and value given to such dialogue in psychoanalytical thinking, especially dialogue around emotional impacts and how these inform interpretation of meaning.

This was an application of the psychoanalytic method of reflection developed through 'Infant observation as a method of research' (Rustin, 2012, pp. 13-23), with the clinical practice of psychoanalytic reflection on observational material applied as research method, to the writing up of transcribed interview material. The researcher's subjectivity is utilised as a way of knowing but without the negative idea of subjectivity in the sense of the closing down of thinking about other points of view.

Rushing to false certainty is guarded against and interpretations about possible meanings are considered carefully in psychoanalytic reflection and supervisory dialogue. This idea of enhanced reflection and reflexivity is endorsed by Hollway (2015) and considered an expansion of the way reflexivity is usually understood in qualitative research. This is due to the adding of the dimension of 'the unconscious intersubjective dynamics in field (and later data analytic encounters)' and placing value on the idea of joining up with other minds to aid reflection (Hollway, 2015 p. 31).

The classic psychoanalytic understanding that meaning and knowledge are learned through experience, (Bion, 1962) beginning with the primary relationship and shared emotional experiences between infant and first caregiver, has been corroborated and enriched by modern developments in neuroscientific research concerning the co-construction of meaning in intersubjective dialogue and relationships. Trevarthen (1979) developed modern theories and descriptions of 'primary intersubjectivity', the infant and carer's ability to act together and share experience in harmony, and to develop a complex form of mutual understanding based on close observational research of mothers and infants (1979, p. 346).

Tronick (2018), building on this earlier research, has further outlined a theory of the relationship of the infant with the mother as prototype of all social-emotional relationships with others, suggesting a radical idea about the nature and expansion of human communication and knowledge. Tronick characterises communication between mother and infant as highly variable, and describes a quality of 'sloppiness' and 'thickness', regarded as part of their uniqueness and arising from a process of back-and-forth communicative exchange and turn-taking. This is seen as leading to a process of co-creation which, over time, allows for the establishing of shared meaning. This idea of co-creation positions each partner in the communication as active, and gives rise to Tronick's additional concept of 'dyadic states of consciousness', the idea that individuals, when mapping each other's meanings in social interaction, literally incorporate meaning 'assemblages' into each other's states of consciousness, thus expanding each other's consciousness in the process (Tronick, 2018, p. 36).

Hollway and Jefferson's (2013) psycho-social approach has not only been informed by these psychoanalytical ways of knowing but also by narrative inquiry approaches and the narrative view of experience, which embraces the phenomenological view that lived stories represent and speak for themselves more effectively than dissected themes presented in a detached way. Narrative inquiry exponents have often combined and developed innovative approaches, conceptualising an idea of 'borderlands in the spaces between methodologies,' arguing that researchers frequently find themselves crossing ideological and institutional boundaries, honouring the 'richness of diversity' rather than searching for one unified voice (Clandinin and Rosiek, 2007, pp. 42-43, cited in Clandinin, 2016, p. 12).

Narrative inquiry has developed as one form of narrative research, largely through the work of Clandinin (2006, 2016) and also in collaboration with Connelly (Clandinin and Connolly, 2000). This approach is described, in summary and the simplest terms, as beginning and ending with facilitating the telling of participants' stories (Clandinin, 2016) and underpinned by the view that narrative ways of knowing are fundamental to the ways human beings make and share knowledge and meaning.

Framed within the narrative view of experience, as described by Clandinin (2016), the focus of narrative inquiry is not only on individuals' experiences but also on the social, cultural and institutional narratives within which individuals' experiences are constituted, shaped, expressed and enacted. Narrative inquirers study the individual's experience in the world, by listening, observing, writing and interpreting texts. A pragmatic view of knowledge is suggested where representations arise from experience and return to that experience for their validation. The narratives which inform the researcher's experience are also seen to interact with the narratives of participants in this view, resulting in a process of co-construction of meaning. Meaning is construed in this way, as collaboratively generated and negotiated through transparently shared and discursive research processes (Clandinin, 2016).

CHAPTER FOUR
PARENTAL AND GRANDPARENTAL NARRATIVES, ANALYSIS AND DISCUSSION

Each participant is now introduced, and for each of their narratives, the themes running throughout identified. Key quotations are selected and presented as sub- headings, intended to sign-post the various themes as they arose chronologically in the transcripts of the narrative interview material. These are shown linked to the relevant section of field text, that is the interview transcript after it had been reviewed, anonymised and discussed with participants. Extracts are shared in abridged format, maintaining the sequence, wording and natural 'voice' of the participant, retaining as much of the integrity and authenticity of their narrative as possible, while also condensing this, in order to be succinct.

After presenting this analysis and discussion of the individual participant's various narrative themes as they arose, using the narrative retelling approach, further discussion is given to the two or three most prevalent pervasive themes identified within each individual narrative, in terms of their relationship to wider literature. Finally, the most significant themes and issues raised by all three narratives are highlighted, considering how these findings resonate with, add to, or further develop the existing knowledge base on parent work in Child Psychotherapy.

4.1 Joyce: Grandmother and Kinship Carer

I was cautious after contacting Joyce about involvement in the study, as she told me on the phone when we arranged our first meeting, that she would do 'anything for CAMHS', so grateful was she for what they had done for her family as a service. Joyce seemed almost to give consent before she really knew what that might entail, but we were arranging to meet to discuss the inquiry more fully.

Joyce is a kinship carer and let me know at this initial meeting that interviews would need to fit around her sometimes unpredictable caring commitments. I was mindful of adding to these pressures, however, Joyce communicated her determination to participate in and see through what she saw as a project that might be beneficial to our service and to others like her.

Joyce also told me at her first meeting, as I described the informal discursive approach the 'interviews' would take, that she saw participation as positive for her, as talking '*Is the only therapy I get!*'. With her enormous caring responsibilities, and the drain on her physically and emotionally, she let me know she was feeling isolated when we began the inquiry in April 2021, and this was only compounded by the restrictions of COVID 19.

First Interview: Joyce's Story of How the Work Began

I invited Joyce to tell me from the start, how she had come to work with CAMHS and how she came to have support work as a carer. She told me she was a grandmother in her late 50's, who had herself worked professionally with adults with learning disabilities for many years, before having to give this up to become primary carer for Freya. Freya was her 15-year-old granddaughter who was in long term Child Psychotherapy and now in her sixth year of treatment. Freya had become extremely anxious, and quite suddenly completely mute, at the age of nine, after witnessing her mother's drastic mental breakdown and eventual removal into psychiatric hospital.

It was only discovered later that Freya's mother Elizabeth had become so severely unwell because she was suffering from a rare degenerative neurological disorder, which once discovered, was understood to be terminal. She eventually required 24-hour medical treatment and personal care after leaving hospital. Joyce took on responsibility for co-ordinating her care and continued to do so throughout the time of her involvement in the inquiry.

I quickly formed the impression of Joyce as a natural storyteller; a modest woman with a huge heart, who'd suffered more than her share of turmoil and loss in life and carried an awareness of this with stoic grace and dignity. Joyce felt she was already mourning the loss of her daughter, even though she was alive, as her daughter was so altered by the severity of her condition. Joyce's narrative was flavoured with ironic humour, self-deprecation, metaphor, drama and a sense of her current mourning and impending loss as she anticipated the death of her daughter. While I listened, prompted or asked questions, I was often moved by the emotional impact of her words.

I was hitting my head off brick walls trying to get somebody to help

Joyce told me about traumatic events in the family background and those leading to Freya first being seen at CAMHS, the severity of her difficulties eventually leading to a recommendation that she begin Child Psychotherapy. She told me that Freya:

> *…could at one time vomit from it she was getting so wound up… like she was taking terrible anxiety attacks, and no matter how much I tried to help her, nothing would take them away. There was lots coming in and out of the house at that time, social workers and things.*

Joyce shared her sense of gaps and omissions in her account of this early and traumatic part of the story, and her feeling that her own mind and ability to remember how it all started had been impaired by events. She invited me to interject, as if she thought I might require more detail or a completely coherent story from her:

I probably missed out so much and there's just so much went on in my life and her life, if I'm missing things out that I should be telling you then let me know. I'm brain dead wi' it all, I really am, between when my daughter's mental health was the way it was, I've never witnessed anything like it in my life. I couldn't get help, nobody would help me. I was hitting my head off brick walls trying to get somebody to help and it took for Freya to need help for anything to move, which is sad, because If I had got the help from the beginning Freya wouldn't have been affected the way she was. However, it is what it is.

Joyce paused and took a deep breath after saying this to me, communicating the painful emotion involved in the recounting of these traumatic events. She then added, conveying a sense that this trauma was also still ongoing: *The trouble is that I can't cope with the stress of this any longer.*

I asked Joyce at the end of this interview (as per the ethical protocol which had been agreed at the start), if she would like myself or the professional she had the working relationship with to contact her for further support later that day after the interview or over the coming days. Joyce told me that while she appreciated the offer, she felt she was likely to be okay but she would not hesitate to contact myself or the worker if she needed to.

I don't know what they talk about, that's nothing to do with me

Joyce told me that she was aware from her parallel grandparental support work of some of the general focus of the work with her granddaughter, and while she noted a sense of being on the outside of this work, due to the confidentiality of her granddaughter's therapy, she expressed being easily able to accept not being party to the more intimate details of this:

So Karen (the child's psychotherapist) was going to be working on, well I don't know what they talk about, that's nothing to do with me that's between they two, and maybe she's opened up a wee bit, but there's just something, there's just something in her that, I don't know, she's so deep.

Second Interview: Further Discussion About the Work

It was just kind of an arrangement, that we had grown into

Eleven days later, when we met again, I asked Joyce what she understood at the beginning about what would be available to her in terms of support work while her granddaughter attended Child Psychotherapy and how the support work with her had begun. It was hard at first for Joyce to remember many details about this, but what she did remember was a feeling of an arrangement which had seemed to her to evolve naturally over time:

At the very beginning, Mia (providing the support work) wanted to go back to the very beginning, as far as Elizabeth telling *me she was pregnant with Freya, and how that affected the dynamics of the family, and different things like that, how it affected my daughter's mental health 'blah blah blah'. So we started back from the beginning right up probably until she started and came in being involved… I'm sorry I don't know, it all runs into one. I don't ever remember her specifically stating what the set-up was to me, because she still wanted to come to the house on a regular basis, and she always did at that. I don't ever remember it being like stated out as such, it was just kind of an arrangement, that we had kinda grown into if you like.*

The death of a relationship

Joyce's original worker left to go to a new post, and Joyce was open about the profound sense of loss she felt, and resistance after this to starting a new relationship, including her initially strong negative feelings towards that new person, which she emphasised changed as time went on.

For me personally it was like the death of a relationship because, since all of the trouble and the trauma in this family had started, I felt that Mia was the only constant, she was the only person that was always there for us. She always said the right things, she always had something to say that would make things feel better, she always gave us a goal to work towards, you know we can get over this mountain, you know, and I was very sad, very very sad. I was also very happy for her, she's got a life, it's a job, and she'd got a better job, end of. But... it was really difficult and in that space o' time I think we'd had about six, up to then, different social workers, so you were constantly having to go over the same story over and over again and it was… traumatising….So it was very difficult, so it was, and as I told you before, may God forgive me, we didn't want to like Anne (the new worker) and we decided we didnae like her before she even came through the door, and we didn't want anything at all to do with Anne and it was just because we wanted Mia.

I'm terrified her mental health is going to get to the extent that she'll be the same as her mum

When I asked whether the support work helped Joyce understand her daughter's mental health issues, or helped her make connections between this and her granddaughter's mental health, Joyce focused in her response on her terrible fear of things being passed on. She also shared that she herself was adopted, which added another level of fear for her, in case there might be some unknown genetic aspect to the neurological issues her daughter had suffered.

I would say that I have struggled for a lot of years thinking, I'm terrified Freya's going to turn out like her mum, I'm terrified her mental health is going to get to the extent that she'll be the same as her mum. They would calm me down and say well, she's a different person and Elizabeth has got a lot of problems due to the trauma she suffered in her life and also, because, her brain was damaged at birth. Although, in a logical reason I know that, but when I'm worrying about her I'm not logical, I'm just emotional. And they would be very good at reminding me, she (Freya) is not her mum, she's a different person, and just because she's having problems now doesn't mean she will have all her life, which I was so sure was gonna *happen, so they both, in different ways, have helped me with that…. I knew it wasn't the reality but, I'm not only mum, I'm a gran and I could get myself all worked up and they knew how to say the right thing to shut me up and reassure me, that emotion doesn't give you the right answer always, does that sound right? I don't know how to put it quite. And like I say Anne would come in and the two of us would be like 'waah !!' (mimics crying), but sometimes it's good to get that out and it's a good release, a helpful thing at times. I try not to cry because I sometimes feel, now, if I start crying I won't stop... I could cry when Anne was here, she'd hit the nail on the head, and got it out what was needing to come out, but then, laugh about it, and be fine after it.*

I just think I'm too old for this, I cannae deal with this, it's exhausting

Joyce expressed feeling treated equally as a kinship carer and was feeling the strain of being a parental grandparent, appreciating the parent worker being able to help her cope with adolescent issues and mediate the generation gap in some of her knowledge.

I don't think they've ever treated me any different, to be honest with you… Anne is very good… she's very very good with teenagers, with social media and that, and she'll say to me do you know they do this and do you know they do that, so she's on the ball… I don't think there's ever been a difference made about me being the gran and not the mum, and as I say, if I phone Anne, she gets back to me immediately, she just deals with it and I can't thank them enough because I don't know where I'd be without them…And I just think I'm too old for this, I cannae deal with this I'm too old, it's exhausting, I'm too old, and I know it's because I'm running up and down with Elizabeth. I've got something going on with my body so I feel I'm physically going downhill. So between worrying about her (Freya) and worrying about her (Elizabeth), there's nobody but me to run after everybody d'you know what I mean?

I am happy with everything I get, because if I need more, I would ask for more

When I asked about Joyce's sense of being able to ask for help and the responsiveness of the parent work, she expressed a sense of feeling forgotten at times, and missing more regular contact during the pandemic, although was quick to minimise the effect of this.

We very rarely see Anne now, especially with lockdown and everything. I don't know the last time I physically saw her, but I know that Anne is there at the end of the phone, if I have a really bad problem, and if she doesn't answer her phone I leave her a message and she comes back right away…She (also) did then say that in a few weeks she'll be putting a date for her and I to sit down and have a chat, but she forgets. She tells me things like that and then she forgets, I don't have a problem with that, I know she's busy. I know that there are people who need them more than me, when I really needed them, they were there and I got help, like three visits a week, so I am very happy to step back, I am happy with everything I get, because if I need more, I would ask for more, and I've had more.

Sometimes people can be good at their job, but they don't show compassion

I asked Joyce if she had anything more to say towards the end of our interviews, and she added:

I think sometimes people can be good at their job, but they don't show compassion, so I think all the people that I've encountered have all shown that greatly.

When I wondered to Joyce if this quality of compassion was an important aspect of her trusting professionals, she told me with emphasis:

Greatly, especially when it's a thing like that.

You can't even get a drink of water

I asked Joyce, finally, if she could wish for anything to be different in the work, and her answer highlighted a wish for a more welcoming and nurturing environment:

The only thing I would fault is I hate trailing up and down on the bus every week to the clinic. Well I'm sick of it, the thing is the weather could be like this (raining) and I used to have to trail down to the school to pick Freya up and then get the bus, and then get to that bus stop and by the time we got there we were soaked to the skin and miserable, do you know what I mean?… I'm just too old for it… The one thing I would wish for is that CAMHS would have a water machine or something in their waiting room, honestly because I do generally take a coffee in with me, and if I don't take coffee, I take a drink of juice because… this must be the only NHS or government run place in the world, that you can't even get a drink of water, you can't even get a drink in the toilet, it's not drinking water and even if it was you couldn't get a cup under it, but yes, after COVID's by I think they should get a water fountain, but apart from that everything is fine.

Reflections

Negotiating Meanings within the Research Relationship

The first interview had involved Joyce telling a painful story, and when I acknowledged this as we drew it to a close, Joyce confirmed it was upsetting but shared a slightly embarrassed sense of a positive emotional impact from sharing her story:

It is but do you know what, and may God forgive me, I do actually find that it can be painful talking about a lot of it and I can get really quite upset at times, but it's also therapeutic for me, does that sound daft?

Overall, Joyce was emphatic about her positive experience of the parent work, but seemed careful about moderating any negative aspects she might have experienced, minimising criticisms and balancing them with expressions of gratitude. She expressed anxiety about sharing negative perspectives, for example, putting her hand to her mouth, as if horrified by what she was about to say, when expressing difficulty in telling me honestly about her granddaughter's early negative response to her child psychotherapist. She told me she understood that this arose from Freya's anxiety and thought she probably would have discussed this with her parent worker, but could not remember any details:

I would be half way there to the clinic and she would run away, but once she got in and started a pattern of going to see her she was fine, but at first she would say that the child psychotherapist was 'weird' and 'queer' and she didn't like sitting talking to her.

When we read through and revisited this part of the transcript together at the follow up meetings, Joyce expressed, once again, some discomfort hearing me repeat this part out aloud, explaining she did not like to say anything hurtful or bad about the child psychotherapist. Here arose some complexity in the process of researcher and participant negotiating, in a spirit of co-creation, what should remain in the text. The question of the distribution of power in the research relationship had to be considered and how to maintain an ethical stance. On the one hand there was a wish to respect Joyce's desire not to be critical or offend, to allow her to be author of a narrative acceptable to her in this way, but also there was a sense of the need to encourage her to feel able to express her views honestly and authentically, allowing the more critical aspects of her experience to be heard. In the event I explained that a child having mixed feelings about the therapist was an expected and ordinary feature of the work, which would be unlikely to be understood as personal criticism or presented as such in any final research texts. I asked her to consider how she felt about the idea of us keeping it in or cutting it out of her narrative, making it clear she was in charge of the choice. After a brief pause Joyce reflected, saying : '*Well it's the truth and it's just how it was…*' and in this way let me know she had decided it could remain in the full-text narrative.

Similarly, when we reviewed the section where Joyce expressed her wishes for changes in the parent work, the need for a water fountain, she became self-conscious again about sounding, as she saw it, as if she were '*moaning*' or '*complaining*'. Her reaction was initially to tell me to remove it. I felt there was room for discussion about this, again, understanding that it was unfamiliar for her to be open about feelings of criticism, but also feeling it was a legitimate point she was making and not wishing to accept without discussion the impulse to self-censor any expression of criticism. I explained one aim of the research was to try to represent hers and other's experiences truthfully, stating my hesitations about compromising this by removing it. Joyce said it could be included but what seemed most important to her that I was aware there was some conflicting feelings for her about expressing criticisms, and acknowledged the clear sense of gratitude she felt and overall wished to emphasise.

Later, during further reflection with my psychoanalytic supervisor on the final transcript of Joyce's story, we thought about how Joyce had also expressed a note of ambivalence about having been asked by the parent worker to go back to the beginning, which we felt might be discerned from her somewhat dismissive tone and turn of phrase '*blah blah blah'*. This, at one level, off-the-cuff shorthand phrase, may have at another, less conscious level, contained veiled irritation which, at this early stage in the study, I did register but did not explore further. Joyce may have been communicating a negative feeling about Mia's wish to go over territory which was perhaps guilt-inducing or painful to remember. It was also possibly a communication of ambivalence that now ***my*** questions were also requiring her to go, rather painfully, back to the beginning, and alerted me to the need for the process of the inquiry and my questions within it, to be very gentle.

When Joyce told me about the lack of provision of drinking water, I was aware of my own indignant counter transference response, some anger about the way the institution I was a part of treated her, resonating perhaps with some split-off critical feelings Joyce was generally at pains to keep at bay. This arose towards the end, as Joyce was becoming more in touch I think with a sense of entitlement, helped by being asked the question about what she would wish for if she could change anything.

Discussion: Pervasive Themes in Joyce's Narrative

Theme 1: The Importance of the Holding Environment and Significance of the Relationship with the Parent Worker

A resounding theme throughout Joyce's account is the sense of her valuing the compassionate, emotionally engaged approach of workers, and of their support containing her anxieties and sharing their knowledge and insights. The worker who provided the parallel grandparental work in Joyce's case once the Child Psychotherapy had begun was clearly felt by her to work in a responsive, emotionally supportive way. Delivery was not always consistent, and Joyce is open at times about the difficulties, and periods of non-contact during COVID-19, but she maintains an overall positive relation to the service and the parent worker whom she emphatically trusts. The work described by her appears to have been relatively informal, but intimate and personal in its approach, delivered at the level of very down-to-earth, practical and emotional support for Joyce as a grandparental carer, with contacts planned as and when required, beginning more intensively and regularly but gradually becoming more occasional, responding to need.

In this, Joyce's account of the parent work resonates with, and further corroborates, an argument asserted by Monica Lanyado (1996), concerning the priority of creating an 'external holding environment', through direct and responsive working with the network (especially parents and carers) around a child. Lanyado argues such direct work with parents and carers is very important and should create a relational context reminiscent of the mother-infant relationship, paying close attention to and accommodating the needs of the individual. The need is emphasised, to adapt to individual circumstances and changing needs adopting, where necessary, a more 'conversational' rather than classical interpretative psychoanalytic stance (Lanyado, 1996, p. 439).

When Joyce was at her most critical about the setting and the difficulty of access and travel, describing a visceral sense of being soaked and left out in the rain, and the lack of available drinking water in the CAMHS setting, she gave voice to more deep-seated feelings of deprivation which may be evoked when the environment and setting do *not* live up to the standards required for such a holding environment. Joyce's references to feeling *too* wet (the rain) and t*oo* thirsty (nothing to drink) suggest the feeling of lack of emotional holding and containment, the clinic experienced now as a depriving, *withholding* place. Joyce's vivid description and focus on these difficulties encountered when bringing her granddaughter to her weekly sessions reinforces just how significant, both practically *and* emotionally, a warm, welcoming, clinical environment might be, in signifying an emotionally holding context, to a vulnerable, or unwell parent or an older grandparental kinship carer like Joyce.

Joyce's narrative also vividly describes a depth of relationship developed and valued with supporting professionals in this work, and she made early mention of the helpfulness of the one step at a time, goal-setting type of approach provided by her first parent worker at the start, when things had been most difficult. Her narrative also conveyed a sense of appreciating the feeling that both workers were really engaged in a spirit of teamwork with her in terms of tackling the grave difficulties and emotionality of her family situation. In this, once again, Joyce's narrative of parent work further corroborates recent research and thinking in the field. Marks (2020) has argued the case, based on extensive clinical observations, for engaging actively and with more depth in relationships with parents in this work. Marks states that 'emotionally richer' (2020, pp. 21-23) work with parents, requires the development of deep, trusting, goal-oriented and respectful relationships with parents. She states this has become a significant gap in provision which needs to be addressed, and also emphasises the importance of using ordinary practical language, despite the work drawing on considerable specialist theoretical psychoanalytic concepts to further support a teamwork approach.

Theme 2: Splitting-off Negative Feelings in Parent work

Psychoanalytic theory and research conceptualises the idea of 'splitting', a primary mechanism of defence arising from the difficulty inherent in tolerating mixed good and bad feelings towards the same person (initially the mother during infancy). There is then a general tendency, especially at times of internal anxiety, stress, or loss, for people to 'split' negative feelings off and project them into one 'good' and one 'bad' object, and this can be observed in Joyce's narrative. Joyce is self-reflective about - and discloses early in her narrative - an example of such splitting in her extremely human, deeply sad and angry reaction to loss, through her description of the difficulty of the work moving from one (cherished) worker to a new one (whom she felt predisposed not to like). Splitting has also been observed in other research contexts about parent work. O' Dwyer (2021), in her analysis of the content of 36 sessions with five sets of parents of children hospitalised with eating disorders, observed splitting to be a prevalent defence (1996, p. 112), noticing the way parents often struggled to articulate 'even ordinary complaints' against the eating disorder unit. Although they inevitably had negative feelings about it, these were more often expressed in indirect ways such as cancelling or missing sessions.

Joyce showed similar difficulties in expressing mixed feelings of praise and criticism about the parent work in her impulse to redact parts of the narrative which she felt was 'moaning'. The emphasis on co-creation and shared negotiation of meaning provided by the narrative inquiry methodology went some way towards holding onto a tension with Joyce, between what was felt and what could be voiced. It became an issue which could be thought about together so that so Joyce did not, in the end, feel the need to censor all of her 'bad' feelings in this way.

Theme 3: Grandparental Strain and Loss, Mourning and Making Use of Narrative

Lanyado (2019) has highlighted the relative under-representation of 'parental-grandparental' work in psychoanalytic thinking, given large numbers of grandparents who now have guardianship or 'kinship care' of their children's children. Joyce's narrative powerfully conveys the kinds of pressures, exhaustion and level of emotional challenge she is facing at this time of life and how she made use of the parent work to support her with this. Lanyado has also drawn attention to the prominent theme of painful loss of their own children in work with grandparents, and how supporting them with mourning this loss can also help the child with the loss of their parent. Although Joyce did not talk directly about the parent work having supported her to think about the loss of her daughter, it had been a constant anxiety for her and was a preoccupation for her throughout the study, while her daughter was gravely ill. Expressing feelings of loss seemed to emerge as a part of Joyce telling her story right from the start, and part of the value of the experience for her. When we met at our closing meeting to officially end our work together and I handed Joyce her copy of the narrative text, she told me she would keep and treasure this and intended to lock it '*somewhere safe'* to give to her granddaughter when she was old enough to read it, as she thought it would help her understand '*everything that had happened'*.

Lanyado (2019) draws attention to the high motivation and potential she observes in grandparental carers (often at a wiser, more reflective stage in their lives) to make such use of opportunities to repair, internally and externally, some of the traumas and relationship problems of the past (2019, p. 310). The value of such life stories has been supported by recent neuroscientific research, with Baylin (2017) showing how the development of the type of complex activity which narrative thinking utilises, can support recovery from trauma, helping children and their care-givers to express 'stories of their pain' and co-construct new, more hopeful stories. In other neuroscientific research Zac (2015) has been providing evidence for the idea, long cherished by proponents of narrative approaches in therapy and research, that the sharing of stories builds social trust and that narratives have a particularly powerful impact on individuals that hear them. Zac found a close correlation between release of the hormone oxytocin and an increased social connection response to narrative. The process of the development of the narrative with Joyce over the course of the study, so rich with the sharing of her emotions, had fostered a rapid sense of connection. Joyce can be seen here, to be communicating her own wise appreciation of the potential helpfulness of narrative, seizing the opportunity she saw for using her story for posterity to help her granddaughter make sense of their shared life experiences.

The mood felt hopeful as we said goodbye, although tinged with sadness, too, in the light of Joyce's many experiences of loss, and her previous comment about the 'death of a relationship' with her first parent worker, as we too marked the ending of our researcher-participant relationship.

4.2 Hazel: Mother and Carer of a Daughter with Autism

Hazel is in her late 40s, a woman with a long history of depression, who described herself at our first meeting, as both parent and carer to her youngest daughter Brooke, who has autism. Brooke was 17 at the time of the inquiry and Hazel has three other children, young adults, two of whom also have a diagnosis of autism. Hazel is married to Ronan, who she also suspects is autistic, although this has never been diagnosed. Hazel's mother-in-law, Leonie, who has had an important grandparental role supporting Hazel with the family, joined us for the two narrative interviews to support Hazel. Hazel's parent support worker was Angela.

First Interview: Hazel's Story of How the Work Began

The head teacher at that time, she gave me a really hard time, with me having the depression

Hazel told me during this first interview about the many years when her daughter was at primary school, where she endured a desperate sense of her family's difficulties being misunderstood, resulting in a prolonged and devastating period of having to cope with severe problems unaided. There was a sense of a traumatic struggle for her daughter's difficulties to be understood and Hazel had felt isolated, blamed and let down.

It really started with my daughter Brooke… we had problems right the way through, from nursery, she was just selected mute, she wouldn't speak to the teachers, we couldn't get her to speak and…. she just kind of played solitary… she struggled, she really struggled at primary. The head teacher at that time, she gave me a really hard time, with me having the *depression, she put it down to that, that that was what was wrong with Brooke, and that it… wasn't autism… Then a new head teacher came in at primary 7, and when she came in, she picked up on it right away, because she had worked with autistic children and selective mute and things like that, and she said she thought that's what it was… she was really good… So eventually we got a diagnosis then she was in primary 7 (when)… she was at the end of her primary school.*

We just felt that… you know it's just like banging your head against a brick wall

Hazel's story conveyed a visceral sense of the psychological impact of traumatic and long-standing frustration.

I had depression and things, and they think now, looking back… it's obviously impacted because I had such a hard time with them when they were young… So I was just glad that finally, in primary seven, somebody had noticed that there was something going on… we didn't have anybody (up until then), we just had to cope with it ourself and it really was a struggle… It was devastating… I thought I'd failed and that was just feeding more and more into my depression... It was a nightmare… We didn't have a lot of faith in the system, I felt very let down… eventually I just went to my MP and I just told all the story, when you start the story it just all comes spilling out… and that's when things started kind of moving from there… We just felt that… you know it's just like banging your head against a brick wall.

Second Interview: Further Discussion About the Work

Nearly two months after the first interview, when we met again, I reminded Hazel that the last time we'd talked, she had mentioned losing faith in services, by the time she came for this parent work, and so I wondered how it had felt coming to the service and starting with a new person. She described a sense of hopefulness about a new beginning.

It was a change and it was somebody different stepping in and maybe this was going to be different.

I was actually quite looking forward to getting somebody different, because we'd had… like… obviously there was some help there, but we didn't feel as if it was moving us forward any, so getting someone new I thought maybe they'll come in and they'll be different and it turned out they were because Angela has been, oh I can't fault Angela at all... So with getting somebody new, although it's kind of daunting starting with somebody new, you feel as if you're starting way back at square one again. Angela did have a sort of background with what was going on with Brooke, but erm it was also, I felt it was good, because then it was a change and it was somebody different stepping in and maybe this was going to be different.

If Brooke's mood got low, that was a fear for me

I asked Hazel if she remembered any specific fears or concerns as she started the parental support work. Her answer focused on fears around her daughter's disability being life-limiting and also affecting her own chances of development. There was a fear of her daughter suffering mentally the way Hazel herself had.

I think that was my biggest fear, if things kept goin' the way they were goin', is Brooke ever going to be able to do anything, have a life of her own and then, probably quite selfishly, thinkin' does that mean I'm never gonna have a life either now? And if Brooke's mood got low, that was a fear for me, because I've experienced, really, the depths of despair, really bad depression, and I know what it's like, and on top of her anxiety, and struggling with her autism, you just think, is she gonna retreat completely… and then would she hurt herself? You know, things like that so, that was quite, that was quite a fear.

Hazel had mentioned sometimes coming into the clinic for sessions, and I wondered if that meant the sessions followed a predictable pattern or not. I asked how the sessions were set up at the beginning and whether and how that changed over time.

The trust has been built up, so I could go along and I could maybe have a wee rant to Angela

Hazel described sessions starting more frequently but then gradually becoming less, with a sense that this felt proportionate once the trust had built up enough that Hazel could reach out when she needed to.

Angela was seeing me a lot more regularly like when we started, obviously because I was saying about these fears and my mood was getting a bit low and I felt a bit kind of defeated a lot of the time, as if I was letting Brooke down, you know. I'm a parent, I'm supposed to protect her, and she's having all these struggles, so I would see Angela quite regularly, if not weekly when Brooke was in at her session, then it would be maybe every fortnight, I think… But as things started I could see, I got more trust in Angela because when you asked her to do something it would be done for you… Angela followed through on what she said she was gonna do, every single time, so the trust has been built up, so I could go along and I could maybe have a wee rant to Angela and she would talk about things and make me feel a wee bit better… so it got kinda less and less, but then she tried to make sure it was at least every month she was seeing me, to catch up, get a wee review, see how I thought it was going wi' Brooke.

Hazel expressed being able to call for help at her most vulnerable times with a sense that this was a result of the trust which developed with her parent worker developing an understanding of her needs over time.

She's seen me when I have been quite low…. and she's seen me at my peak when I've been feeling alright, so she knows

Something that I've never done with anyone else... there was one of the times that I was in a terrible panic about stuff, I can't remember what it was that Brooke wasn't at that week, but they (someone from another service) said that if Brooke didn't keep going to services and all that… (recounted in a tone of a warning or threat) and my thing was are they gonna withdraw everything?! And I got myself into such a state about this and I picked up the phone and I phoned Angela, that's not something I'm very good at doing, and I never hesitated, I picked up the phone, phoned Angela, she calmed me right down… She talked me through it, and I felt much better, that's the first I've done that wi' any worker, because that's my anxieties coming out, but wi' Angela I feel so comfortable with her and I just picked up the phone automatic to her, so that was a big thing, erm, definitely. She's very calming, I know I can go to her… and she'll calm me, she calmed me right down that day, because she could tell how anxious I was, cause she's seen me when I have been quite low, cause she can tell when I go in, and she's seen me at my peak when I've been feeling alright, so she knows...

Hazel let me know she valued the practical input and signposting for further training and resources which was also provided.

All these things that Brooke is doing, most of it's come from Angela.

Hazel expressed a clear appreciation of the signposting and practical support provided by the parent worker.

Anything that Brooke is getting now, it's because Angela set it up, it's because of Angela, it was her that put her forward for (name of an equine therapeutic resource), she's got Brooke involved in (another equine centre)… She put in the referral for that, it was her that told me about the online course with the National Autistic Society, all these things that Brooke is doing, most of it's come from Angela.

We don't know how she's progressing… Mary liaises with Angela but I'd like to hear back from Mary herself with feedback

When I asked Hazel about any barriers or challenges in terms of her support work, she let me know about her anxiety about her daughter's attendance and the practical difficulties of travel to the clinic. She also expressed frustration about not being able to hear more directly, and regularly, about the work with her daughter.

I would say that, that every week you've got that is she going to go? Is she going to go? And she did go, so really... that's the main barrier I would say… The travel as well at first was a bit of a worry as well, because I'm from (an area 30 mins from the clinic) and I'm thinking, I'm from (there), I don't drive, how am I going to get through to…? The only thing I would say is that because of her age, nearly 18, they don't have to tell me what's happening in the sessions and I don't get to see what's happening in sessions… and, not that it's secret, but, Brooke doesn't really give me anything … so that kind of concerned *me a wee bit, because I'd like to hear how she's doing… we don't know how she's progressing… Mary (Brooke's psychotherapist) liaises with Angela but I'd like to hear back from Mary herself with feedback… but we had a review meeting, at the end of the year we had another review meeting to see how it's goin' with things, we had that bit of feedback there. It's really hard to get the balance right, not pushing Brooke too much that she retreats and does nothing… I struggle with that, I've always struggled with that… but many a time we've went in and she's been crying on the train, proper sobs, and I can see people looking and thinking look at that girl breaking her heart and they're making her come out… and she comes out and she's alright and smiling when she comes out, but without feedback coming you're struggling to know is this really helping… and that went on for a couple of months…*

It's put a lot of strain on our relationship... it was a bit of resentment there, why aren't you helping more?

I asked Hazel if having the parent support work affected her relationship with her child, or other members of the family. Her answer focused on the strain the relationship with her husband had been put under generally, on the one hand expressing feeling resentful about an imbalance in care of their daughter, but on the other feeling it was mainly her role.

It's put a lot of strain on our relationship anyway, things as they are. Ronan (Hazel's husband) was working more hours and I was asking if he could help in the mornings, because I struggle in the mornings, and he would say oh I need to get to work… and I would get quite resentful, because I was doing all the phone calls for her I go to all the appointments, because I'm her carer, I've got all that to do, plus everything else, and you can just go out to work, back in, lie in the couch and watch the telly or whatever, so it was a bit of resentment there, why aren't you helping more? It's difficult dealing with him as well, it's like dealing with the kids so a lot of the time I don't want to put extra pressure on him as well… I'm her carer, it's me that will primarily deal with it all. I'll feed back to him and he'll ask how did she get on and that, he has been at review meetings as well, but he's working full time as well, and I'm in a better place as well, so he doesn't get… and that's why Leonie (mother-in-law) comes along, because it's still my support which I still feel I do need, and it gives her a wee bit of understanding as well… The offer was there for him to do that and he has met Angela and was involved in the meeting to say how it was going to be as well.

I think it's the feelings for me… I think it's a lot of guilt that I feel, that I could've done better

I asked Hazel what stayed with her the most about the experience of the parent work. She highlighted and reflected on the feelings of self-blame and guilt she had become in touch with through it.

I think it's the feelings for me… because I was ill too, and we didn't know what it was... That sounds as if it's a disease or something, but we didn't know that Brooke was autistic, and Jack and my older daughter, so I think it's why didn't we pick up on those clues and those… signs? Cause obviously we were seeing it every day, we knew, but I mean we just thought it *was anxiety or just the way they were… and I think a lot o' it's guilt, a lot o' blame, like, why did I not pick up on that? And then, erm, with myself being ill, I could have been in a better place for them and... so I think it's a lot of guilt that I feel, that I could've done better…*

She did answer a lot of questions for me… we'd so many, like… how far do you push her?

I reflected back to Hazel that in our first meeting, she had talked about there not being any answers, about the difficulties she was having with her daughter, and whether this was something she'd hoped for from the parent work. In answering this she revisited the memory and shock of the diagnosis, and how it had been given without a sense of there being a need for follow-up advice or support. She told me she very much had hoped for this in the parent work, and that it had given her a feeling of having these questions answered.

Yeah, cause I felt as if we just got like a, a diagnosis, and then you were offered maybe a couple of, you know, go here, or… but there was just nothing after that. You're just kind of left to get on with it yourself, so obviously, when we came, when we got Angela… that really did help, she did answer a lot of questions for me and she put me in touch with lot of places to try and expand things for Brooke as well, which I felt was really lacking because we felt as if we were asking for help, but we were just hitting a brick wall and getting nowhere and we'd so many things, we didn't know, like, do you, like, push her and try to get her to go out, how far do you push her?

***I can kind o' stop and take stock and say right, what you gonna do in this situation, what's the best thing to do*?**

Hazel mentioned that she had changed the way she dealt with her children, and I asked was there anything that came to mind from her parental support that had helped in relation to that. Her answer suggested she felt had been helped to stop and reflect before acting, and had also developed more capacity to do this independently.

I'm quite er… a worrier and, er, if I would come in in a panic or whatever, she could help me break it down or think, well I've never ever thought about it that way, or she would say well I will do this for you, does that ease it a bit for you or something…I can do it a bit more, yeah definitely, I can kind o' stop and take stock and say right, what you gonna do in this situation, what's the best thing to do, what's the best way to handle this and I can do that. I can think right okay, and kind of sort it out a wee bit easier.

It was just this feeling, like, is it me, have I done something?

I asked whether Hazel had been able to talk about the feelings of failure as a parent which she had referred to, and whether she had been able to address that in the parent work. She let me know she had, and reiterated again the profound sense of guilt she'd carried, which had even at times led to suicidal feelings.

Yeah, constantly, it was, it was, very low self-esteem, a lot of that came from my childhood, because I don't have a great relationship with my family. My mum put me down a lot, and so, when someone's putting you down often enough you start to believe that and so I didn't have a great, a great self-esteem to start, and obviously with that with the kids I felt so out of control, I couldn't control anything… And it was just this feeling, like, is it me, have I done something? And I was taking my tablets when I was pregnant so I'm thinking, has that affected it, my kids, is that what's caused the autism, is that why the kids are like that? So it was just a lot of guilt on myself and, er, blaming myself for the situation, er, a few feelings of like, they'd be better off without me, erm, which I had acted on, about two or three, no longer, maybe two or three, maybe four years ago... I went away for a few days, roundabout Christmas time, and I'd just had enough. I think Ronan had come in, and said something, and it was just, I just snapped… and I just took off and I went and I stayed in a B n B or something in (name of nearby city) and I just stayed away, I just didn't want to come home, erm, and I had wine, and I had tablets and it was… it did cross my mind, erm, but eventually obviously I was found and… but Ronan and I have never spoke about it, never spoke about, it was never mentioned.

I just feel as if it was never resolved properly

I asked Hazel if she thought it would have helped her and Ronan as parents to talk about that, and she was clear that she wished they had been able to, with a suggestion that it would have helped her for them to think about how she had got to such a low point. However, she was pessimistic about her husband's capacity to engage in personal dialogue and thinking.

I think it could definitely but… Ronan is not great at… wi' his feelings, at communicating that, and he's autistic as well, although he's not had a diagnosis, it's clearly apparent, sometimes it's like he doesn't want to… come and speak to a stranger about things that are going on in the family, and he doesn't want to talk about it… But what he doesn't realise is that I think about it and I do think about it and I just feel as if it was never resolved properly, it was never… we've never spoken about it and how did that happen.

A lot of the time I just thought ah she's saying that to try and lift me... it's not that she really means that

I asked Hazel if she had been able to tell Angela about her lowest point in the parent work, and she let me know that she had, and she'd been helped to restore faith in her parenting and to keep going, although a part of her still doubted the positive affirmations given.

Yeah, yeah, I've been able to talk to Angela about that, and that was when she was kind of seeing me every week, and she would come out. She had been out to the house I think two or three times, because obviously she was kinda, what she said was you've got to be strong, as well, you've got to be in a good place to help Brooke, so if I'm not in a good place then, you know it's having an impact on them so…We did speak a lot about things like that, and I knew myself that if I was feeling upset, then Brooke picked up on that, and if I was feeling upset I tried not to show it in front of her but sometimes it's just so hard but it was, it was spoke about… and again, it was just trying to reassure me that you're doing a good job, you've done it all this time, you know the kids have come on, you know Jack is doing great now, and you know you have done it, but obviously it's still a struggle... A lot of the time I just thought ah she's saying that to try and lift me... it's not that she really means that.

It's just that wee bit of time out and then when I go back… I'm recharged and I'm like right, I'm ready to deal with this now

Hazel told me how she had been helped by Angela's encouragement to take some time away for herself and she had found she could let go for short periods of time and feel more able to manage her daughter's needs again afterwards.

I've found that getting out, I try and get up to (a local café), it's like a social thing for me, it was actually Angela who suggested that I try and do that, because Brooke is a bit older, that just for an hour or maybe a couple of hours herself, she would probably would be okay… It gives me a bit of time out and I thought well that might be a good idea, but I was bit reluctant at first, I thought oh how she's gonna be and you know worrying, but I did it and find that it's a… blessing and because there's a wee group of us, and we sit and we talk… but it's just that wee bit of time out and then when I go back to Brooke I'm recharged and I'm like right (clapping hands) I'm ready to deal with this now… You know it's like a standing joke in my house now…. If mum's not in she'll be at (name of café) kind of thing… (laughs).

I didn't feel as if she was judging me in anyway

Hazel let me know how much she felt able to talk to Angela, and not feel judged or ashamed, with a sense that this non-judgemental attitude is what she had needed, but not had, for so long a time.

She was really good, she was so easy to talk to Angela, I didn't feel embarrassed, you know no holding back, I didn't feel as if she was judging me in anyway or… you know she was… (Hazel paused and I interjected, suggesting the phrase 'on your side'?) Absolutely, absolutely, she was you know, after all these years (smiling).

In hindsight I wish maybe I had… sort of stood my ground and said, well no I want to know

I asked was there anything else Hazel would like to say, that we hadn't thought about, about the parent work. At first Hazel didn't think so, but then after a pause, made some strong reflective statements, suggesting she wished she had been more assertive and sought answers sooner.

Not really, I wish I had maybe been a bit more assertive with it in the beginning, because it wasn't Angela we had in the beginning,… but that's not in my nature. I wish I had… asked more questions and pushed things, maybe it would have moved quicker, maybe it wouldn't?... Sometimes I think if maybe I'd pushed it…., would it have maybe moved things faster? But again, that's a 'what if? question' and obviously I can't answer that, but in hindsight I wish maybe I had…., sort of stood my ground and said, well no I want to know, and I want to know what's gonna happen and what you're gonna do for Brooke… You know we just kind of let it go along and see what happened and see what they came up with.

I'm definitely more assertive now... I've found my voice!

I said it sounded as if Hazel had been through a development and found her voice more with professionals. She was very affirmative and happy about this in her response.

Absolutely, definitely... take no prisoners now! I'm definitely more assertive now... (laughs)…I've found my voice!(Laughing again).

Reflections

Ethical Issues, Counter transference and the Development of Trust in the Research Relationship

At Hazel's first meeting in the clinic to discuss the study and the process of entry into it, she had come alone, so when she brought Leonie to the first interview, I was taken by surprise and reflected on what this might mean and what, if any, the ethical implications might be, in terms of the consent process. It occurred to me that perhaps Hazel felt under pressure about coming along.

My intention was for a fully democratic and inclusive approach to this research given this too often marginalised, parental population. It was important that if Hazel wanted to take part with support then I needed to ensure Leonie also understood the purpose and process of the study if she was going to be involved. Hazel had already told Leonie all about the study and so I described the protocol and she confirmed she was happy to take part in her supporting role with Hazel. Later, I reflected that my sense of surprise and somewhat disproportionate cautious and anxious feeling, could have been an example of counter transference arising in the research relationship. Hazel had experienced, as I found out through the interviews, so many shocks, feelings of being worried about getting things wrong, being alone and out of control, and although she was keen to participate, she was also anxious about beginning. These were the sorts of feelings I was registering as I took in the unexpected news that Leonie would be joining us.

At times, Hazel was emotional, particularly during the first interview. I acknowledged this at the end of the interview and Hazel reflected that it was because she was '*going through her story'*. This was bringing a lot of old feelings and memories up and giving her a new perspective and sense of how much she had really been through.

Yeah…you hear you're saying it out aloud and you think gosh… we've been through all that you know like… I mean I can feel quite emotional just now... just goin' through it all.

I'd agreed, echoing strongly the sense of just how much she had been through, it was a lot emotionally and that this had had quite an impact. There had been preparation for this during the design of the study, due to potential for distress arising as parents and carers revisited inevitably some difficult experiences in the telling of their stories. I let Hazel know, as described in the information we had discussed during the recruitment and consent process, that I could contact her afterwards to check in and see how she was feeling, or I could arrange for my colleague (Angela) to contact her. She became emotional again at this point, but then apologised for doing so. I let her know that she did not need to apologise to me, that it was a lot she had been through and I understood it was hard telling me about it. She reiterated what was hard.

It just brings it all back… it makes it hard to… (stops and takes a breath, doesn't finish sentence).

There was additional time at the end of the interview to debrief about the process in this way, and we agreed I would text her later on and see if she wanted me to call, or arrange for her to speak further to Angela if she wanted. Hazel seemed supported by this and by the steady presence of Leonie as well, and she calmed and gathered herself up, telling me, laughing now as she did so:

Thanks very much, it's like a wee bit of therapy! (The three of us then laughed together).

Reading back through all the transcripts and my 'field notes' of feelings and reflections during the inquiry, it is striking how much the research relationship developed over the series of meetings. With Hazel, the time taken to complete the inquiry was quite protracted, spanning many months with planned meetings often having to be cancelled due to COVID or other family health issues. I revisited ongoing consent with Hazel, in case her cancellations were a way of communicating that it was too much, emotionally, and that she didn't want to complete the process. Hazel, however, consistently said she remained committed and would be apologetic about needing to cancel, thanking me for my patience and saying she really appreciated it. She let me know at one point that she was going through a low period with her depression but wanted to carry on again after this had lifted. There was always the possibility in my mind that Hazel might not in the end feel able to complete the process, but I think reiterating that this was her choice and my willingness to keep going with the series of meetings at a pace Hazel could manage, enabled her to feel she could be honest with me, which her very personal disclosures through the interviews also suggest.

Discussion: Pervasive Themes Arising from Hazel's Narrative

Theme 1: The Impact of Trauma on Parental Functioning and Capacity

Hazel's narrative is filled with details and reflections that link to some key issues highlighted by Klauber (1998), whose reflection on her clinical experiences draws attention to the severe impact of trauma and post-traumatic stress, where a child is either highly disturbed or developmentally compromised, on the parent's capacity to parent and ability to work closely with a professional worker. Klauber especially underlines the importance of the professional staying emotionally attuned, of being aware of projections and transference and counter transference dynamics, and the potential to join in with unconsciously blaming the parent for children's difficulties. Hazel's narrative resonates strongly with these issues and further corroborates Klauber's assertions by her personal account. Hazel was parent to not one, but *three* children with autism. Her story of late diagnosis, of failures to see and understand, and the extremely painful account of the way that she experienced her depression as being blamed for all their difficulties, points to the failure of professionals to explore other factors and arrive at a more balanced and complex understanding of the child and the situation. Hazel's perception of this blame chimed with her already harsh internal self-judgements, compounding low self-worth and depression in a negative vicious cycle.

Klauber draws attention to how often, historically, the effects of children's difficulties have been confused with causes in this way, arguing that parents themselves are preoccupied with causation and aetiology, and professional judgement may be clouded by unconscious professional 'bias' towards blaming mothers and finding a 'cure' (Klauber,1998, p. 87). The argument is for increased support and training for those who choose to work with parents in order that they can maintain the receptiveness necessary to support and contain highly traumatised parents.

Another theme present in Hazel's narrative concerns her experience of severe feelings of panic arising when facing a setback. Hazel's panic was described with a sense of her feeling it was disproportionately triggered, the type of post-traumatic stress reaction which Klauber also observed as very often present in work with traumatised parents of atypical or developmentally compromised children. Hazel identified it as significant then when, for the first time, she was able to reach out with a phone call to a worker. She says she had never done this before, once again attributing the blame for this with herself, saying it was something she wasn't very good at. Klauber draws attention to the feelings of fear and shame that often underlie a reluctance to reach out in this way, when seeking help from professionals is being experienced as a 'minefield' filled with the fear of judgement and criticism (Klauber, 1998, p. 89). Hazel's references to the shock of diagnosis and the lack of follow-up, and her positive response to gentle outside encouragement to be able to allow herself the space to move beyond feeling gripped by her daughter's needs at all times, are also very much consistent with observations made by Klauber.

Theme 2: Working with (or without) the Parental Couple

Several psychoanalytic writers have focused on the potential benefits, as well as barriers, to involving both members of a parental couple in the parent work delivered alongside Child Psychotherapy. Ludlam (2005) sees benefits in focusing on both the *couple* relationship, as well as the parental couple relationship, and also notes the temptation for professionals to give in to powerful unconscious defensive dynamics such as pairing, resulting in the exclusion of fathers. In a similar vein, Barrows (2004) emphasises the missed opportunity for enhanced therapeutic impact when mother-child interactions are privileged at the expense of also reflecting on the father-child relationship. Barrows argues that fathers are important primarily as part of a parental couple and it is the quality of the couple relationship which is critical in supporting parenting capacity, when from birth it is the infant's encounter with the parental couple, and ability to be able 'to envisage a relationship between two other significant adults', which is paramount for the infant's future mental health (Barrows, 2004, p. 413).

In terms of her reflections on the involvement of her husband in the work, Hazel expressed mixed feelings about this, for example, regret that she and Ronan had never spoken about the circumstances and feelings surrounding her having reached a breaking-point. There is, in her narrative, a tangible sense of her sadness at the missed opportunity for them as a couple to reflect on and heal from what had become an unspeakably painful incident in their relationship. Hazel emphasised Ronan's lack of availability due to work commitments, but also what she regarded as his fairly limited capacity to join in emotionally reflective work about their family functioning. Hazel's husband had a rather marginal role in the parent work and his peripheral care-giving role in the family seemed rather defined and limited by his contribution in terms of work and providing financially as he was described by Hazel.

In her writing about working with parental couples, Morgan (2020) places emphasis on the importance to psychic development of the 'internal couple' and how this may impact on a parent's state of mind, seeing this as crucial in helping couples to be able to occupy a third position, that is one from which they may reflect on their own relationship, their parenting and their relationship to their child. Hazel was aware of a quality of resentment which had been an ongoing source of tension impacting her relationship with her husband, and seemed to have an intuitive sense that *had* they been able to reflect on some critical points in their lives together, and to have experienced an opportunity to reflect like this together, their family lives may have been enriched. One of the particular issues which Morgan (2020) identifies as problematic for couples is where they experience their partners as not able to take in and contain each other's emotional communications, with one common response to this to withdraw and to develop what she refers to as an 'alone parent' state of mind (Morgan, 2020, p. 200), functioning as if the other parent is not available to address problems creatively as a couple. The evidence from Hazel's description during the interviews of her lowest point, during which she left her family feeling suicidal, and her focus on the fact it was never spoken about again, along with her link to resentful feelings, demonstrates that Hazel had often operated in just such an 'alone parent' state of mind, and experienced a lack of containment of her emotions by her husband.

In a contemporary context, as has been explored in detail by Davis and Eagle (2013), it is important to recognise that although psychoanalytic literature, as discussed here, emphasises the importance of working with the parental couple, and alongside this the importance of fathers, there is wide acceptance that it is the paternal function that is significant, rather than masculinity or an uncritical acceptance of traditional male/female gender roles. Many children, including the children of the parents and carers in this research study, are raised in alternative relationship configurations, or by single parents. Davis and Eagle break the concept of paternal function down into four areas, the first being assisting with separation, and from their summary of the literature in this area, conclude that it is the quality of 'alternativeness' that is generally viewed as protecting against a merging with the mother, not the individual's gender. What is needed, they argue, is an 'engaging third' in the family, and there is room for the performance of all four functions of the secondary care giver by a range of people in the mother and child's world. (Davis and Eagle, 2013, p. 569).

Novick and Novick (2013) make the argument that of those who agree with the importance of parent work, nevertheless many work predominantly with mothers, and that giving more weight to the maternal rather than paternal relationship can lead to 'rationalized explanations for tolerating father avoidance' (2013, p. 129). Hindle (1998) also observes from her work, the importance of father's involvement, as well as wider family, in helping young people develop a separate identity and internal world less enmeshed and constrained by their mother's conflicts, and recommends focusing support work on the more well parent in families affected by mental illness. In this case Leonie, as grandmother, Ronan's mother and Hazel's mother-in-law, performed a variety of supporting roles, representing this kind of wider family or more 'well parent' functioning when necessary, by coming along supportively to appointments with Hazel, including the research meetings.

Although Hazel has reasons for preferring her mother-in law to join her for appointments, and Angela did *attempt* to include father in the work, her wish that painful issues in their family life together might have been able to be confronted in the parent work, add further validity to assertions about how important it is to find ways to include fathers (and all secondary carers), to help develop their potential to support their partners and children more.

Theme 3: Increased Capacity for Parental Reflective Functioning

Woven throughout Hazel's narrative can be seen an important theme of gradually developing capacity over time for parental reflective functioning through the parent work. When she began parent work with Angela, Hazel was at a low point, having suffered years of severe depression, compounded by powerful feelings of failure and at a loss about her daughter's difficulties with mutism, separation, attending school and with toileting. Despite feeling blamed by and let down by services, her trust was not entirely shattered and she describes remaining hopeful about the work beginning with somebody new.

As Hazel's narrative unfolds, what is described then is a sense of stages and progression in the work, with frequent support focused at first mostly on her own intense feelings of anxiety, then a sense she could come for sessions a little less frequently, as time and trust built up, yet still sufficient experience of containment of her frustrations and worries, seen in her reference to '*a wee rant'*. There can then be seen in her descriptions a subtle but significant shift, with an increasing focus on her daughter's state of mind, and their relationship, with more shared thinking about this beginning to be elicited in the parent work, with meetings '*to catch up, get a wee review, see how I thought it was going wi' Brooke.'*

Hazel's narrative goes on to reveal an increased capacity for reflectiveness and self-awareness, as she describes grappling with the complexities of promoting her daughter's development when her internal world can be hard to fathom, as shown in the statement '*It's really hard to get the balance right, not pushing Brooke too much that she retreats and does nothing… I struggle with that'*. Hazel then comments that what stays with her from the parent work is feelings of guilt, and this also suggests a discernible shift and progression, from earlier debilitating feelings of harsh self-blame/blaming of others, to a qualitatively more thoughtful and regretful sense of responsibility, shown in the statement '*I think it's a lot of guilt that I feel, that I could've done better.'*

While still finding it hard to come to terms with the past, Hazel's tone here was calm and what she conveys is now a more constructive sense of guilt, the regretful thoughts and feelings experienced when perspective is enlarged and with hindsight, what might have been or could have been done better can be thought about. Hazel describes the way she had been able to process feelings of guilt and failure through talking with Angela, and spontaneously shares reflexive links she has made with her own childhood experience of her parents *'My mum put me down a lot, and so, when someone's putting you down often enough you start to believe that'*. Hazel's narrative reveals this enlarged capacity for a reflective stance and also a greatly increased sense of self-efficacy, she feels she is more capable now when addressing stressful situations, of thinking about them herself, tackling them more effectively, emotionally and cognitively: *'I can do it a bit more, yeah definitely, I can kind o' stop and take stock….I can think right okay, and kind of sort it out a wee bit easier.'*

Developed originally as a theoretical concept, arising from psychoanalytically oriented attachment research (Fonagy *et al.*, 1995), reflective functioning has been understood as an overt manifestation, in narrative, of an individual's mentalizing ability, and refers to a care-giver's capacity to reflect on the current mental state of their child and own mental states, and link these to thoughts and feelings about their relationship with their child (Slade, 2011, p. 215). Slade's research on Parental Reflective Capacity, (Slade, 2007), is illuminating in terms of considering the significance of the shifts and progressions seen in Hazel's narrative over time and the sense in which this has been supported through the parent work. Slade measured reflective processes within the context of the parent-child relationship, and found that highly reflective parents grasped the interplay between their own mental state and that of their child, between their own internal experience and behaviour, and between their child's internal experience and behaviour, and concluded that this is central to the parent's capacity to guide their behaviour and respond sensitively (Slade, 2007, p. 279). Slade (2011) also suggests how, within the framework of what she regards as often 'messy' parent work, that is, working in often quite ill-defined treatment situations, filled with counter-transferential challenges for the therapist, there are key opportunities with parents to engage their capacity for reflective functioning and draw out their capacities.

In the light of these ideas, Hazel's narrative can be seen as a vivid, and integrated example-in-action, of the way parent work, adapted to differing needs and capacities over time, with high levels of trust and empathic connection, and engagement with her personal feelings and history, supported significant change in reflective capacity over time.

4.3 Clare: Mother of a Young Child with Autism

Clare is a single parent in her early 40s, with a diagnosis of complex post-traumatic stress disorder (C-PTSD), for which she has had long-standing involvement with an adult psychologist. Her C-PTSD arose after a series of traumatic events, which Clare suffered between her mid-teens and her 30s, including a violent assault. Clare has a grown-up daughter who lives at home and a young son, John, with a diagnosis of autism. Aged six at the time of the interviews, he had been attending weekly Child Psychotherapy for approximately one year.

First Interview: Clare's Story of How the Work Began

Clare told me John developed concerning behaviours and became aggressive towards her, a few months before her father had died of cancer. John had been very close to and adored by his papa and was four years old when his papa was given six months to live. There was a stark deterioration and decline, and Clare described a previously really 'big man' becoming skeletally thin and weak.

My brain just started shifting because he was so into this Billy…

During this distressing period for them both, Clare had been helping John to get changed one day, when quite suddenly he became terrified, insisting that he could see 'a man' appear in the house. Afterwards his initial fear subsided and Clare began to overhear John regularly talking to this 'man' as if he were an imaginary friend.

…he used to get really angry at me wanting to know anything about it, and then he used to sort of, as he went on, say 'Billy (the name he gave him) doesn't like you! Billy wants you to get out this house and never come back!' 'Billy's gonna stab you so that you die,' and I was like oh my god… It was really sort of like horrible things that John was saying 'he's gonna chop your head off so that you never come back here and it's just us!'… and then my fear started changing and I thought, what if something happens that this Billy tells John to do something? I don't know my brain just started shifting because he was so into this Billy…

I was like, at the end of my tether… I kept phoning and phoning, they must have hated me!

Clare felt very anxious and called the autism resource centre locally, to see if they could help, and they directed her to an optometrist, suggesting it might be a visual issue which was affecting John. Although the optometrist was registered with the NHS, Clare said he seemed a bit 'cookie' and described his methods as unorthodox. Before prescribing colour tinted glasses for John (a broadly accepted intervention for visual stress), he had undertaken a 'visual aura reading' and told Clare she needed to organise some kind of exorcism of the home to get John's imagined 'man', who the optometrist said was a 'spirit', out of the house. He also suggested to Clare that this spirit had taken a 'grip' of her son in some way. After being on a CAMHS waiting list for some time, Clare and her son were finally seen and eventually, signposted to the specialist service.

…and I was like a bit on the fence here, I didn't know what to make of it, but I thought no, I need to get CAMHS involved... and then John just stopped eating as well, just like that, overnight… wouldn't eat a thing, would only drink milk… I kept taking him to the doctors and they were like oh he'll start again,… At this point it was 4 and a half weeks and I went back and said my son has not put one bit of food in his mouth… and I was like… at the end of my tether… so I phoned (the hospital). I had the number. I phoned it and I just blurted it all out, I was crying, snotters the lot, (laughs) and I said my son's not been eating and nobody is listening to me... and... we brought him up and they said we need to start him on some, some milk that's got all the nutrients in it… she said that we'll get him to a dietician and at that point I said, I'd been on the phone for CAMHS because I'd already told them about him seeing this 'Billy' and that, and she says well that's good because we need to get to the root of why he's no eating… So, we went to CAMHS, eventually we got there, I kept phoning and phoning, they must have hated me!… I was constantly on the phone. So eventually it was our time to go

and we got the sort of twelve standard appointments to kind of assess him... and at the end of it the lady said, he needs further assessment and further, sort o' work, she wasn't happy or comfortable just leaving it and sort of saying 'bye!'... and she knew that I had a lot of anxiety as well, so that's how she thought like the (name of our specialist service) was like the best sort o' next step for us and that's how we came.

Clare told me that, once referred to the specialist service, John was assessed straight away for Child Psychotherapy, which then began weekly.

I don't remember who told me or how it came to be that that was happening, I don't really remember… that was a horrific time

I asked Clare if she could tell me about the setting up of the parent work. Her answer conveyed some confusion in her memory of this anxious time, and a mixture of feelings, happiness about it but also a sense of passive compliance with being *told* what was going to happen.

I don't really remember. I just remember I was told I was going in to see Harry (therapist providing parent work) and John was going into see Stewart (child psychotherapist), which I was kind of quite happy about, cause it feels like you're getting your say in it, sort of thing, rather than sitting in a waiting room while he's in. You're getting to get your load off about what's going on with John n' stuff you know, but I don't remember who told me or how it came to be that that was happening, I don't really remember… but it's the fear, is John going to be susceptible to imaginary friends, like seeing things, you know because that was horrific, a horrific time you know... anxiety is a huge part of my mental health so that just adds on to it.

Second Interview: Further Discussion about the Work

Two weeks later, when we met for the second interview, I asked Clare if she'd remembered any particular thoughts and feelings about starting the work.

I was like why am I goin' in here, is it, is this about me, is it for me, like, is this aimed for me to open up about me personally?

Clare let me know she'd felt apprehensive about starting with a new professional, with a sense of not knowing what it was going to be about, and this leading to some anxiety.

A bit nervous to be honest. I didn't know what to expect and things so, a bit apprehensive I suppose, about what it entailed really. Erm… I was like why am I goin' in here, is it, is this about me? Is it for me, like, is this aimed for me to open up about me personally, or is it about opening up about John? So, I was sort of like why am I here? I was like I don't know you yet…. I was a bit sort of, paranoid about that, because it was… having to get to know a different person... I *wasnae sure if it was going to be me I was talking about with him, or if it was John I was talking about, so that was just a bit sort of, nerve wracking you know.*

It's really good, you know, that's what I like, that like there's a balance of both, you know

I asked if it had become clearer over time about whether it was more about Clare or her son. Her answer conveyed a sense of feeling that the work was quite balanced, with a focus on both parent and child. Clare emphasised that a positive, indirect benefit, was that during time with her own psychologist from adult mental health services, she was now able to focus on her individual personal issues.

It's a bit of a mixture, we talk about both of us, which I actually quite like, we talk about both of us, which is actually quite good because I find that… when I come to CAMHS, I can kinda offload all the John things here, so when I go to my own psychologist, I don't have… I don't waste the time. Not waste it, I don't mean that… but I'm not talking about John, I'm not talking at my psychologist about John, I'm getting to offload all my John issues here, which is really, really good.… I'm now able to do that here, but I'm also, sometimes, talking about my own issues as well, so we do talk about both. It's really good, you know, that's what I like, that like there's a balance of both, you know.

There followed at this point during the interview a period where Clare's responses became quite stilted, with a more shutdown quality. What had previously been flowing with a back-and-forth conversational quality seemed to dry up and felt hard to retrieve. I discuss in the Reflections section the area of questioning this arose from and some possible explanations for what may have been happening. For the sake of clarity at this stage, however, I return to the themes which emerged in this second interview after the easier flow of narrative exchange resumed.

We'll maybe try this and we'll maybe try that

I asked Clare if the work had affected her relationship with her son in any way and she shared a sense of positive changes and a sense that she and the parent worker approached thinking about issues together as a team, trying new approaches.

…cause he'll tell me things, like we'll maybe try this and we'll maybe try that, you know, wee things, and maybe I'll say maybe I'll try that you know... Sometimes the things'll work, sometimes they'll no, you know... He'll offer me wee bits of advice n things so…

The journey can be a bit of a nightmare

When I asked Clare if she had experienced any barriers to attending, at first she said she didn't think so but then expanded about some difficulties accessing the clinic.

No, I don't think so… well the journey can be a bit of a nightmare, the taxis can be difficult, there aren't many available at (the time which suits best for getting back to school) as they are busy with the school runs but there's nothing I can do about that.

Is it like a sorta, I don't know, are they kinda watching me, to like see if my mental state's okay really? I don't know like…

I asked Clare if she could tell me what stayed with her about the experience of the parent work with Harry, what it felt like coming. After a pause, she focused on the positive feeling of getting things off her mind, but then returned again to the troubling question for her about the role and function of the parent worker.

It's good, you kind of feel lighter after, like you've offloaded everythin, a bit, you know, like you're getting, kinda, everything that's built up during the week, you're getting to kind of offload a lot of it. That's how I feel anyway, no matter what it is, whether it's some of my issues as well, and some of John's issues… and I like the fact that he (Stewart) can then feed some of it back to Harry. Erm, I would like to know, like, I don't really understand what Harry is doing, like is he my psychologist or is he John's psychologist? I don't really know, like why is he seeing me, like is he there as my psychologist, is he there as a second psychologist for John? Cause I thought that was like Stewart's role, is it like a sorta, I don't know, are they kinda watching me, to like see if my mental state's okay really? I don't know like...

I asked Clare more about this feeling, that she might be being checked up on, and acknowledged the sense that it might not feel very nice to feel like that. She shared more concerns and a feeling of being excluded, left in the dark about her son's treatment, stating her wish for more regular and joined up communications with the child's therapist.

I don't know what the aim is, and because the review meetings are so far apart, I feel a bit lost with it

A bit like, because I don't know, I don't worry about it all the time, just sometimes, I think… like cause the first time he was at CAMHS, ages ago, it wasnae like that, so why this time am I… why's it like this, this time? I like it but I don't know what the purpose of it is. I don't know what the aim is, and because the review meetings are so far apart, I feel a bit lost with it, like I'm coming in every week and kind of spilling my guts and opening up about a lot of things, personal for me. And John is going in to Stewart, like I'm letting John go away in, like there's kind of like no talking allowed, it's literally kinda like 'bye'… And then when he comes out it's like 'bye', I cannae say to Stewart, 'how did it go'? And then we're leaving and weeks go by and I don't know how John's going on. I don't know how John is going on in there, for weeks *and weeks and weeks and I'm like I'm going in there and I don't know why I'm talking, and John is going in and I don't know what he's doing or how he is, for weeks, and it can get quite 'what's happening?!' It doesn't bother me from week to week, it's just when I step back, I think, am I kind of being watched, am I being sussed out here, are they trying to suss out my mental health state here, or something, like I don't know…*

I don't ever get a review meeting of why I'm in here, so why the hell am I in here?!

I wondered to Clare that it could lead to her feeling quite vulnerable or stop her from opening up. Her answer suggested a mixed experience, partly trusting and partly not trusting that it was a safe space to talk and, once again, really not feeling clear about the purpose of the parent work.

Sometimes you feel like you need to watch what you're saying a wee bit, and I don't like that, but I know I'm fine. At the same time, I'm absolutely fine and I know I don't need to watch what I say, but sometimes it's in your head, like, a wee bit, why am I here, just in the back of my head, it's a bit weird, but I always just talk away because once I start… (laughs), I've always got some sort of thing going on with John... It's a very long time, it's months and months in between (review meetings) it's such a long time, so it just feels like me in one room, John in another, and months and months in between when I don't know what's going on, why am I here and what's going on in there. And at the review meeting I find out what's going on with John but I don't ever get a review meeting of why I'm in here, so why the hell am I in here?! (laughs). No one ever tells me why I'm in here, is it just to get a general feel of what's goin' on with John, if it is, can someone just tell me that?

Clare laughed as she said this but it felt like a serious and significant point she was making. I checked with Clare whether she would like more clarity.

Yeah I think so, I'm not shy to say, and yeah I think I will (ask) because it's kind of annoying me, like niggling away at the back of my head and I've been coming here like 15 months so... it's when you think about it, I would probably like to know why I am here but week to week I go in and it's fine, it's just when I think about it it's like, no, I'd probably like to know why I am here.

Reflections

Mis-Attunement in the Research Relationship and Interviewing Process

I return here to the discussion of the period during the second interview when dialogue was not developing well. This began when I asked Clare, fairly early on, a question about her own state of mind and her anxiety influencing her son's state of mind. I was interested in whether she thought the parent work had provided a space for thinking about this. My asking about this had the effect of shutting Clare down. She had already mentioned unsettling feelings about her own mental state being investigated during parent work and, on reflection, it seems obvious to me that further probing of this topic triggered anxiety, touching on a difficult to think about area.

I present below the sequence of question and response in full and some of the exchange which followed, as I think there is evidence of a small, albeit temporary, breakdown in our shared communication, an example of how mis-attunement and failure to arrive at a sense of reliable shared meanings emerged in the research dialogue.

Me: *So, this relates to what we were talking about before, you mentioned having high levels of anxiety yourself. Have you been able to talk about that in your sessions, the impact on you, as a mum, as parent of John, the impact of that anxiety?*

Clare: Pause… No response.

Me: (trying again/reframing the question): *So, I'm wondering did you talk about your state of mind and how that affects things with John?*

Clare: *Oh definitely, definitely. I'm able to express how I'm feeling and things like that, definitely. How I'm feeling has never really, it's never affected, John in any way so… Like how I'm feeling a bit impacts John but I'm able to go in and say, 'oh my god I'm really stressed the now, I'm really stressed about the school situation'. So, I'll go in and talk about that, so we'll sit and have a long conversation about that and I'll say, 'I'm really stressed about the school' and I'll talk to him about that and things, you know, like, erm, my psychologist. I've got a lot going on with my psychologist the now, he's leaving, I'm quite stressed about that but I've spoken to Harry about that, like, saying for me, like the impact that would have on me, and it's… it's quite good, it's like having a wee second psychologist, it's great (laughs).*

Examining this part of the transcript it can be seen that Clare is feeling pressure to answer affirmatively ('oh definitely, definitely,' she repeats), while at the same time the actual content of what she goes on to say suggests a contradictory meaning, reflecting what can be seen as her own conflicted feelings about this. Clare on the one hand (emphatically) refutes the link my question implies between her state of mind and her son's, but then she goes on to say maybe 'a bit'. Finally, her narrative changes back to, I think, a more comfortable and less conflicted area of thinking, the subject of relief from stress in sessions and the positive feelings derived from this.

After this exchange things felt stilted for a little while longer:

Me: *Can you think of a particular session, or anything you could think of that stood out in your mind as something you and John had thought about together, a particular thing?*

Clare: *A good thing or…?*

Me: *It could be a good thing or a frustrating thing or a particularly difficult thing, or anything that comes to mind.*

Clare: *Like about John?*

Me: *Yes, or about parenting in general.*

Clare: *I don't know what you mean. What do you mean?*

Me: *Is there anything that you've thought about with Harry that you've perhaps thought, 'Oh that's a helpful way of thinking, that's a bit different, or I hadn't thought about that before'?*

Clare: *Nothing that really comes to mind, no...*

Me: *That's okay*

Finally, I gave up and changed the direction of conversation, returning to my open questioning style and a change of subject. It can be seen above how my questioning lost its open narrative style as I struggled to repair the communication and restore the flow but instead adopted a less open, more insistent and focused questioning style temporarily. This was not my intention, or even consistent with my methodology and led to rather a dead end, as the dialogue above demonstrates. There was a feeling of our emotional connection being temporarily lost, and at the end of this I noticed in my counter transference, an interrogative feeling in Clare's tone as she challenged the focus of my question and asked '*I don't know what you mean. What do you mean?*

Clare was (understandably!) becoming a little irritated with the interview process I think here, finding me confusing, possibly even *wilfully* misunderstanding. My registering of this irritation finally prompted me to change the subject and move on from this line of inquiry, which had perhaps demanded a level of reflection not accessible to Clare at this time, and made her feel under pressure.

Discussion: Pervasive Themes Arising from Clare's Narrative

Theme1: Ethical Issues Surrounding Aims and Consent in Parent Work

During the follow up meeting when I met with her to review the content of her interview transcripts, Clare had made a further important summative statement to me about her experience of parent work, saying:

I don't care what it is... I'd just like to know what it is I'm supposed to be doing!

This statement of willingness to engage, while wanting to know more clearly what she is engaging in, goes to the heart of some broader complex issues around aims and consent in parental work. In a discussion of ethical dilemmas to do with ongoing consent in clinical work with parents and child patients, Daws (1986) cites the example of a challenging question once posed to her by a parent after a session where the child had reported falling asleep for a few minutes: 'Are you hypnotising my child?'. From this extreme example, Daws exposes what she calls a useful 'universal element' (Daws, 1986, p. 104), that all parents are bound to have queries and issues about what we are doing with their children, when Child Psychotherapy requires a degree of privacy that can sometimes be at odds with the parent's felt need to know. Daws pays attention to the vulnerability of the parent who asked the question and suggests that what the parent really wanted to know, in relation to the child's treatment, is if the therapist is qualified to do what they are doing and also whether they are taking advantage of the child's vulnerability. Clare's statement above strongly suggests this wanting to know and beginning to feel she is entitled to know, something similar in relation to her parent work.

> 'The difficulty for the therapist is in remaining able to hold on to what the patient has consented to, that is, to work on the pain of his conflicts within the boundaries of this consensus.' (Daws 1986 p. 110).

Psychoanalytic writers and researchers (see for example, Rustin 2018, Marks 2020, O' Dwyer 2021) have frequently confronted and considered this issue, succinctly framed in the above quote by Daws. There is an understanding and consensus that aims in parent work vary and the work may be pitched at different levels (Rustin, 2018, Holmes, 2018), according to the individual needs and capacity to access different levels of work, which can fluctuate. Sometimes therapists work on painful aspects of the parent's childhood and past with considerable sensitivity, and their skill and careful judgement is required to decide on the limits of this (Whitefield and Midgely, 2015). Complexity, ambivalence, confusion and conflict can easily arise, and this can be seen both in Clare's consent to participation in the research *and* in her experience of the parent work. A person may commit, at the conscious level to participation, but an unanticipated subject or unconscious area of conflict arises, anxieties can be raised, followed by resistance and even shutting down of an area of thinking or discussion. Ultimately, Clare was quite angry, when she thought about it, about how little she understood about what she was doing in the parent work.

Theme 2: Epistemic Trust, Mistrust and the Capacity for Mentalization

Throughout Clare's narrative there can be seen a theme about fluctuating levels of trust and mistrust in professionals, an uncertainty about who to trust and to what extent, as well as a varying capacity to think about the emotional meaning of her own and her child's thoughts and feelings, that is a capacity to mentalize.

Fonagy and Allison (2014) have linked two key concepts, epistemic trust and mentalization, arguing that the 'mentalizing therapist' is the universal feature of effective psychotherapy. Mentalizing in therapy, the process of observing and then making explicit emotional and cognitive connections, modelling thinking about feelings and feeling about thoughts, is seen as an effective way of establishing epistemic trust, an individual's willingness to consider new knowledge from another person as trustworthy, generalisable, and relevant to the self. The idea is put forward that by feeling thought about in therapy the patient feels safe enough to think about themselves in relation to the world, and to learn something new about that world and social relationships within it. This epistemic trust is conceptualised as generated in infancy, where there are securely attached relationships, by cues coming from the mother or other care giver, through behaviours associated with maternal sensitivity, naming feelings and experiences for the infant out loud. It is contrasted with its counterpart epistemic vigilance, a self-protective suspicion towards information coming from others and, in more extreme cases - seen in those with anxious or disorganised attachment histories - as 'epistemic hyper-vigilance', which can manifest as cognitive rigidity, intolerance of ambiguity and a tendency to feel overwhelmed in the face of new learning.

These concepts are illuminating of some key themes and develop around the theme of trust and mistrust arising in Clare's narrative. When her son first saw his imaginary friend 'Billy', there was a sense that Clare could not easily, by herself, think about possible meanings of what was happening for John in terms of his emotional and internal world, that she was unable to mentalize and instead read the behaviour in a very concrete manner, almost as if the imaginary man was real. Clare was frightened already and finding it hard to think, and in her initial search for help, professionals seemed to further reinforce concrete thinking and explanations, as well as quite bizarre ones, suggesting visual stress causing a kind of hallucination or possession by an evil spirit. A more psychologically informed and mentalizing response might have been to try and explore with Clare the emotional context for John of what was occurring and what could be understood as an understandable reaction, albeit quite an extreme one, to the impending traumatic loss of his grandfather. It was disturbing for Clare losing her father and watching him diminish before her, as she described vividly to me, and of course very difficult for her young son. It would have been very challenging for Clare on her own, given her severe trauma history (she had actually been violently attacked in the past in her own home), to provide the sort of containment for John's fears which he needed at this time. Clare was unable to think about the meaning of the emotional outbursts and behaviour, the terrifying figure of Billy seemed to overwhelm her and trigger gripping anxiety, feelings of horror even, and made her vulnerable to relying at first on untrustworthy sources. However, Clare requested help from CAMHS thinking this would be positive for John, and ultimately did trust and act on a feeling that the optometrist was '*cookie*', partly we might speculate, because she already had, as her narrative tells, a positive experience and trusting relationship with her psychologist in adult mental health services.

Clare communicates something of a predisposition to mistrust at the beginning of her narrative, in her assumption about the strong negative feelings she believes professionals would have had (*'they must have hated me!')* as she kept calling, trying to communicate the urgency of her son's need for treatment. Clare then describes a positive experience of John's first assessment and a trust in the recommendation for further referral to the specialist service, a service she understood was for children affected by parental mental health difficulties: 'S*he knew that I had a lot of anxiety as well, so that's how she thought like the (name of specialist service) was like the best sort o' next step for us and that's how we came.'*

In her description then of the parent work, with someone she was apprehensive about at first, there can be seen the way that a sense of working together contributed to a building of epistemic trust, in the spirit of collaborative learning expressed, with Clare willing to try new things: '*he'll tell me things, like we'll maybe try this and we'll maybe try that, you know,... and maybe I'll say maybe I'll try that... Sometimes the things'll work, sometimes they'll no, you know... He'll offer me wee bits of advice n things so…'*.

As Clare became more comfortable with me and perhaps it can be argued something of a researcher/participant relationship of epistemic trust had built up (involving some mis-attunement and repair), Clare reflects openly in the narrative, noticing how she can feel trusting in the parent work process week to week, but at the same time, experience more ambivalent and mistrustful feelings: '*It doesn't bother me from week to week, it's just when I step back, I think, am I kind of being watched, am I being sussed out here, are they trying to suss out my mental health state here, or something, like I don't know'*.

Clare goes on to become increasingly in touch with and open about the conflicting feelings of trust and mistrust, which it transpires are quite a dominant and anxiety provoking feature of her experience of the work: *'Sometimes you feel like you need to watch what you're saying a wee bit, and I don't like that, but I know I'm fine. At the same time, I'm absolutely fine and I know I don't need to watch what I say, but sometimes it's in your head, like, a wee bit, why am I here, just in the back of my head, it's a bit weird, but I always just talk away because once I start…'*.

Clare finally does arrive at the crux of her issue about the work being that she doesn't feel it is clear enough what the parent work is about, but it can be seen that it takes quite a while for her to get in touch with trusting this feeling and recognising she feels quite angry about it.

The concepts of mentalizing and epistemic trust have inspired some innovative practice in psychotherapy and psychotherapy research in work with parents, including with parents predisposed to a very high degree of epistemic mistrust due to being referred by the courts for compulsory parent work due to their harmful and abusive parenting (Byrne, 2020). Midgley *et al.* (2017) describe specific aims and goals as being an important aspect of their mentalization based treatment approach, these aims defined in summary as follows: To help them gain or regain the capacity to see past behaviours to the child's experience and mind; to become more aware of their own feelings and behaviour, especially at times of stress and conflict; and to encourage parent-child interactions which help the child feel understood and support basic self-knowledge and self-regulation (Midgley *et al.,* 2017, p. 164).

Given her increasing vocalising through the study of quite indignant feelings about not understanding what the process was supposed to be about, '*why the hell am I in here?*, and her difficulty with the sense of ambiguity, it seems that Clare would have appreciated and might have benefited from such transparency of goals. In addition, noticing moments of misunderstanding and talking about them, seen as key in a more mentalizing approach to parental work, might have helped to contain the worst of her feelings of mistrust. Clare could be helped by an explicit conversation about why the work might be sometimes about her and sometimes about her son, in order to allay her worst fears that this would lead to judgement and condemnation of her, as a mother with mental health difficulties.

4.4 Significant Themes and Findings

Analysis and discussion has concentrated thus far on the uniqueness of each participant's story and the major themes identified therein, maintaining the close link between the 'data', the individual and their particular experience, the teller and their narrative re-telling, evidencing how each theme was identified. Eight findings with a high degree of significance to contemporary theory and practice in parent work are now outlined, discussing how these relate to the existing literature, the new insights gained and implications for practice and further research.

1. Severe trauma and its impact

All three participants conveyed a powerful, visceral sense of mental impact and trauma as they told their story of how they came to the parent work and service in the first place. Their frustration and stress prior to receiving significant support through the parent work with the specialist service and the felt urgency of support for their child was severe, with two of the participants utilising the same metaphor to convey it, with Joyce *'Hitting my head off brick walls trying to get somebody to help'* and Hazel *'We... felt it's just like banging your head against a brick wall'*. Clare felt she was '*At the end of my tether*'.

The impact of trauma reported by the parents and grandparents in this study vividly corroborates the arguments presented by Klauber (2018), that trauma renders parents highly vulnerable, liable to difficulties in their ability to cope with and process everything that is happening at their point of entry into children's mental health services.

All three participants articulated uncertainty about their memory of the original setting up of the parent work and their prior understanding of the aims and parameters of it, being vague in their memories about it, with Joyce feeling '*It was just kind of an arrangement we had grown into if you like* ', Hazel's descriptions of the work starting *'quite regularly, if not weekly when Brooke was in at her session, then it would be maybe every fortnight, I think'* and Clare's *'I don't remember who told me or how it came to be that (the parent work) was happening'.*

What is striking about this vagueness about the contextual framing of the parent work, is the gap between the reality of the lived experience of such highly vulnerable parents, and the preoccupation of the profession, clear from the literature review, with aims in parent work in child psychotherapy. The literature has focused, in a substantial body of writing, on the complexity and variability of this task, fluctuating levels of work and various nuances of technique and interpretation. Particularly significant contributions have been made over time by Daws (1986), Lanyado (1996), Klauber (1998), Sutton and Hughes (2007), Whitefield and Midgely (2015), Holmes (2018), Rustin (2018), and Marks (2020) in this regard. Many of these writers particularly emphasise the importance of clarifying the parameters of the work with parents, doing so early on, as well as the need to review this as the work develops. However, the experiences of the sample of parents in the current study suggest there remains a substantial gulf between theory and practice.

Given the severity of the trauma and its impact on functioning evidenced in these participants' narratives, this study draws attention to the need to mind such gaps; for services to critically review current practices and ensure that efforts are made for transparent negotiation of aims, with frequent and regular reviewing of these, never taking it for granted that the function and therapeutic value of parent/carer work is clear to those receiving it.

2. A sense of exclusion

All three participants registered a response to the parent work with them being separate from the work with the child, conveying to varying degrees, a sense of lack of feedback and integration, varying from Joyce's '*That's nothing to do with me that's between they two'* and Hazel's, '*Without feedback coming you're struggling to know is this really helping'* and Clare's stronger sense of feeling quite lost and disorientated, '*John is going in and I don't know what he's doing or how he is, for weeks, and it can get quite 'what's happening?!''.*

There is generally a consensus in the literature about the importance of the need for clear boundaries between the parent work and the child psychotherapy work with the child, valued as helping facilitate and model a healthy process of separation, addressing issues of enmeshment which are frequently problematic in parent-child relationships. There may be an assumption that essential issues of overlap or integration of thinking are sufficiently addressed while bringing together the parent worker and child's worker together in the review meetings, which are the traditional practice in Child Psychotherapy, with children seen prior to adolescence. However, two participants in this study were carers of adolescents where such meetings are not routinely held, and communicated in their narratives a sense of disconnection, and one a stronger feeling of being left out, somewhat in the dark about their child's progress, while their adolescent child was seen more regularly. There was clear dissatisfaction associated with too long periods between meetings to review progress, communicated by the third parent in the study who had a younger child.

Many writers included in the literature review , such as Novick and Novick (2013), Gvion and Bar (2014), Goodman (2017), Braithwaite and Edgcumbe (1967), Nilsson (2019), and Christogiorgos and Giannakopoulis (2015), while acknowledging the difficulties and complex web of transference and counter-transference feelings which may arise when working with a model of same therapist for parent and child, suggest positive benefits to this method of working, especially around integrating insights gained in the work with parents and children and being able to identify and work with feelings of exclusion when they arise. A pragmatic reconsidering of the benefits of alternative ways of practising, addressing issues of exclusion, such as same therapist for parent and child, could be considered helpful at times in NHS settings, not only private ones. The provision of adequate time for the professional delivering parent work to join up with the child's therapist to share observations and reflections can be extremely restricted in practice, and this may exacerbate the parental experience of being left out in the cold, not knowing what is happening. This is an issue which these parental and grandparental stories of parent work once again echo and amplify, suggesting it should be taken more seriously, especially with parents suffering mental stress who may be especially liable to intense persecutory feelings of exclusion.

Daws (1996), draws attention to ways parents remind the professional, 'I am the parent and I have a right to ask questions and be answered' and the sample of parents in this study certainly echo this feeling of a wish to know more, conveying precisely this sentiment. Once again, the narratives of the sample of parents in this study, corroborate through direct experience, the idea of the need for the profession to look critically at practice, taking steps to ensure parents are consulted regularly and proactively, engaging with and anticipating feelings of exclusion, and their sense of entitlement, in an active way.

3. Impact of loss and the importance of continuity

All participants registered different degrees of anxiety about changes of worker, ranging from Joyce's sense it was like the '*Death of a relationship*', to a sense of trepidation for Hazel *'You feel as if you're starting way back at square one again',* and for Clare really quite considerable anxiety about opening up with a new person '*I was a bit sort of paranoid about that, because it was... having to get to know a different person'.*

The depth and quality of the relationship with the parent worker was appreciated as time went on, with '*Compassion*' identified as the most important quality of this by Joyce, and for Hazel the experience of not feeling judged, apparently for the first time '*I didn't feel as if she was judging me in any way'*.

As highlighted in articles by Daws (1996), Trowell (2003) and Novick and Novick (2013), loss of the relationship with the parent worker are significant issues in parent work, often echoing the losses, feelings of isolation and loneliness already experienced in parents' own lives. The parents and carers in this study further corroborate through their narratives, the degree of impact experienced due to loss and changes of worker. This is an issue which many professionals in contemporary CAMHS settings would recognise as of particular concern currently, given the very high turnover and loss of high numbers of NHS staff and climate of professional strain, with many posts unfilled. The participant narratives in this research study vividly convey the high importance of continuity of relationships in family mental health contexts and the need to address this as a significant issue in the delivery of parent work.

4. The fragility of trust

The three participants conveyed different degrees of epistemic trust and mistrust through their experiences, with Joyce sceptical about her new worker, *'We decided we didnae like her before she even came through the door',* Hazel, despite developing a very positive relationship with her worker, still remaining distrustful of whether the worker meant the positive things she said '*A lot of the time I just thought ah she's saying that to try and lift me... it's not that she really means that',* and Clare, the most wary and concerned by this '*Are they kinda watching me, to like see if my mental state's okay really?'*. Clare in particular was highly anxious about being judged and at a much earlier stage in her relationship with her parent worker, struggling to make sense of and establish what level of trust, sharing and authenticity might be available to her.

The importance of deep, egalitarian, open partnership working and trusting relationships with parents has been emphasised previously by a number of writers, notably Lanyado (1996, 2019), Byrne (2020) and Marks (2020). This study once again adds the weight of direct parental experience to this, evidencing how much sensitivity, tact and commitment are required when maintaining relationships which sustain parents, especially those who are emotionally and psychologically vulnerable.

5.Increased ability to mentalize and capacity to reflect

Linked closely with the general growth of trust in their parent workers as time went on, all three participants conveyed being supported to think calmly, and their appreciation of an increasing experience of emotional containment, with differing degrees of learning to adopt a more reflective and mentalizing stance, Joyce reflecting '*When I'm worrying about her I'm not logical, I'm just emotional'* and '*Emotion doesn't give you the right answer always... I don't know how to put it quite'*. Hazel describing how '*She (Angela) could help me break it down or think, well I've never ever thought about it that way',* and Clare '*I'm getting to offload all my John issues here, which is really, really good.... I'm now able to do that here, but I'm also, sometimes, talking about my own issues as* *well, so we do talk about both.'*

Participants articulated many positive aspects they valued in the work but their strongest appreciation was expressed for the way their supporting professional had been able to help contain strong emotions during the work, conveying a sense they had been able to learn a greater capacity for thinking calmly about emotional issues from this. Slade (2007, 2011), Fonagy and Allison (2014) and Byrne (2020) have emphasised the links they perceive between *trust in* and the ability to *learn from* professionals. Once again, the participant narratives in this study confirm this through direct testimony. These parents spoke of an increase in their ability to mentalize and reflect being modelled by professionals, whose calm approach and compassionate and non-judgemental attitudes they valued highly, and often relied upon, to get through periods of crisis in their and their family's mental health. They conveyed a strong sense of this work in this way increasing confidence and helping rebuild damaged parental self-esteem. Their experiences testify to the value of mentalizing approaches, that is thinking about one's own thoughts and feelings, and being supported through this to think about the thoughts and feelings of the child, being brought into the centre of the field of parent work in Child Psychotherapy, for parents impacted by significant anxiety and trauma.

6. A sense of complaint being difficult to express

Participants struggled with the expression of difficulties and more ambivalent feelings but from their narratives some clearly emerged.

Access and travel were issues for all, with Joyce minimising any sense of criticism about this but clearly finding the journey on public transport very difficult. Hazel similarly finding the journey hard and at times distressing and Clare describing the journey as '*A bit of a nightmare'*. They all made significant journeys, with no possibility any more for claiming back travel costs, and the time commitment involved was only possible because they were full time carers willing to make considerable effort and financial sacrifice.

Although reticent about their ambivalent feelings, participants were ultimately able to give voice to negative aspects of their experiences, expressing wishes for better things, more accessible and welcoming clinics, compassionate attitudes from *all* professionals, and some considerable anxiety and difficulty created arising when aims in parent work were not understood from the start.

All voiced some sense of complaint, arriving at this usually towards the end of the research process, and there were expressions of anger and indignation, although participants went to great lengths on the whole to politely minimise these. For Joyce it was the lack of water, and sense of a non-welcoming and nurturing environment, Hazel focused on the feeling of not enough information, with too long between reviews, and for Clare it was the niggling but growing sense that she really did not understand enough about the purpose and methods of the parent work '*I don't ever get a review meeting of why I'm in here, so why the hell am I in here?!*'

In this way, once again, the narratives in this study corroborate, through direct participant feedback, an idea articulated by Lanyado (1996) about the importance of the 'external holding environment', and the need to take care of the needs of such vulnerable parental and grandparental patient populations. Attention needs to be paid to basic aspects of clinical environments, such as welcoming waiting facilities, access to water, in order to communicate an atmosphere of respect and dignity to families who are struggling against many social and emotional barriers in order to attend.

7.Parent worker as helpful third

All three participants were main or sole carers and so their relationship and work with workers providing parental support work could be seen as helping to perform the function which, under different circumstances, might have been fulfilled by a partner or additional carer, providing a helpful outsider perspective, from which the relationship with the child could be thought about. With Joyce this helped her think about her granddaughter as a different person from her daughter '*And they would be very good at reminding me, she (Freya) is not her mum, she's a different person, and just because she's having problems now doesn't mean she will have all her life.*' It helped Hazel to be able to separate a little and have confidence her daughter could cope without her for a few hours, *'But it's just that wee bit of time out and then when I go back to Brooke I'm recharged and I'm like right (clapping hands) I'm ready to deal with this now'* and with Clare the relationship with the parent worker and regular sessions and setting provided an important chance to '*Offload'*.

Many psychoanalytic writers (Edwards 1998, Ludlam 2005, Davis and Eagle 2013) have explored the importance of a 'third', an additional adult mind available to think about and discuss parental issues with. This study provides some evidence of parents valuing and making use of this function, when in all three cases there was no other available close and supportive co-parent or partner. Participants conveyed a sense of relief derived from the support available to them through their relationship with the parent worker.

8. Valuing participation and finding a voice through research

All three participants identified involvement in the study as therapeutic or helpful in itself, with Joyce jokingly referring at the first meeting to talking about her experiences as '*I can get really quite upset at times, but it's also therapeutic for me, does that sound daft?*' and that it was '*The only therapy I get*', Hazel saying '*it's like a wee bit of therapy!*' and Clare expressing a sense of liberation in finding her voice and identifying a wish to be more assertive about her questions about the work in future. All valued their stories, wanting their own printed copies and expressing a keenness to be informed about any publication arising. All expressed hoping others could be helped by their sharing of experiences. It was important for them to know that their contribution could have a positive impact and help parents and they expressed pleasure in the sense of being able to give something back to a service they felt grateful for having received. They seemed to experience participation as dignifying, being proud of their stories and the collaborative work involved in developing them.

All three became more clear and vocal as the study went on. All three had a huge amount of caring responsibility, mostly carried out on their own, yet during the research process could show a tendency to assume emotional responsibility for the research as well. Participants often apologised for their lapses in memory, or for speaking 'too much', or if they thought they might have taken too long to get back to me to arrange interviews or meetings, and expressed self-deprecation at times, as well as a sense of trying to 'get it right' for the interviews. It helped to reassure and remind participants that being themselves and true to their experience was what was important and valuable, to help them relax into telling their stories.

CHAPTER FIVE
CONCLUSION

5.1 Strengths and Limitations

This study was innovative, multi-disciplinary in approach, and unique in being undertaken in a specialist service setting for families affected by severe mental health difficulties. By obtaining perspectives of parents and carers from this population, whose experiences are under-explored in the existing Child Psychotherapy research literature, a significant knowledge gap has begun to be bridged.

The Free Association Narrative Method enabled a compelling exploration of parent work, allowing parents to share their stories and experiences in a largely self-directed way, meaning that *their* preoccupations and priorities came to the fore and were the main focus of exploration. Through this methodology, the participants found their voices increasingly as the study progressed, with two parents and one grandparent in this way enabled to articulate *what mattered to them* through the process.

An unanticipated outcome was the degree of enthusiasm elicited by the narrative inquiry approach, with participants valuing both the process and the personal narratives produced. This enthusiastic engagement with the process resulted in rich stories of parent work being created. By sharing extended extracts of the narratives it was possible to illustrate, challenge or confirm, in a compelling way, the relevance of some theoretical ideas previously asserted by practitioners in their studies of parent work. The narratives presented here represent a unique contribution by extending, elaborating and providing parental comment on prior theories and assertions, adding a crucial dimension previously missing, the validity and nuance of parental perspectives derived from first-hand experience.

The application of listening and observation skills, honed through experience and training during the long journey to becoming a psychotherapist, combined with holding the position of practitioner-as-researcher, made it possible to pay a high degree of attention to the wellbeing and needs of participants. Time involved in the inquiry from start to finish was variable, on the whole longer than the originally aimed for three-to-six months, with Joyce involved for 4.5 months, Hazel a total of 8.5 months, and Clare entering and exiting the inquiry in under 2 months. A patient, hopeful and careful ethical approach was required to support vulnerable parents and carers through their, sometimes interrupted, journey of participation in the research, inevitable during the challenging social context of COVID-19, when all involved were emerging slowly and tentatively from varying degrees of isolation after successive lockdowns.

Participants were able, through this supportive approach, to maintain openness, authenticity and provide great depth of emotional and reflective response, demonstrated throughout the course of their interviews.

The researcher was also able to pay attention to unconscious aspects of communication in the research relationship, supported through discussion in psychoanalytic supervision of the interview transcripts. This added rigour to reflection on moments of mis-attunement, misunderstanding and repair, and enabled reflection on issues of transference and counter transference, which was innovative.

The sample size was inevitably limited by the number of participants who met inclusion criteria in such a specialist intervention within an already specialist service, particularly as at the time of the study the service was operating at a much reduced capacity due to COVID-19. Due to this, it was beyond the scope of the study at this time to aim for 'saturation' in terms of breadth of themes explored, where saturation is understood to mean, as defined by Kim (2016, p. 161), a point when new interview data do not yield any new knowledge, but confirm or are redundant with what has been found in the existing data. The priority, and significant outcome from this first research of its kind and with this particular population, was the exploration and communication of the unique lived experience of each individual, directly and with impact.

The literature review allowed a look at the total scope of research in this area, past and current, and enabled a comparison of quality across a wide range of studies. Encompassing a broad scope and applying a methodical search strategy, a comprehensive literature review of available studies on parent work in psychodynamic Child Psychotherapy was created by conducting searches over the entire lifespan of databases, with hand-searching of the main professional Journal of Child Psychotherapy. This established an unanswered and original research question and ensured the study focus and design would result in an original contribution. A limitation was that conducting a literature review on this scale was an ambitious task for a single practitioner-researcher. Books were excluded meaning some high quality contemporary literature of relevance could not be incorporated, for example, Tsiantis (2000), and it is possible that some other studies of relevance were omitted.

In terms of research type, the study was innovative in adopting interdisciplinary qualitative approaches; the narrative approach blended and integrated well with a psychoanalytic lens and process of reflection. The method of incorporating psychoanalytical dialogue and reflection into supervision of a small-scale practitioner research project was innovative, as well as effective in helping to consider multiple, sometimes conflicting and unconscious, layers of meaning. This was truly psychoanalytical qualitative research, and it is hoped it may inspire further exploration of ways to include psychoanalytic research reflexivity in Child Psychotherapy research designs. There is controversy about what constitutes Child Psychotherapy research, and feedback from the wider professional community about the approaches incorporated in this design will be interesting.

5.2 Further Recommendations for Research and Practice

The service specific audit carried out prior to undertaking the study highlighted the lack of incorporation of explicit and direct feedback from parents and carers about this work. A key aim had been to address this and make changes and improvements to this aspect of parent work delivery locally, in this service aimed at children for parents with severe and enduring mental health difficulties. The importance of incorporating more regular reviews of progress in the parent work, as part of ongoing evaluation of clinical practice, has been indicated as a key finding and outcome of this research. This has particular relevance in the researcher's specific setting, but could be a practice other Child Psychotherapists and wider CAMHS practitioner researchers may wish to trial.

Between 10% and 23% of children and young people live with a parent who has a mental illness (Social Care Institute for Excellence (SCIE) 2009, The Royal College of Psychiatrists (RCP), 2011). Recent estimations suggest that 68% of women and 57% of men with mental health conditions are also parents (The Royal College of Psychiatrists, 2016). The research findings from this small study therefore have broader implications and relevance to a range of child and adult mental health service settings.

By sharing these findings from participatory research involving parents widely, it is hoped this will inspire researchers to gather and further explore parental perspectives, including their voice and what matters to them about a number of aspects of process and outcomes in work with them as well as their children. The Scottish Government's Mental Health and Wellbeing Strategy emphasises a core principle that the voices of lived experience in particular should be driving policy and practice, stating:

The lived experience of individuals and practitioners brings a rich and diverse type of evidence, and we want to ensure it is sought and appropriately gathered. This can contribute to significant improvements to policies and services, actively support collaboration with clinicians and researchers, and support shared learning of what works. (Scottish Government Mental health and Wellbeing Strategy p.19).

The study showed how fruitful it can be to create space for the therapeutic application of narrative techniques in parent work, encouraging the telling of parental stories and building on opportunities for reflective capacity which emerge in these.

It is in the context of democratic endeavour that qualitative psychology of whatever tendency should be judged. For, usually it is only qualitative research that has a proper awareness of the diverse experiences of individuals, and will, in particular, provide a hearing for the voices of the excluded. (Peter Ashworth in Smith, 2015, p. 24).

The lives and struggles of families affected by severe mental health difficulties remain relatively hidden in society and largely excluded from research. This study provided an important opportunity for parents and grandparents to feed back on their experiences in parent work, and their voices and experiences can and should shape and improve mental health services.

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APPENDICES

Appendix 1.2

From ‘Meta competency: working with diversity’

6. Ability to draw on psychoanalytic understanding of issues of diversity and difference in work with children, young people, their families and their relationships with institutional and social contexts.

From ‘Psychoanalytic therapeutic competences: ability to track change and outcomes using subjective and standardised methods’

3.1 Ability to draw on a range of views to track progress, including those of the child or young person, carers or parents, and other parts of the system, using tools and other feedback systems.

5.1 Ability to use appropriate outcome measures and processes to assess the impact of an intervention in a way that is meaningful to the child or young person, to the wider system and to the service and its commissioners.

Extracted from the competency framework Association of Child Psychotherapists (www.childpsychotherapy.org.uk June 2017).

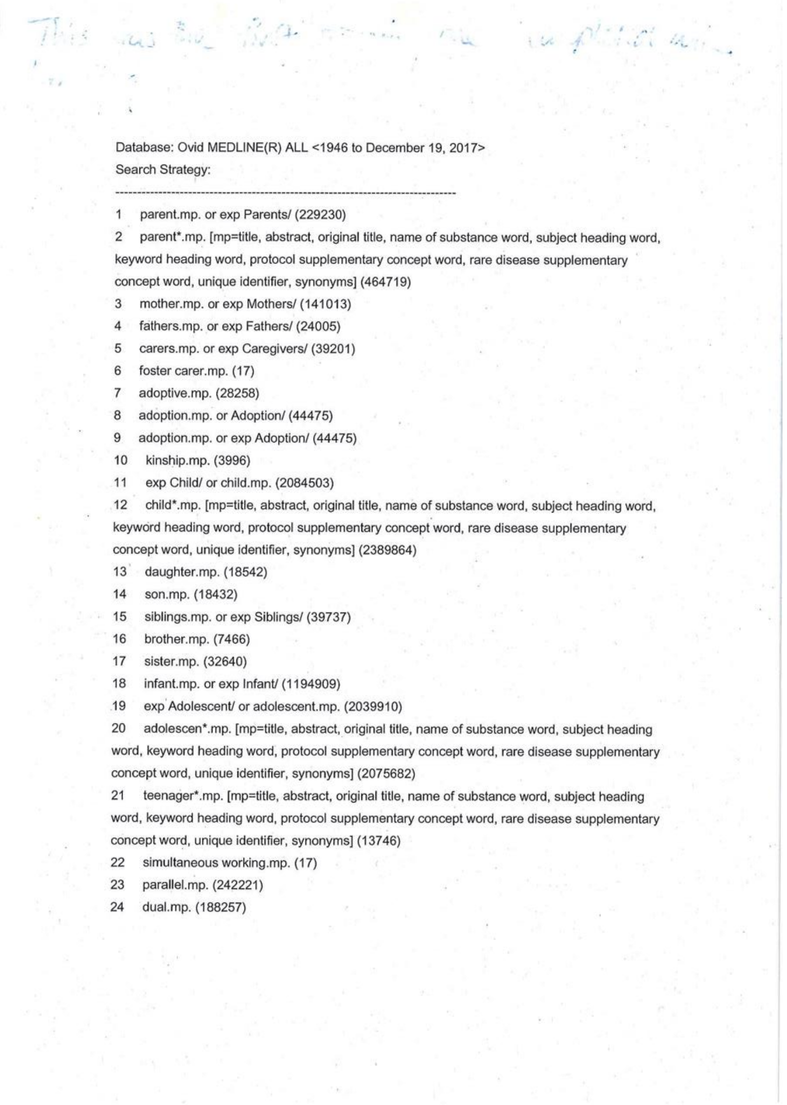
Appendix 1.2

Audit form and Questionnaire:

Form code number	
What is your professional role within the service?	
How many parents / carers are you currently seeing for parallel parent work where the child has child psychotherapy?	
How frequently do you see the parent(s) carer(s)?	
How do you obtain the parent or carer's feedback about this work?	
(prompt): Also note whether both or sole parent/carer is seen.	
Is there anything you would like to add about parents' experiences of your work with them?	

Appendix 2.2

Example of Detailed Search Record using Ovid Medline



This was the [illegible] in [illegible]

Database: Ovid MEDLINE(R) ALL <1946 to December 19, 2017>
Search Strategy:
----

1 parent.mp. or exp Parents/ (229230)
2 parent*.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms] (464719)
3 mother.mp. or exp Mothers/ (141013)
4 fathers.mp. or exp Fathers/ (24005)
5 carers.mp. or exp Caregivers/ (39201)
6 foster carer.mp. (17)
7 adoptive.mp. (28258)
8 adoption.mp. or Adoption/ (44475)
9 adoption.mp. or exp Adoption/ (44475)
10 kinship.mp. (3996)
11 exp Child/ or child.mp. (2084503)
12 child*.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms] (2389864)
13 daughter.mp. (18542)
14 son.mp. (18432)
15 siblings.mp. or exp Siblings/ (39737)
16 brother.mp. (7466)
17 sister.mp. (32640)
18 infant.mp. or exp Infant/ (1194909)
19 exp Adolescent/ or adolescent.mp. (2039910)
20 adolescen*.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms] (2075682)
21 teenager*.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms] (13746)
22 simultaneous working.mp. (17)
23 parallel.mp. (242221)
24 dual.mp. (188257)

25 dual-group.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms] (58)

26 parent-child consultation.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms] (1)

27 concurrent.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms] (108083)

28 joint working.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms] (482)

29 exp Psychotherapy/ or psychotherapy.mp. (200899)
30 exp Psychoanalytic Therapy/ or child psychotherapy.mp. (17291)
31 psychoanalysis.mp. or exp Psychoanalysis/ (13621)
32 exp Object Attachment/ or exp Psychoanalytic Therapy/ or psychoanalytic.mp. (45013)
33 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 (688717)
34 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 (3996313)
35 22 or 23 or 24 or 25 or 26 or 27 or 28 (531941)
36 29 or 30 or 31 or 32 (227919)
37 33 and 34 (353305)
38 35 and 37 (5935)
39 36 and 38 (389)
40 limit 39 to (english language and yr="2007 - 2017") (219)

****

Appendix 2.2 cont'd

Search Strategy Records

Detailed search forms showing strategy for two main searches using advanced searching of selected databases.

Question: PARENT INTERVENTIONS IN CHILD PSYCHOANALYTIC PSYCHOTHERAPY What issues and outcomes emerge in the literature?
Limits / filters / parameters: 2007-17 English Journal articles Terms identified in either abstracts or keywords (not 'whole text' but sometimes 'anywhere')
Keywords: Parent OR synonyms: mother father carer foster adoptive

Child OR Adolescent and synonyms:

son

daughter

Psychoanalysis OR Psychotherapy OR Psychoanalytic

Parallel OR Dual OR Concurrent

OVID MEDLINE 08/01/2018	TAYLOR AND FRANCIS 18/01/2018	PROQUEST 13/01/2018	WILEY ONLINE 29/01/2018
This allowed the most systematic search strategy to be applied (see saved search record on next page), expanding all the key terms, producing tens of thousands of results. Combining them reduced the list to 37 articles, 8 of which met my inclusion / exclusion criteria for the study so I added them to my saved preliminary reference list.	Parent / Carer / Psychotherapy / Parallel / Child / Adolescent. Parent / Carer / Psychotherapy / Parallel / Child / Adolescent. This search expanded by looking 'anywhere' for the terms, which yielded 257 results. Skimming the titles and reading the abstracts of these selected and determined whether to include in preliminary reference list.	Parent (and synonyms), Parallel (and synonyms) Adolescent (and synonyms) Child (and synonyms). With limiters, this was reduced to a list of 180 relevant results. However, it was apparent that a relevant article had been lost. I expanded the search again and found it challenging to get fewer than tens of thousands of results. The final strategy adopted was to screen the first 200 results. This was a pragmatic way to sift through the most relevant results, which became progressively less relevant as the list went on.	Parent and Child and Psychotherapy (removed search term parallel as this limited results to nil). This produced 15 results, five of which were selected as highly relevant. Wiley automatically generated searches for related terms / synonyms so they were not inserted manually. I searched for 'keywords ' only as a more inclusive search yielded unmanageable results.

Question: As before’
Limits / filters / parameters: As before
Keywords: As before

PSYCINFO 18/02/2018
Search terms: child or adolescent and psychotherapy, or psychoanalysis, psychoanalytic, and parent or carer and dual, or parallel, or concurrent. Limiters: Dec 2007-2017 English All Journals. 262 results and only one relevant. No repeat of this search in 2nd search as did not seem sufficiently efficient or relevant.

Question: As before
Limits / filters / parameters: As before but expanding dates on each database from when records began to current time.
Keywords: As before

OVID MEDLINE May 2018	TAYLOR AND FRANCIS May 2018	PROQUEST May 2018	WILEY ONLINE May 2018
Search repeated as before using key terms but this time removing the time limit and this led to 81 results. An initial rapid screening of these reduced this to a list of 20 relevant results.	Repeated search this time with no time limits and obtained 160 relevant results. Screened abstracts and this reduced to 4.	Repeated the search refined slightly from last time. Initially 385 results were yielded but when abstracts were screened none met the inclusion criteria. This database is possibly too focused on public health for this search.	Repeated as before removing time limit, retrieved 164 results.

Results of Main Database Searches

Table A: Search 1

January 2018

The Knowledge Network 2007-17	4348 results

Ovid Medline	219
Taylor and Francis	257
Proquest	200
Wiley	15
TOTAL	691 results

Screening of 691 abstracts	19 meeting inclusion criteria

Table B: Search 2

May 2018

Repeat of same searches with adjustments to time limits, this time searching from when records began until the current time.

Ovid Medline	81
Taylor and Francis	16
Proquest	385
Wiley	164
TOTAL	646 results

Screening of 646 abstracts	30 meeting inclusion criteria

Next Step

Merging search 1 and 2 results and checking for duplicates	44 articles

As illustrated, main database searches, combined, resulted in a total of **1,337 abstracts,** which were screened using inclusion and exclusion criteria. From these, **44 articles** were selected for sourcing full-text papers.

Table C: Search 3

2021

Repeat of searches for articles published from 2018-2021.

Ovid Medline	40
Taylor and Francis	23
Proquest Public Health Database	156
TOTAL	219 Results

Online screening of abstracts identified texts meeting inclusion criteria	1 ovid medline

Next Step

Hand search of key Journal	6

As illustrated, main database searches, combined, resulted in a total of **227 abstracts,** which were screened using inclusion and exclusion criteria. From these, a total of 7 **articles** were selected for sourcing full-text papers.

Inclusion Criteria

- Article contains description of parent work with parents and carers (foster, adoptive and/or kinship) running parallel to child psychotherapy **or** uses empirical data to explore therapists' experiences of such work.
- Brief models or intensive or longer-term psychoanalytic psychotherapy interventions were delivered to the child or adolescent by a child and adolescent psychotherapist.
- Parental aspect of intervention could be delivered by a more inclusive range of professionals, including psychiatrists, play therapists, clinical psychologists and/or family therapists, reflecting the variety and flexibility of clinical practice.
- Under 5's parallel interventions with parents or carers were included only where they included a focus on some separate and parallel work with parents.
- Studies must have applied clinical relevance to the question and including a minimum of descriptive clinical material or empirical data, i.e. could not be simply theoretical or conceptual.
- Articles or chapters that might appear within whole books but which were also available as shorter texts within their own right were included.

Exclusion Criteria

- Those where parent intervention which did not go beyond the 'standard' level of minimal engagement, with parents for the purposes of consent only or participation in introductory and termly review meetings only. This was the sentence I got lost in, in the main text.
- Where the paper was purely conceptual with no case examples or descriptions of clinical parent work or other empirical data to illustrate or evidence conceptualisation.
- Parent-infant dyadic work (working with both together) was excluded as a different approach with different issues and has been the focus of the systematic review study already carried out elsewhere.
- Studies where intervention was not carried out by psychoanalytic psychotherapists even though may use child psychotherapy in the title (in line with aim of examining the psychoanalytic literature on this specific mode of intervention).
- Brief consultation-only work with parents without ongoing parallel work with children in individual psychotherapy was also excluded.
- Whole books on the subject of parent work were excluded from this review as the intention was to focus on the quality of individual studies and research.
- Group work models were excluded.

Appendix 2.3

Memo 1

Parent work In Child Psychoanalytic Psychotherapy: What themes emerge in the literature?

Full Ref of Article:

Summary of the article:

What is the context/setting/demographic?

Core features of the intervention frequency / duration / model?

Themes within the work (psychoanalytic and / or other fields): e.g. mental health / separation / engagement / transference / cross- generational / attachment?

Was there direct feedback in relation to the experience of the service given by the parent, carer or child?

Was there direct reference to psychoanalytic themes?

What were the findings and outcomes?

Transferable knowledge / link to own service setting?

Memo 2

Study Design and Quality Appraisal Tool

Description of Study Design in terms of Desmarais 'Network ' of Psychotherapy Research

Using descriptors and distinctions gathered in Desmarais (2007) paper:

Is it 'research **in** Psychoanalysis' or '**on** Psychoanalysis'?

Is it research carried out in a 'Context of Discovery' or a 'Context of Justification' ?

Is it Clinical Research? Empirical Research? Conceptual Research? Interdisciplinary Research?

Note: Categories are not mutually exclusive.

Quality Appraisal:

What was there a reported explicit method for obtaining and analysing the data?

Are issues of bias addressed by the study? (consider reporting bias, selection bias, attrition bias, funding bias?)

Were reliable outcome measures used?

Is the intervention clearly described or defined?

Are the findings of the study generalizable?

Was the research conducted in an ethical manner?

Was there indication of whether participants verified the findings of the research (did the findings resonate with them)?

Appendix 2.4

Superordinate and subordinate table of themes

Relationship between parent and child (23 articles)

Need for Separation versus merging or 'enmeshment' to promote positive relationship and facilitate child's development	6
Separation experienced as abandonment	1
Difficulties with separation due to anxiety around fragility of parental connection	1
Lifelong interdependency emphasised as well as need for separation	1
Anxiety around feeding and projection of bodily issues onto child	1
Oedipal issues 'resulting in father's exclusion'	1
Unconscious sexualisation of child by parent	1
Unconscious collusion or 'pairing' of parent with child	2
Potential for mother or parents as couple to project or split into child	2
Autism and learning disability in child and coming to terms or adapting to child's needs	1
Parental feelings of worthlessness and expectation of disapproval	1
Loss of 'good relationship' with adolescents	1
'Good hate' as positive and necessary feature of relationship	1
Link between role, 'zonal', and 'geographical' confusions	1
A need to rethink relationships with adolescent children and think about the child	1

Parents needing permission not to be controlled by the child's illness	1

Nature of and Challenges within Therapists' relationships with Parents Including Complex Field of Transference and Counter transference (19 articles)

Negative parental transference: intensifying as part of work	1
Split transference (splitting of parent's transference onto child's worker)	1
Feelings as evidence	1
Potential for rescue fantasies and potential rivalry in counter transference	1
Confusion between real parent and internal parent leading to complexity in counter transference response	1
PTSD/element of trauma always exists and leads to fear of the professional	1
Easy for therapist to slip into role of expert and undermine parent	1
Advantages and disadvantages to working with parent and child: increased knowledge versus great challenge in working with double transference and counter transference, and guarding against over-identification with either parent or child, potential for envy of both patients in sharing analyst	1
Parents 'ganging' up as sibling pair on therapist in transference	1
Interpretative work with parents	1
The need to gently and gradually move into this	1
Resistance to change in early phase of work	1
The idea of 'grandparental transference' as prevalent	1

Use of interpretation of initial 'shame reaction' as useful for dissolving this feeling. If therapist performing dual role this can create unhelpful sense of omnipotence/hard to divide focus	1
Difference in style of interpretation with parents than 'transference work' in individual therapy	1
Importance of therapist's own supervision or 'processing' (usually linked to the above themes)	4

Termination and ending as issues (6 articles)

Termination of parent's work	1
Limiting effect on child work if parent terminated	1
Ethical implications around consent for child's treatment if parent terminates parental work	1
Parent unable to tolerate separate treatment with separate analyst	1
Preparation for ending important for child and parent	1
Difficulty in ending work with parents as such painful issues around guilt and blame	1

Cross generational themes (14 articles)

Pathology in historical family relationships	4
Loss	1
Suicide	1
General	1
Cultural trauma: holocaust	1
Transmission of positive experiences of attachment 'angels in the nursery'	1

'Unresolved Oedipal issues' with grandparents	1
Repression and denial	1
Parent's own childhood and adolescence seen as core part of assessment process	1
Discussion of historical factors in the family where appropriate	1
Making use of insight into repetition of parent's history	1

Interdisciplinary themes (7 articles)

'Dyadic affect regulation theory' and the 'relational baby'	1
'Anxious attachment' / 'attachment issues' /positive 'attachment' experiences	3
Need for worker to have a coherent knowledge of child development	1
Intersubjectivity	1
'Parenting issues'	1

Papers which provided some meta/historical analysis and/or overarching conceptual view of parent work (6 articles)

Construed as 'continuum of models'	2
Flexibility and adaptability in models	1
Distinct and clear levels of working identified and training for this role a priority	1 (Rustin, 2018)
'Psychotherapy of parenthood' and clear model for concurrent work argued with defined areas and levels of work	1 (Sutton and Hughes, 2005)

‘Dual-Goal’ work with parents of Adolescents	1 (Novick and Novick, 2013)

Functions and opportunities of parent work (24 articles)

Provision of ‘triangular space’	1
Space for feelings: hope, gratitude, guilt, jealousy	1
Grieving	1
Awareness of external vs internal factors with bearing on work	1
Parental work construed as offering partnership to lone or unsupported parent	1
Providing ‘ holding environment’ / ‘Emotional holding’ / ‘containment’	4
Reduce Anxiety	1
Naming Painful Issues	1
Therapeutic Alliance	3
Multiple aims of, to support treatment and to transform relationships, multiple benefits of	2
Mutual transformations	1
Turning Points	2
Distinguishing child from parental anxiety (awareness of projections)	2

'Dual contract'	2
Parallel processes	2
Four different levels or functions; support with child's therapy, support in parental functioning,change in family functioning, individual therapy for parent(s)	1 Rustin (2018) and Holmes (2018) were outstanding key papers for this category.

Importance of father or awareness of impact of marginalisation explicitly recognised: 7

Linked to this recognition that internal family consists of a combined object	1
Single parenthood as deficit due to reduced capacity for 'triangulation'	1
Work with fathers 'taking extensive effort but being important for the young people'	1
Reconceptualisation of ADHD as DADD, 'dad's attention deficit'	1

<u>Other less developed themes (3 articles)</u>

Daws 1986 and Lanyado 1996 key papers

Importance of relationship between parent's and child's therapist: working as a 'parental couple'	2
Keeping the 'couple in mind', combining couple therapy and parental therapy	1
Importance of preparation for parent work in child psychotherapy training. Particular strengths and suitability of child psychotherapists for this work, possibility that senior experienced colleagues suited due to the levels of assertiveness required, ethical issues raised by increasing vulnerability of parent, splitting of adult and child services	1 (All in Rustin 2018 seminal and recent paper here)

Parental mental illness or impaired parental capacity tended to be an implicit theme - an overarching background theme throughout papers. Holmes (2018) paper was exceptional in measuring the number of parents in sample, 72%, who, in the clinical judgement of the therapist, had an undiagnosed mental health problem.
Confidentiality: difficulties of managing the boundaries between fields of work with child and with parent: The difference between and preference for 'privacy' over 'secrecy' was emphasised in four papers with examples given of ethical dilemmas and how they were managed. One paper drew attention to the particular need to think carefully about what to 'process and contain in supervision' and what to share in order to maintain boundaries between parent and child work: 1 paper
Consent as active and ongoing process was emphasise: 2 papers (Daws, 1986 and Sutton and Hughes, 2005).

Outcomes

Diverse benefits to parents, young people and children form the parental intervention (27 articles)

Less pathological projection onto child	2
Unresolved parental dependency needs relieved	1
More realistic acceptance of child as they are	1
Unresolved cross-generational impediments relieved	1
Conflict with child resolved	1
Mother more able to be emotionally close to child	1
Mutual 'transformations' to relationship with child/young person	2
Parent work negative impact on child work in that both prematurely ceased	2
Treatment alliances strengthened	2

Permission to explain mental health condition to child with great benefit to child	1
Increased general self-worth derived when mother enabled to value self as a mother	1
Adolescents very positive about involvement of parents	2
Serious child protection issues identified as having a reality basis through the contact with parent	1
Reduced high expressed emotion/over involvement between adolescent and parent	1
Child's enuresis disappeared as parent's appreciated developmental needs better	1
Child's toileting improved when verbal communication improved	1
Anxiety (general) reduced	1
Parents able to provide improved 'good enough' parenting	1
Parents improved couple functioning, less conflict	1
More flexible, more realistic and less painful family functioning	3
Parents more self aware of own states of mind and impact on parental functioning	2
More active father role activated	1
Father seeks therapy for self leads to 'rapid mutual transformations'	1
School non-attenders returned to school/increased attendance as parents supported to achieve	1

Appendix 3.1

Meeting three:

Afte writing up two recordings* or process notes (see note below) of our interview meetings, I will meet you to feedback to you what you told me based on my listening and reflection on the recordings. I will be doing this in a way that aims to tell your overall story, the most important parts of what you have told me about the experience of coming.

I want us to think about and agree this story of your experience of parent work together and make sure I describe your experience in a way that feels real and true to you.

* I am going to be asking your permission to record meetings, either using a dictaphone to make a digital audio recording or by doing a ‘ process note’ which is where I write it up the meeting from memory very soon after the meeting has finished.

Meeting four:

I will bring along the agreed final version of what I have written up and give you your copy to keep, if you would like it. I will ask you if you would like me to contact you again in future, to inform you of any publication of the story of your experience of the parent work in a professional or academic journal. The purpose of any publication of my writing about this work is to share the learning from your experiences.

T**ravel:**

We are not able to give travel re-imbursements at this time if these are incurred when coming to the clinic. If travel to the clinic is a barrier for any reason, there are options for me to come to you or to meet on-line and we can agree between us what works best. for you. **See accompanying supporting information leaflet for who you can contact if you have any complaints.**

Your privacy and confidentiality:

What you tell me during our discussions will be confidential, unless you tell me something that indicates a risk of serious harm to a vulnerable adult or a child. In that situation I will discuss this with you and let you know if after this discussion I need to share this with my line manager. If necessary I would make a notification of concern to social services. This is in line with child protection procedures and guidelines always adhered to in Reach Out within North Lanarkshire CAMHS.

I will ask your permission at the start to either write up from memory or audio record the meetings, so I can think about what you tell me and write up our conversation. I would not store any audio recordings and only I would listen to it before deleting it. I will be discussing my research and our meeting with my academic supervisor , always using a made up name so that this is confidential . If you would like to speak to someone else about any aspect of this study , the academic supervisor is Dr Gillian Sloan Donaghy T: 0141 3312419 E: info@hds.scot

From the beginning and right through this research, I will not use your real name or the name of anyone you mention, instead in my write ups of our meetings. I will use made-up names, to protect confidentiality and your privacy. I will also change other details like names of places mentioned, or any other details, to make sure that you and your family would not be recognisable. I will ensure you and your family are not identifiable in anything written up. Nikki Gauld
Child Psychotherapist in Training

07.12.2020

NHS
Lanarkshire

ROBERT GORDON
UNIVERSITY ABERDEEN

TEF
Gold

Participant Information Sheet
Version 3 11.12.2020

Study Question—What do parents, affected by mental health difficulties, tell us about their experience of coming for parent work at the same time as their child receives child psychotherapy within a specialist Tier 3 CAMHS service?
Research Project ID L20009

NHS Lanarkshire

CAMHS
Coathill Hospital
Hospital Street
Coatbridge
ML5 4DN
Phone: 01236-703010

Invitatio to Participate

As you are a parent or carer who has attended for parent support work within the Reach Out service, while your child is having child psychotherapy, I would like to invite you to take part in some research.

I am inviting you as I am interested in your experience, particularly because you, or your someone in your family, have been affected by mental health difficulties.

Purpose of the study

Where a child is receiving Child Psychotherapy it is usual for parents or carers to meet regularly with a colleague in the team.

I want to hear about and learn from your experiences of coming for this support work which I am calling in this study' Parallel parent work' because it is delivered separately from the work with your child.

Parents and carers have not often been asked about this aspect of the work in child psychotherapy research. It would really help our understanding to hear about and be able to share your experiences of it.

It is also important that parents and families affected by mental health issues are included in research; this can help with our understanding of their needs and so improve services.

Joining the study is entirely up to you and before you decide I will explain why the research is being done and what it would involve.

If you want to go ahead, the on-going work with you and your child will not be affected in any way whether or not you decide you want to take part. Please feel free to talk to others about the study if you wish.

What will be involved if you take part in the study

If you think you would consider being part of this research, then I will arrange to meet you, to go over what is involved. This will take 30 minutes, and can be at the clinic or at your home, or we can meet on-line if you prefer. I will explain more about the researchrand answer any questions you may have.

Afte this meeting, you can take some time, up to two weeks, to think about whether you want to go ahead or not.

What is Involved if you decide to go ahead:

Some meetings with me, on-line or in person as you prefer. Guidelines for working safely during COVID –19 pandemic will be adhered to.

Meeting 1

I will ask you to tell me about what it was like coming to the sessions of parent work while your child was in psychotherapy. I will ask you to tell me generally about your experience. You might tell me things like when you started, where it was, how often you had appointments and what your first impressions were, how it went on and that sort of thing.

07.12.2020

Meeting 2

I will ask you more about some of the things you talked about the first time and explore the experience in more detail and with further questions.

Each of these two meetings would take approximately one hour for our discussion, which is called a 'research interview', but which should feel more like a relaxed and informal conversation, where I ask you tell me about things in your own way.

Talking about your experiences may bring up some feelings which might be unsettling. I will be sensitive to how you are feeling and not ask you to talk about things more than you want to.

This won't be like therapy, but may feel beneficial because sometimes people find sharing the story of their experiences enjoyable and being listened to positive and helpful.

I am planning time after the interview to chat and relax, so you can de-brief and be supported. I feel it is important you know I have this time planned, so if anything discussed in the interview becomes unsettling, you can talk a bit more and there is no rush.

I will also ask you if you want me to call you after a couple of days to check how you are feeling.

What should I do if I have a problem or complaint ?

If you wish to make a formal complaint about any part of the care provided by NHS Lanarkshire, including care provided to you as a participant in a research project, you can contact your local NHS Lanarkshire Patient Affairs Department. Their contact details, and full information on our complaints procedure, are available on the NHS Lanarkshire website at http:// https://www.nhslanarkshire.scot.nhs.uk/complaints/

07.12.2020

Where can I find more general information about research?

If you would like to find out more about research and what happens to the data generated in research please see:

https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/data-protection-and-information-governance/gdpr-guidance/templates/template-wording-for-generic-information-document/

Insurance and legal indemnity:

The Robert Gordon University as sponsor covers the insurance and indemnity for any potential legal liability for any harm to participants arising from the management or design of the research. NHS Lanarkshire as clinical host covers liability for any harm to participants arising from the conduct of the research.

If you would like this information in a digital format please let me know.

Nikki Gauld

NHS Lanarkshire

ROBERT GORDON UNIVERSITY ABERDEEN

Further Supporting Information
Version 3 07.12.2020

Project ID Lanarkshire L2000a

Study question : What do parents, affected by mental health difficulties, tell us about their experience of coming for parent work at the same time as their child receives child psychotherapy within a specialist Tier 3 CAMHS service?

NHS Lanarkshire

CAMHS
Coathill Hospital
Hospital Street
Coatbridge
ML5 4DN

Phone: 01236-703010

Further Supporting Information for study :

What happens if I decide I don't want to carry on?

You can withdraw from participating in the study at any time and it is your right to do so without experiencing any negative effect from that.

You might decide to do this for example if you become unwell for a while. If so, I could keep hold of your data and you can re-join before the end of the study if you want to. This is possible as long as there is still time to complete participation before my study finishes in September 2021.

Alternatively, if you tell me you want to stop completely, that will be okay also. I will ask you if you want me to keep and use the information I have already gathered from you , or if you prefer me to dispose of this data altogether.

How will my information be kept and for how will it be stored?

Your personal information will be stored during the study by me, as named data controller, and will be kept strictly confidential, stored on an encrypted NHS laptop computer. I will use a made up names in all my writing up of the research data from our meetings, right from the first meeting, in order to make it anonymous. This data will be stored in a separate file on the same encrypted, password protected laptop computer. After the study finishes, in Sept 2021, the research data will be stored for five years in the Robert Gordon University password protected long term storage repository.

Who has reviewed this study?

The study has been reviewed by the Robert Gordon University internal ethics review group and also peer reviewers at Lanarkshire NHS .

All research in the NHS is looked at by an independent group of people, called a research ethics committee, to protect your interests. This study has been reviewed and been given favourable opinion by the West of Scotland Research Ethics Service.

Confidentiality and corporate protection of information :

NHS Lanarkshire take care to ensure your personal information is only accessible to authorised people. Staff have a legal and contractual duty to keep personal health information secure, and confidential. In order to find out more about current data protection legislation and how we process your information, please visit the Data Protection Notice on the website at www.nhslanarkshire.scot. You can also refer to the copy of the GPDR information which I will give you to accompany this leaflet.

Legal Justification for use of the information in this study:

The justification for my use of the information from this study is that it is for the purposes of furthering research and is a task in the public interest.

Appendix 3.1

Date: 20.11.2020

Version number: 2

IRAS ID: Project ID 273 289 IRAS

Centre Number: RND Lanark L20009

Study Number: RGU ID SHS/20/14

Participant Identification Number for this trial:

CONSENT FORM

Title of Project: What do parents, affected by mental health difficulties, tell us about their experience of coming for parent work at the same time as their child receives child psychotherapy within a specialist Tier 3 CAMHS service?

Please initial box

1. I confirm that I have read the information sheet dated 20.11.2020 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my care or legal rights being affected. ☐

☐

3. I consent to the use of audio taping with possible use of verbatim quotation or the writing up by the researcher form memory an account of my meetings with them during the study.

4. I understand that the information collected from the study will be presented back to me and that the researcher will feedback to me what has been understood from what I have said. ☐

5. I understand that the information from the study may be shared anonymously with other researchers for the purposes of future research. ☐

6.I understand that the information from the study will be held and maintained by Nikki Gauld during the study for up to 12 months afterwards on her NHS encrypted laptop computer and after this will be stored by the Robert Gordon university for five years in their secure computer repository. ☐

☐

7. I agree to take part in the above study.

Name of Participant Date Signature

Appendix 3.2

WoSRES
West of Scotland Research Ethics Service

NHS
Greater Glasgow and Clyde

Ms Nicola Sacha Gauld
Child and Adolescent Psychotherapist in Training
NHS Lanarkshire
CAMHS Glenshirra
Coathill Hospital, Hospital Street,
Coatbridge
G128ND

West of Scotland REC 3
Research Ethics
Clinical Research and Development
Ward 11
Dykebar Hospital
Grahamston Road
Paisley PA2 7DE

Date 05 January 2021
Direct line 0141 314 0212
E-mail WoSREC3@ggc.scot.nhs.uk

Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

Dear Ms Gauld

Study title:	**A psychoanalytically informed narrative inquiry into the experience of parents, with mental health difficulties, who have parallel parent work while their child attends Child and Adolescent Mental Health Services for child psychotherapy.**
REC reference:	**20/WS/0152**
IRAS project ID:	**273289**

Thank you for your letter of 13 December 2020, responding to the Research Ethics Committee's (REC) request for further information on the above research and submitting revised documentation.

The further information was considered in correspondence by a Sub-Committee of the REC. A list of the Sub-Committee members is attached.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ms Nicola Sacha Gauld (nee Hale)
Child and Adolescent Psychotherapist in Training
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CAMHS Glenshirra
Coathill Hospital
Hospital Street,
Coatbridge
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R&D Department
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Monkscourt Avenue
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Date	06.01.2021
Enquiries to	Lorraine Quinn, R&D Facilitator
Direct Line	01236 712445
Email	lorraine.quinn@lanarkshire.scot.nhs.uk

Dear Nikki

Project title: A psychoanalytically informed narrative inquiry into the experience of parents, with mental health difficulties, who have parallel parent work while their child attends Child and Adolescent Mental Health Services for child psychotherapy.

R&D ID: L20009

I am writing to you as Chief Investigator of the above study to advise that R&D Management approval has been granted for the conduct of your study within NHS Lanarkshire.

For the study to be carried out you are subject to the following conditions:

Conditions

- You are required to comply with Good Clinical Practice, Ethics Guidelines, Health & Safety Act 1999 and relevant UK and EU Data Protection legislation.
- The research is carried out in accordance with the Scottish Executive's Research Governance Framework for Health and Community Care (copy available via the Chief Scientist Office website: http://www.cso.scot.nhs.uk/ or the Research & Development Intranet site: http://firstport2/staff-support/research-and-development/default.aspx
- You must ensure that all confidential information is maintained in secure storage. You are further obligated under this agreement to report to the NHS Lanarkshire Data Protection Office and the Research & Development Office infringements, either by accident or otherwise, which constitutes a breach of confidentiality.

Cont...

- Clinical trial agreements (if applicable), or any other agreements in relation to the study, have been signed off by all relevant signatories.
- You must contact the Lead Nation Coordinating Centre if/when the project is subject to any minor or substantial amendments so that these can be appropriately assessed, and approved, where necessary.
- You notify the R&D Department if any additional researchers become involved in the project within NHS Lanarkshire
- You notify the R&D Department when you have completed your research, or if you decide to terminate it prematurely.
- You must send brief annual reports followed by a final report and summary to the R&D office in hard copy and electronic formats as well as any publications.
- If the research involves any investigators who are not employed by NHS Lanarkshire, but who will be dealing with NHS Lanarkshire patients, there may be a requirement for an SCRO check and occupational health assessment. If this is the case then please contact the R&D Department to make arrangements for this to be undertaken and an honorary contract issued.

I trust these conditions are acceptable to you.

Yours sincerely,

Raymond

Raymond Hamill – Senior R&D Manager

cc.

NAME	TITLE	CONTACT ADDRESS	ROLE
Professor Paul Hagan	Deputy Principal	P.Hagan@rgu.ac.uk	Sponsor Contact
Dr Gemma Stevens	Lecturer	g.d.stevens@rgu.ac.uk	Academic Supervisor
Dr Samuel Assan	Lecturer in Public Health and Health Promotion	s.assan@rgu.ac.uk	Academic Supervisor
Mrs Gillian Sloan Donachy	Child Psychotherapist	gillian@hds.scot	Academic Supervisor

Appendix 3.3

Draft Interview Schedules Version 3. 21.04.2021

Interview Schedule 1: Incorporating Elements of the F.A.N.I Approach

Warm up, build trust, review consent for recording and participation. Answer any questions. Note to self: embrace subjectivity, start gently, they are the expert and need to feel comfortable and supported.	Thanks for coming today, acknowledge the new context, aiming to show that they are the expert and I'm here to learn from them about their experience.
What led you to have the parent work? Can you tell me how you came to think about having parent work? What was it like? Or how did you find it? Research suggests that the impact on parenting of having mental health diffs has been neglected… do you mind telling me about the nature of your own mental health challenges, do you have a diagnosis? This might be left until 2nd interview …depending on how relaxed and open the first one becomes.	Can you remember how you came to the service/when you first heard about the parent work? Tell me about what you remember, even if it is a while ago, anything at all that comes to mind?

Interview 2

This interview schedule remained flexible includes some suggested prompts to pick up on themes or narrative strands which could be raised after the transcript of the first interview has been reflected upon. What follows is therefore was a pre-drafted range of possible questions generated of as far as possible open questions which might generate memories, thoughts and feelings about the experience. These were then individually tailored to suit what feels most important or pertinent having reflected more on the outcome of first interview.

When did you come/how long have/did you come for parent work? Who came was it you or both parents or	Was it a long time ago, does it feel like ages ago or not long ago, did it feel like a lot/a little /too much too

carers? If this did not emerge in first interview.	little ?
What did you think it would be like coming for the parent work? How did you feel about starting?	Any thoughts or feelings before coming, worries/fears??
What expectations did you have if any? Was there anything that you hoped for from it?	Did you have any aims or goals in your mind?
How did it work out (generally) for you?	Might want to ask for thoughts about specific examples they could remember ?
How did coming to the parent work affect your relationship with your child/family members?	Again might want to ask for thoughts about specific examples they could remember ?
How do you feel that your mental health challenges were understood when coming to parent work?	Were these talked about too much too little? Ignored / listened to / taken account of.
Tell me about a particular session or experience you had while coming to parent work that stands out in memory or comes to mind?	Did it change the way you dealt with something or the way you parent ?
What do the rest of the family think about you seeing someone for the parent work?	
Did you experience any barriers or challenges in attending ?	
Is there anything that stays with you as a parent about the experience?	Could be a feeling, positive or negative, something learned, something learned but was it retained or did it feel after learning got lost / was forgotten about ? If they can't remember I could prompt, do they

	remember reflecting about anything ?
How did you feel about the work ending? After it had ended ?	Prompts : Pleased / relieved / worried / too much too little / satisfied?
Is there anything else at all you would like to say that hasn't been thought about?	What else?

Appendix 3.3 cont'd

Individualised Questions for interview 2 (participant A)

During the times that you had with (caseworker) back at the start, can you tell me what you talked about with her in relation to your granddaughter, at that time?

What did you understand about what was on offer in terms of carer support while your granddaughter attended child psychotherapy? (what did you think that would be like ?)

You mentioned that (name of original case worker) gave you books that helped you to speak to (x) about and help her with her anxiety attacks, can you tell me a bit more about that?

The last time we spoke you told me how (x) was running away on the way to her with (CP), was there anything in your sessions with the caseworker that helped you understand that ?

Can you tell me a bit more about what it was like when the work with (original worker) ended ?

What was it like starting with the new worker?

Did the times with either worker lead you to make any links between your daughter's mental health and your granddaughter's mental health?

You told me you can 'read' your granddaughter and know when her anxiety attacks are coming, can you tell me a bit more about how you think that happens or has developed?

Have your sessions changed your relationship with your child or with other family members?

Thinking back overall about to your sessions, do you think they have helped and if so how?

Do you feel as a grandmother caring for you granddaughter, that you can expect the same sort of help as if you were her mother,(does it make it any different ?)

What about help supporting her now she is a teenager? Do you feel you can ask for support with this from the worker now?

Does anything else stay with you about the experiences you have had with the Reach Out workers in their support of you with your grand-daughter ?

If you could wish for something to have been different what would it be ?

Individualised Questions interview 2 (participant B)

Can you tell me what stays with you about the experience of the parent work ?

You spoke before about not having much faith in services by the time you came and saw (parent worker)? I was wondering what that felt like starting with her?

Did you have any thoughts and feelings or fears before coming?

Do you experience any barriers or challenges in attending?

You mentioned you come in sometimes for sessions ? Has it been irregular or planned or how has it been set up?

You mentioned it being a struggle at first to get your daughter along to her sessions of Child Psychotherapy, was that something you talked about in sessions?

You talked before of there not being any answers about the difficulties you were having with your daughter and you had lots of questions about what was going on. Was that something you hoped for from this parent work and if so did it help with understanding?

Did coming to the parent work affect your relationship with your child? Or other family members?

You mentioned at one point your daughter had started going in to school three times a week, had the support work had any impact on that or helped in any way ?

You mentioned that the parent worker does things she says she will do, and that she's ' brilliant 'can you tell me more about that ?

(You talked about a feeling of having failed as a parent in the past, can you tell me a bit more about that and did the work have any impact on this?)

You mentioned changing the way you dealt with your children, is there anything that you had talked about in parent sessions that may have helped that comes to mind in relation to this ?

You mentioned the impact on your depression of the difficulties with your child, and the impact of difficulties with your child on your depression. Were you able to explore that vicious cycle understood when coming to these sessions?

(Were these talked about too much / too little / ignored / listened to / taken account of ?)

Can you tell me about any particular session or moment in the work with (parent worker) that stands out or comes to mind ?

You mentioned your daughter does not communicate and can shut down / get stressed and upset, has anything in the parent work helped with that ?

You mentioned worries for your daughter's future, has this been something you address in sessions ?

You mentioned some worries about passing on difficulties through the generations, can you say more about that and if it's something you have mentioned to parent worker ?

Is there anything else you'd like to say that hasn't been thought about ?

If you could wish for something to have been different what would it be ?

Individualised Questions interview 2 (participant C)

So this interview picks up where the last one left off and asks in more detail about the parent work with (x) ….

What did it feel like starting with (x) ? Did you have any thoughts and feelings or fears before coming?

You mentioned your son's period of not eating, is this something you been able to talk about this with (x)?

You talked about his seeing his 'imaginary friend', have you been able to talk about in sessions?

You mentioned worries for your son's future mental health, whether he'd be likely to imagine things in future, has this been something you address in sessions ?

You mentioned having high levels of anxiety yourself, have you been able to talk about the impact on you as a mother/parent of (s) that in sessions? (Have these issues been talked about too much / too little / taken account of ?)

You have described your son as missing his papa and the loss of him having a big impact on you both, do you/have you felt able to talk about the loss for you and your son with the parent worker?

Has coming to the parent work affect your relationship with your child? Or other family members?

Can you tell me about any particular session or moment in the work with (parent worker) that stands out or comes to mind ?

Is there anything else you'd like to say that hasn't been thought about ?

Have you experienced any barriers or challenges in attending?

If you could wish for something to have been different what would it be ?

Can you tell me what stays with you about the experience of the parent work ?