Returning: A mixed-methods study exploring the experience of child psychotherapists engaging in parent work following the parent's previous involvement with mental health services as a child or adolescent

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Abstract

Background and aims: Psychoanalytically informed parent work is central to supporting progress in child psychotherapy treatment. Although recognised by the professional body (ACP), and present in theoretical literature, the research base for parent work is limited.

This study aimed to investigate the frequency that child psychotherapists conduct parent work with parents who previously accessed professional mental health support as children or adolescents; and explore the lived experience of child psychotherapists engaging in this work.

Methodology: This study employed a mixed-methods design involving an ACP profession-wide audit. The audit results were analysed using descriptive statistics. Moreover, 4 child psychotherapists, with experience of working with parents who previously accessed mental health support as children or adolescents, engaged in semi-structured interviews about their lived experience. The interview data was analysed using IPA.

Findings: Only 3.2% of ACP members completed the audit, within this group, which is not representative of the whole membership, 84% reported experience of working with this parent population. The IPA analysis generated four group experiential themes (with sub-themes): **1.** Parent work environment: what it stirs up for the parent, **2.** The influence of past experiences of accessing mental health support as a child or adolescent into the parent worker – parent relationship, **3.** Working on trans-generational issues, across the family system and creating a support network, and **4.** When the past interferes: Ending parent work in light of parent's previous experiences of accessing mental health support as a child or adolescent.

Conclusions: While not generalisable the findings indicate that parent's past experiences of child and adolescent mental health services impacts on their engagement in parent work. The findings support existing literature emphasising the need for parent work; and importance of attentiveness to parent's previous experiences, and addressing intergenerational aspects within parent work. Clinical implications and suggestions for future research are given.

Table of Contents

List of Tables and Figures

Chapter 1: Introduction

This chapter explains how experiences during my training placement as a child and adolescent psychotherapist led to the development of my research questions. It provides an overview of the societal and research context in which the project is situated. The research aims, and an overview of the thesis structure summarising the remaining chapters will be provided.

1.1 Research purpose

Whilst training, two parents of children I saw therapeutically had previously accessed CAMHS themselves as adolescents. Both parents shared with their parent worker their stories of coming previously, and their preconceptions about returning to the clinic. Strong feelings were evoked when recalling their experience which affected their perceptions of the current service. I became curious to understand more about this experience of returning to the position of receiving professional mental health support, but now as a parent. These cases inspired my interest in the experience of child psychotherapists working with parents who were previous child mental health service users, and how this may assist or cause barriers to engagement in their child's treatment.

I was familiar with carrying out parent work from my previous experience as a speech and language therapist. Sensitivity was needed within this role when discussing children's communication difficulties with their parents, some of whom disclosed having had communication difficulties themselves as children. Some parents shared their stories about receiving speech and language therapy and expressed gratitude for the support offered; whilst others shared experiences of having to manage their difficulties alone when these had been overlooked. These experiences were sometimes painful for parents to recall, as their

communication difficulties had affected their future outcomes including their social relationships and academic success. This raised my curiosity in thinking about the perhaps more sensitive topic of parent's own mental health difficulties either current or in their past childhood, and their experiences of receiving mental health support or not. I was curious as to whether these previous experiences may lead to conscious or unconscious barriers to engagement in their child's therapy.

1.2 Context

According to the 2023 Mental Health of Children and Young People Survey report (NHS England, 2023); around one in five children and young people in England aged between 8 to 25 years old had a probable mental health disorder. Despite the prevalence remaining stable since a rise in recorded numbers from the 2017-2020, the continued high prevalence of mental health difficulties places increased pressure on child and adolescent mental health services (CAMHS) to provide effective and timely interventions.

Psychotherapy is a core therapeutic intervention offered by professional mental health services such as CAMHS (ACP, 2018). This typically involves direct therapeutic work with children or adolescents and/or work with their parent, guardian or carer. Work with parents has long been regarded by the profession as key to children's treatment, as it is recognised to be; 'essential to support those upon whom they depend if the professional intervention is to be successful' (Association of Child and Adolescent Psychotherapists (ACP, 2011).

Parent work has several purposes including supporting the care-giver to understand their child's difficulties and promote the child's emotional development (Rustin, 1998). Parent work may involve practical support for the child and wider network, communication about the child's therapy, supporting parental function and exploration of family relationships and the

parent's own childhood (Sutton and Hughes, 2005). There is consensus within the child psychotherapy profession that parent's engagement is central to children's therapeutic progress. As Novick and Novick's (2005) book title conveys; 'working with parents makes therapy work.'

Child psychotherapy remains behind other treatments offered in CAMHS in terms of evidence-based research; however this is growing. Although parent work's importance has been acknowledged and written about for several decades in theoretical literature, (e.g. Rustin, 1998, Tsiantis et al., 2000); empirical research regarding parent work as part of children's treatment has been somewhat neglected (Sutton and Hughes, 2005). This is beginning to shift with empirical studies evidencing support for parallel parent work alongside a child's therapy having better outcomes than when no parent work is provided, (e.g. Trowell et al., 2007).

Genetic inheritability of mental illnesses and the impact of environmental factors associated with parent's mental health on children's well-being and mental health has been well established through research (e.g. Polderman et. al. 2015 and Campbell et al. 2021). There is also significant amount of research evidencing experience of adverse childhood experiences (ACES) including living with someone with a mental illness impacting on later mental health (Rutter et. al. 1983). Research has shown that 50% of mental health difficulties are established before age 14 and 75% by age 24 (Kessler et al., 2007). Therefore the onset and establishment of a large proportion of mental health difficulties in adult parents started in childhood, as well as there being a strong link between parent's mental health difficulties and their child developing mental health difficulties.

Many studies demonstrate the importance of therapeutic alliance with parents in supporting children's progress, (e.g. Garland et. al. 2012, Stacey et. al. 2002). As well as impacting on children's development and future life outcomes, there is growing research regarding the impact of parent's mental health difficulties on parent's capacity to reflect on their child's emotional experience (Fonagy et. al. 1993), and ability to engage in their child's treatment (Stapley et. al. 2017). As the ACP notes; 'the task of any worker in CAMHS is to stop disturbance and damage being passed unmodified from one generation to the next,' a key factor in preventing this is how well a 'parent can reflect on a child's experience' (ACP, 2011, p.2). The need to provide effective treatments to children and their parents particularly parents with their own past or present mental health difficulties is clear.

1.3 Research Aims

1) To investigate:
    a) The frequency that child psychotherapists carry out parent work with parents who had previous mental health service-user involvement as a child or adolescent.
    b) The reasons parents accessed the above support, and the type of support the parent received when they were a child or adolescent.

2) To explore the lived experience of child psychotherapists engaging in psychoanalytically-informed parent work with parents who previously accessed mental health support when they were a child or adolescent.

3) To add to the growing body of empirical research regarding parent work carried out by psychoanalytic child and adolescent psychotherapists.

1.4 Overview of methodology

Interpretive Phenomenological Analysis (IPA) was the methodology chosen as this fitted with my curiosity to explore the lived experiences of child psychotherapists carrying out parent work. I was also aware this phenomenon may be coincidental to my placement period or localised to the particular deprived area I worked in. I therefore wanted to find out how frequently child psychotherapists across the discipline, working in different areas and for longer had come across parents who were mental health service-users themselves as children. I therefore adopted a mixed-method approach to implement an audit across the child psychotherapy discipline to investigate the prevalence of this phenomenon.

1.5 Rationale

As mentioned, parent work is a long-standing and large aspect of work undertaken in CAMHS. Therapeutic engagement is needed for successful treatment outcomes (O'Reilly and Parker, 2013). Parents who have their own previous experience of CAMHS are likely to bring preconceptions about the service which may affect their engagement. Gathering data about clinician's experience could provide insight into how to support engagement.

Anecdotal data was shared by parents on my placement who reported that things may have been different if they had engaged with CAMHS when younger, and noted similar difficulties to theirs in their child. Parents with a history of deprivation, neglect or abuse have been found to encounter problems at later stages of life, including psychiatric problems in their children and relational difficulties (Rutter et al. 1983). This proposed study may provide further insight into how to support families where trauma may be passed through generations.

Past studies have shown how psychoanalytically informed parent work can be helpful (e.g. Fitchie, 2023). However, the pool of research remains small and more research is indicated

(Holmes, 2018). This study will hopefully add to the growing body of research for psychoanalytically informed parent work.

1.6 Role of researcher

I was the sole researcher for the study and therefore carried out the data collection and analysis with supervision from my research supervisor at the Tavistock. This study was implemented as part of my training as a Child and Adolescent Psychotherapist at the Tavistock in conjunction with Essex University.

1.7 Researcher assumptions and conceptual framework

The psychoanalytic lens with which the data will be collected and analysed will hopefully enrich the understanding of both conscious and unconscious thoughts and feelings that arise in parent work with child psychotherapists. My clinical role as child psychotherapist and personal role as parent are noted as both these factors fuelled my interest in the project. They were also continually reflected on throughout the project in order to gain as in depth understanding and answer to my research questions whilst being aware of potential bias in order to stay grounded in the data.

1.8 Definitions of key terminology

For the purpose of this study the term ‘parent’ refers to biological parents (mother or father) who have parental responsibility for the child accessing professional mental health support. I will not be including foster carers or adoptive parents as this particular group of parents may require specific focus in a separate study. By child or adolescent I am focusing primarily on the typical age range seen in CAMHS and will use the World Health Organisation (WHO)

definition of children aged 0-19. Further details of inclusion and exclusion criteria for participants are detailed in the methods chapter.

1.9 Overview of thesis

The following chapter details the literature review carried out in relation to my research aims, as a starting point to gather what is currently known about parent work with parents who have previously accessed professional mental health support as children or adolescents. Chapter 3 outlines the chosen design, method and analysis of data which involved two stages: Firstly, a quantitative element involving an audit to all ACP members and secondly, a qualitative element involving semi-structured interviews with child psychotherapists about their experience. The fourth chapter details the findings from both parts of the project. This is followed by a more detailed discussion of the findings in chapter five in relation to current research and implications for clinical practise and further research.

Chapter 2: Literature Review

2.1 Overview

In thinking about my research aims, I attempted to find out what research currently exists that relates to the experiences of parents and clinicians engaging in parent work where parents had been mental health service-users as children or adolescents. A literature search was therefore the most appropriate method for answering this question and identifying relevant literature.

As my research question has several components, I separated my literature search into these components to enable me to gather a full picture of the existing research related to the topic before synthesising the results.

2.2 Literature search aims

I aimed to answer the following questions:

1. What research exists that looks at child psychotherapist's experience of carrying out parent work and what was found?
2. What research exists regarding parent's experiences of engaging in psychoanalytically informed parent work and what was found?
3. Does any research exist looking specifically at the experience of work with parents who have previously accessed professional mental health support when they were a child or adolescent, from either the parent or child psychotherapist's perspective, and if so what was found?
4. What research exists regarding parent's experiences and engagement with child mental health services in general?
5. What research exists regarding the relationship between parent's mental health difficulties and their child's mental health?

Questions 1-3 were the main aims of the literature review with questions 4 and 5 being secondary aims. Given the size of the project it was not possible to provide an exhaustive account of the literature for questions 4 and 5. However, given the multifaceted nature of my research question it was considered important to give an overview of these additional areas which relate to my research aims.

I'll begin by detailing my literature search process so the search strategy is replicable. Following this I'll summarise the findings from selected papers to help in answering the above questions. The gaps in literature where there is either none or limited research will be illuminated. Finally, I'll gather the findings from the different literature searches together and outline the conclusions drawn and implications for further research.

2.3 Search strategy

With the above literature search aims in mind, I carried out three separate searches using the PICOS checklist to help formulate clear search questions. The first two search aims above were combined when searching the database as the key words using the PICOS checklist for each question overlapped. Separate searches were then made for search questions 4 and 5 as these have a different focus. The third aim of my literature search, regarding the existence of research looking at the experience of parent work with parents who have previously accessed mental health services as a child or adolescent, was investigated across all three of the searches. The steps of my literature searches are detailed below.

Step 1: Identifying concept words and their synonyms

Firstly, concept words were identified for each of the search questions. In order to ensure my concept words were understood by the database and to capture as many studies as possible I

generated a list of synonyms for the key words, using the APA thesaurus on *Psych INFO* to help yield all possible alternatives, (see table below).

Psychotherapy	**Parent work**	**Experience**	**Service-user**
"Play therapy"	"Parenting skills"	"Treatment process and outcome measures"	"Child guidance clinic*"
	"Parent child relation*"		"Mental health service*"
Psychotherap*	"Parent training"	"Therapeutic alliance"	"CAMHS"
Psychoana*	Parent*	"Psychotherapeutic processes"	
Psychodynamic		"Client participation"	
		"Treatment compliance"	
		evaluation	
		"Self-report"	
		engagement	

Step 2: Truncation techniques

I carried out separate searches for each of the four key words (with their synonyms) as detailed in the table above. I employed different truncation techniques with the synonyms to broaden my search. I used the asterix (*) with the root words to include articles containing alternative word endings. I also used speech marks for key phrases, e.g. "therapeutic alliance" so this would be searched as a whole phrase, as without the speech marks the search the concept words may have been too broad and generated too many irrelevant results.

Step 3: Choosing a database

To identify literature relevant to my study a systematic literature search was then completed using the following databases: Psych Info, Pep Archive, PsyArticles, and the University of Essex database. I chose *Psych INFO* initially for my search because it is the most comprehensive database for psychology and related disciplines and therefore should find a wide a range studies. *Psych INFO* also includes limiters like age group that are not found on *Pep Archive.* To broaden my search of psychoanalytic journals I used *Pep Archive.* Lastly I searched *Psych Articles and* but few additional studies were found.

Step 4: Searching by concept

Firstly, I did one search for each of the three concept words: psychotherapy, parent work and experience (with all of their alternatives) as listed in the columns above using the Boolean operator 'or' to capture the maximum number of results possible for the concepts. I searched by subject for each concept word to keep the search relevant to the topic, as using an open search generated many irrelevant results.

Step 5: Combining the search

I then combined the first three separate searches using the Boolean operator 'and' to find all the studies that related to psychotherapy, parent work and experience/treatment outcome and process. As this generated over 1,000 papers, I used limiters to find a reasonable number of papers to review.

Step 6: Applying limiters

The first limiter applied was for articles where the full text was available to review. I then narrowed the search to include papers written in English and only peer-reviewed papers for quality assurance. These are both issues to consider when reflecting on the conclusions of my literature search as my results are likely to exclude studies carried out by researchers in other languages. Having access to interpreting services would be useful in order to capture a greater range of studies. I also limited the search by age to exclude adult studies and link to the specific population of children and adolescents up to age 19. I then refined by search classification to studies looking specifically at psychotherapy and psychoanalytic therapy.

Step 7: Separate search combination

In order to answer the fourth search aim, I then completed a separate search combining the third and fourth columns with the key word 'parent*' to search for articles relating to parent's engagement and experience of child mental health services. I then applied limiters to exclude inpatient and social care settings as my research focus is on child mental health services in the community.

Step 8: Additional search combination

In order to answer the fifth search aim, I completed a new combined search to look for studies regarding the relationship between children's mental health and their parent's mental health using the concept words in the table below:

Parent	**Child**	**Mental health**	**Impact**
Parent*	Child*	"Mental health"	Relationship
	Adolescent	"mental well-being"	Intergenerational
	Infant	"psychological health"	Link
	baby		Correlation
			trauma
			connection
			transgenerational

Four separate searches were made for each concept words and their synonyms and then the four searches were combined using the 'AND' function. Limiters were then applied including full text, studies written English and narrowing by subject to include mental health and attachment related studies to narrow the results and help in answering the literature search question.

Step 9: Ancillary search

Further articles were also searched for using manual searching of reference lists from key papers, and key word searching of the child Psychotherapy Journal and Tavistock and Portman e-library.

Step 10: Selecting articles to review

Articles were selected from the database searches based on their relevance to the search questions. As mentioned above, questions 1-3 were the main focus for the literature search, the findings of which are detailed below.

In addition to the above, a selection of key literature found in response to search questions 4 and 5 is also summarised in the findings below for added breadth to the current existing literature base relating to my research topic.

Literature review findings

2.4 Child psychotherapist's experience of engaging in parent work

The literature search generated very few studies which explored child psychotherapist's experiences of carrying out parent work. This does not reflect the general consensus amongst child and adolescent psychotherapists that parent work is central to children's therapeutic intervention, (e.g. Rustin, 2009; Sutton & Hughes, 2005). The evidence base for child psychotherapy is growing; however, the evidence base for parent work remains small (Trowell, et. al. 2007, Holmes, 2018; Midgley et. al., 2021). I will therefore give a background of the historical context and development of the aims and method of psychoanalytically informed parent work, before presenting my findings from the literature search in regards to experiences of parent work.

2.4.1 Historical context

Following the psychoanalytic approach to therapy discovered by Freud, Melanie Klein was the first psychoanalytic psychotherapist to apply this method to children. Klein starting seeing child patients in 1919 at her home in Berlin and the cases were written about in her first major book; 'The Psychoanalysis of Children,' (1932). Klein developed the object-relations school of thought where work focused solely on the child and their unconscious processes, involving the internal parental figures in the child's mind. With the internal world being Klein's focus, she did not see parents for regular parent work. However, Klein acknowledged parent's important role in supporting their child's mental health and progress. Klein therefore made

contact with parents through letters, phone calls and some meetings as Sherwin-White points out in her book ‘Melanie Klein revisited’ (Sherwin-White, 2017).

The first form of regular parent work occurred as part of the child guidance clinics originally set-up in the 1920s. Early child psychotherapists within the clinics often worked closely with and relied on experienced psychiatric social workers to carry out parent work while the child psychotherapist worked with the child (Harris, 1968). Following the shift towards family therapy as the focus intervention of social workers in the 1960s and 1970s and the reduction of funding for psychiatric social workers, child psychotherapists had to find new ways of supporting parents as part of children’s therapy (Rustin, 1998).

Anna Freud, having developed a different theoretical approach to child psychotherapy to Klein, placed emphasis on direct work with parents being part of the child’s treatment. Anna Freud would only see children for analysis if their parent was also in analysis (Gvion & Bar, 2014). As theory and practise of child psychotherapy grew, with contributions from key thinkers including Donald Winnicott, Erna Furman and Selma Fraiberg, greater emphasis was placed on the importance of parallel parent work (Horne, 2000). Single case studies exist of parent work from the 1960s and 1970s but not much empirical research occurred. The effectiveness of parent work gathered from these single case studies is therefore more suggestive than empirically based.

It has since become more common practise to offer parent work alongside a child’s psychotherapy treatment. Some evidence even exists that suggests it is counter-productive to not offer parent work alongside a child’s psychotherapy (Szapocznik et al., 1989). Key to supporting the child is supporting their care-giver to understand their child thus promoting the child’s emotional development (Rustin, 1998). Rustin (1998) outlines four broad categories of

parent work. These are; to support and sustain the child's individual psychotherapy, to support parental functioning where parents have difficulty understanding their child's behaviour and relationships (this could involve parent-child work), work to change family functioning , and at the other end of the scale where the parent is being seen individually for their own therapy.

2.4.2 Method and aims of psychoanalytically informed parent work

There is some variation amongst psychoanalytic literature on the aims and method of carrying out psychoanalytically informed parent work. Sutton and Hughes (2005) identified five distinct areas of parent work; practical support regarding the child's therapy and wider network, communication about the child's therapy, supporting parental function, exploration of family relationships and of parent's childhoods.

Margaret Rustin (1998) drew attention to the contribution that a psychoanalytic perspective brings to parent work, in particular using transference and countertransference phenomena. She notes the special capacities of child psychotherapists given their training in detailed infant observation and child development (Rustin, 2009). This enables child psychotherapists to understand the changing demands on parents as children grow and develop and 'the intensity with which parent's own infantile difficulties are stirred up by their children's emotional lives,' (p. 218, Rustin, 2009). Rustin (2009) highlights how this knowledge and sensitivity can help in responding to parent's anxieties about their children. Green (2000) highlights how the child in the parent's narrative is a complex picture of reality and the parent's own internal history, and needs space to be understood. A core element of psychotherapeutic work, including parent work, is 'establishing and maintaining a reliable setting … sessions for parents have regularity in time and space, and this helps contain the infantile elements aroused' (Rustin, 2009, p. 213). The ability to attend to both the parental and child

perspectives is valuable in empathising with parents and making sense of children's struggles in order to progress in treatment.

Holmes (2018) carried out a qualitative survey looking at parent work aims by the child psychotherapy team in one CAMHS clinic over a year. Holmes looked specifically at parent work carried out alongside the child's treatment. Thematic analysis of the data found the main aims of parent work to be: increasing empathy with the child; decreasing enmeshment; and containing anxiety. However, Holmes concluded that the pool of research around parent work remains small and more research is indicated.

2.4.3 The experience of child psychotherapists engaging in parent work

The research base is growing for child psychotherapist's work with different types of patients; however, there is still limited empirical research into parent work and in particular the lived experience of child psychotherapists carrying out parent work.

My literature search generated approximately 10 studies relating to the experience of child psychotherapists carrying out parent work. However, the majority of these papers tended to be theoretical or technical papers involving case studies rather than empirical studies. I will therefore focus here on two particular studies which related most to my research question. The first is a technical paper including case studies by Trudy Klauber, a prominent child psychotherapist in field of parent work, and the second is a more recent study involving empirical methods.

Klauber (1998) wrote a paper including case studies about the experience of working with two parents of children with severe difficulties who may be psychotic or autistic. The first case was of a mother of a four year old who was anxious and controlling and the second of parents of a five year old with autism. Klauber highlights the importance of sensitivity when

working with parents of children with severe difficulties, and need for clinicians to be aware of parent work potentially re-traumatising parents rather than feeling supportive. Klauber highlights the need to understand post-traumatic stress phenomena when working with parents who are hyper-vigilant and feel easily persecuted. Klauber highlights the need for long-term work with parents to build trust. Parent work can include giving support and advice around specific difficulties as well as understanding how the parent's history may be projected onto their child.

This paper is a retrospective study focusing on reflecting and learning from past experience to help inform technical approaches implemented in parent work. It is therefore limited in terms of not involving the systematic process of an empirical study and is also written by the clinician carrying out the parent work so limited to the subjective view of the author. However, it does help answer the research question in providing insight into the nature of the experience of child psychotherapists carrying out parent work, particularly with parents of severely disturbed children and the difficulties encountered and highlights the need to build trust in order for the sensitive work with parents to be effective.

A more recent qualitative study by Fjeldheim et al. (2024), involved interviews with child psychotherapists at a CAMHS clinic in Norway about their experiences of perinatal psychotherapy. Through thematic analysis of the interviews, one overarching theme was identified: 'to maintain a reflective therapeutic capacity' with two sub-themes. They concluded that maintaining a reflexive stance in work with parents is key but challenging. The vehicle for change was a safe enough therapeutic alliance for the parent to explore new ways of being, in contrast to past traumatic experiences. The study has the strength of being an empirical study, therefore applying rigour through the systematic research process from recruitment through to the analysis of the results. The theme identified of forming a safe

enough therapeutic alliance complements the findings from Klauber (1998) who highlights the need for building trust in work with parents. However, the sample size is still limited encompassing 7 clinicians from one CAMHS clinic and therefore makes it difficult to generalise the findings to other settings. Fjeldheim et al. (2024) focused on parent-infant psychotherapy and therefore captures parents and their children in the early stages of life. Further research is therefore indicated to explore if the themes of reflectiveness and focusing on addressing generational adversities apply to work with parents at later stages in children's development.

Three recent doctoral studies were found through the database searches which have explored parent work from the perspective of child and adolescent psychotherapists. These are outlined below:

Boyd (2020) explored the nature and function of psychoanalytic parent work with adoptive parents. Boyd interviewed four child psychotherapists working in a fostering, adoption and kinship care specialist service about their experience. Interviews were analysed using IPA and seven superordinate themes were found which conveyed the complexity of this work and dilemmas encountered. These included helping the parent to talk about the pain and trauma of children's past. It also included forming an alliance with parents to enable them to be open and reflect on their own childhood and reasons for adoption. Parallels were found between the interview findings and existing psychoanalytic theory and practise in working in this specialist area and pointed to the need for specialist training and sensitivity when working with adoptive parents. This empirical study supports the findings of Fjeldheim et al. (2024) around the importance of forming a therapeutic alliance with parents. The study also helps answer the research question in exploring the experience of work with parents and the need to take into account parent's own childhood experiences.

Ledger (2024) interviewed four child psychotherapists about their difficult encounters in psychoanalytic parent work with the aim of understanding more about the nature of this often difficult work. Ledger found that difficult encounters parent workers experienced were often associated with being put in the position of something threatening. This was associated with Klein's concept of the 'bad object' and Bion's concept of 'nameless dread' which led to parent work becoming stuck and parents struggled to go on thinking in the work as a way of avoiding mental pain. Ledger discussed the concept of vicarious trauma in the professional network and can lead clinicians to struggle to share their work for fear of feeling exposed. Ledger's study has the strength of providing empirical evidence of the difficult nature of parent work and pointed to the potential need for further training around parent work.

Ward (2024) focused on the particular experience of trainee child psychotherapists and challenges faced in carrying out parent work whilst the child is receiving psychoanalytic psychotherapy. Ward interviewed eight trainee child psychotherapists using semi-structured interviews about their experience. Ward found variation in what trainees understood the nature and main focus of psychoanalytic parent work to be. Ward found that difficulties with the therapeutic alliance can arise when there is not an early agreement with parents about the aims of the work which can lead to parent's disengagement. The study also found that limited parent-work opportunities on placement due to limited resources led trainees to feel less empowered in carrying out effective parent work.

2.5 Parents' experiences of parent work with a child and adolescent psychotherapist

As mentioned above, the majority of clinical case studies written by child psychotherapists form the majority of research regarding parent work. Parent's accounts of their experiences

are virtually absent (Rayner, et. al., 2011). My literature search found only three qualitative studies that explored the experience of parent's engaging in parent work for their child which are summarised here.

Stapley et. al. (2017) explored parent's experience of parent work for 28 parents of depressed adolescents through interviews at three time points over a two-year period. The aim was to find out how parents manage adolescent's symptoms at home and how parent's viewed their CAMHS treatment. Their findings reported three types of experience; 'learning curve parents' who found parent work life-changing in adopting a new way of viewing their child; 'find my own solution parents,' who were initially receptive to parent work but then decided to find their own way of managing their child's difficulties; and 'stuck parents,' who valued the idea of help but did not find CAMHS helpful. Stapley et al. (2017) noted that the last category of 'stuck' parents may include parents with their own mental health difficulties, which become a barrier to receiving and using help. This study has the strength of being longitudinal and therefore helped identify broad categories for the ways parents may approach parent work across different time points over the course of treatment. However, it is limited as by broadly categorising parents it therefore misses out the nuances of parent's lived experience of parent work that may have been gathered in the interviews.

Nunez et. al. (2021) studied parents' experience of the therapeutic relationship as part of a triad consisting of; parent, therapist and child in 12 parent, child and therapist triads where the child was aged between 6-10 years old. In three of these triads the children were engaged in psychoanalytic psychotherapy while the parent attended parallel parent work. The children in the other triads were engaged in systematic and cognitive constructivist therapies. Using grounded theory methodology they concluded that a positive and trusting therapeutic relationship in all 12 triads was experienced as a gradual process, facilitated by positive

emotional exchanges between the three parties and collaboration from parents. Parent's positive collaboration fostered the child's motivation and change to occur in therapy. This study included parent's experiences of parent work, however, the results are limited in terms of its specific link to parent work for child psychotherapy as this only made up three of the parents in the study. Also, the main focus of the study was on the therapeutic relationship and less on parent's own experience which remains less explored.

The third and final study found was a recent IPA study by Fitchie (2023) investigated the theme of 'waiting' as a key element of parent work. Fitchie (2023) interviewed five parents who were engaged in psychoanalytically informed parent work about their lived experience. Through IPA Fitchie identified the following three main themes; ambivalence, containment and temporality. Fitchie went on to develop a theoretical model for the experience of time and waiting in parent work based on these themes. Fitchie describes how parents were often ambivalent about engaging in parent work. However, through the parent's experience of being 'waited with' by the parent worker developed a sense of relief, feeling understood and less alone with their child's difficulties. Through this process the parents were then able to experience time differently which was linked to their increased capacity to wait with their child. Fitchie concludes that parent's feeling 'held in mind' helped increase parent's capacity to wait which is subsequently linked with increased capacity to support their child's development. Although the results are not generalisable due to the small sample size, the study supported literature regarding the importance of parent work and its transformative process. This study interviewed parents about their experiences of parent work and gives their perspective of feeling 'waited with' by their parent worker, however it leaves the question open as to what the nature of the experience of the parent worker is like during this work.

2.6 Experience of parent work with parents who have previously accessed mental health support when they were a child or adolescent

The literature search did not generate any results for research studies regarding parent work with parents who previously accessed mental health services when they were a child or adolescent, from either the parent or child psychotherapist's perspective. The literature search therefore identified this as a specific gap in the research field regarding parent work for child psychotherapy.

2.7 Research regarding parents' experiences of and engagement with child and adolescent mental health services

The majority of studies that the search generated focused on CAMHS; this being the main mental health setting that parent's access for support as part of the National Health Service (NHS). No studies were found in the database search that looked at alternative child mental health settings, e.g. school counselling, charities or private therapy.

2.7.1 Parent's experience of child mental health services

The majority of studies gathered data about parent's experiences about a specific treatment, rather than parent's experience in general of accessing a child and adolescent mental health setting. Only a few studies were generated by the literature search, but only one based in the UK which was carried out by Bone et al. in 2014.

Bone et al. (2014) aimed to address the gap in research and increase the evidence base of parent and child perceptions and experiences of CAMHS. They carried out semi-structured interviews with 11 children (9 boys and 2 girls) and their parents, (12 mothers and 2 fathers) who had been referred to CAMHS. The mental health difficulties of the children included; 5

children with emotional difficulties such as generalised anxiety, 4 with behavioural difficulties and 2 with neurodevelopmental difficulties, one also had attachment difficulties. Through a thematic analysis of the interview data three core themes emerged; 'fear of the unknown,' - which referred to apprehension and uncertainty as to what happens in CAMHS - 'therapeutic engagement' - which refers to the importance of being listened to and building a good relationship with professionals - and thirdly 'making services acceptable' - which included making services more accessible and child-centred. Bone et al. (2014) highlighted the importance, especially where there are limited resources, of hearing about experiences and noted how parents and children felt empowered when listened to. It is not known if any of these parents' were themselves previous CAMHS patients.

2.7.2 Therapeutic alliance

Other studies the literature search generated were not UK based and therefore not directly related to CAMHS or other child and adolescent mental health services offered by professionals working in the UK. However, these studies gave some insights into parent's engagement with child mental health services that could be relevant to work in the UK. The theme of 'therapeutic engagement' mentioned by Bone et al. appears in several studies looking at different aspects of this relationship. Garland (2012) carried out a quantitative study in San Diego looking at the effects of different aspects of the therapist's treatment practises on 181 parent's attendance across six publically funded community based mental health care settings. The study highlighted the importance of parent's alliance with the therapist as one aspect that affected attendance.

Accurso and Garland (2015) carried out a later study where 209 children with disruptive behavioural problems and their primary caregivers were followed up to 16 months after

starting psychotherapy at community-based clinics in San Diego County. Therapeutic alliance was rated by children, caregivers and therapists every 4 months for the length of the treatment. Several predictors of alliance emerged which were; child gender, anxiety diagnosis, caregiver race/ethnicity and therapist's clinical experience. An additional nine child-parent dyads were not included in the sample due to non-attendance. It is unknown why the parents and children disengaged and whether this is directly related to difficulties in the therapeutic relationship and alliance which requires further exploration.

Stacey et al. (2002) through a qualitative research project explored the relationship between change and parent's satisfaction ratings of child and adolescent mental health services in Australia. This was part of a larger consumer satisfaction and outcomes project involving quantitative and qualitative methods. Stacey et al. interviewed 110 parents through telephone structured interviews 12 months after attending the service to gain a richer understanding about the parent's experience. They developed grounded theories from the interview data about what constitutes parent's satisfaction. Statistical correlations found as expected that high satisfaction correlated with significant changes made during their child's treatment and 'no change' correlated with 'little satisfaction. Stacey et al. concluded that there is a range of issues that lead to satisfaction and flexible service delivery is indicated to enhance service-user satisfaction including listening to individual's experience of therapy as part of the therapeutic process.

One study carried out by Kerkorian et al. (2006) in an urban area of Denmark looked at the relationship between parent's past experiences of obtaining mental health care for their child and perceptions of returning to access support a second time. This links to my research question about returning to a child mental health service setting. However, the focus here was on parents who were returning after already accessing support for their child. Similar to other

studies mentioned it is unknown if these parents had accessed child mental health services for themselves in the past. Treatment outcome and aspects of parent's relationship with previous providers had an impact on how they perceived treatment a second time. This study highlights the need to keep in mind if a parent has attended a child mental health service before as this could impact on how they perceive and engage with the service upon returning.

My database search did not find any research studies that looked at the number or experience of parents who attend CAMHS for their child having been previous service-users as children or adolescents themselves. Therefore this category of parents and their experience of returning remains a gap in the literature as does the experience of clinicians working with this group of parents.

2.8 The impact of parental mental health on their child's mental health

My research aims to explore the experience of working with parents who are accessing professional mental health support for their child after previously accessing professional mental health support for themselves as a child. I was therefore curious about what research exists that studied the relationship between parents and their child's mental health. In particular, I wanted to find out what literature exists regarding the ways in which mental health difficulties of parents may impact on the next generation, (i.e. their children) in both obvious ways and perhaps more unconsciously through interactions between parents and their children. Therefore, I carried out a final separate literature search to find out what research exists in this area as outlined in my search strategy.

Many studies were found which identified parental mental illness to be a big risk factor affecting not only children's well-being but also increased the possibility of the child

developing a mental illness. The mechanisms underlying this relationship have been linked with both genetic and environmental factors. The results of my literature search into these different factors are summarised below.

2.8.1 Genetics factors

Polderman et al. (2015) carried out a meta-analysis on the heritability of human traits by looking at fifty years of twin studies. Polderman et al. found heritability to account for the child's mental illness in 40-80% of cases depending on the type of mental illness. Campbell et al. (2021) cite multiple studies which found parental mental illness to be one of the major risk factors in children developing a mental illness for; anxiety, depression, bipolar disorder, borderline personality disorder and schizophrenia. There is therefore strong evidence for the genetic inheritability of mental illness for a range of conditions.

2.8.2 Environmental factors

Although genetics is a strong indicator of children developing mental health difficulties, multiple studies have also explored how parent's mental illness can be passed on to their children through the environment. Environmental factors take various forms, such as through the impact of parent's mental illness on their parenting capacity, exposure to trauma related to the parent's mental health symptoms, or through inadequate care which may involve abuse or neglect as a consequence of the impact of the parent's mental illness on their parenting.

A large proportion of people diagnosed with mental illnesses are also parents, therefore the numbers of children with mentally unwell parents who are therefore at risk in terms of their mental health and well-being is high. For example, it is estimated that around 62% of women and 55% of men with psychosis are parents (Nicholson et al., 2004). Wolfendon et al. (2022)

noted the demands of managing parenting and poor mental health and the impact of this stress on the outcomes for parents and children.

A better studied area is the impact of maternal depression on parent's relationship and attachment to their infant and subsequent child development. For example, Mennen et. al. (2015) studied the impact of maternal depression on young primarily Latino children in the US (aged 0-5) accessing a mental health treatment programme for children at risk of needing welfare system support. Mennen et. al. found that children with depressed mothers had higher levels of behavioural problems and poorer development. All children made progress during the treatment, but those with depressed mothers made slower progress.

Vanska et al. (2017) highlighted that the majority of research has focused on maternal mental health and aimed to study further the impact of both maternal and paternal mental health on predicting children's mental health and development. Vanska et al. carried out a study in Finland with a large sample of 763 mothers and fathers, (half who had conceived through assisted reproductive treatments). They measured self-reported psychological distress and depression at different intervals from pregnancy to when the child was age 7-8. A large proportion of parents (485) reported the child's internalising and externalising symptoms and social and cognitive difficulties. They concluded that pre and postnatal mental health of mothers and fathers is important for the child's later development.

In summary, there is a fairly large research base for both genetic and environmental factors associated with parental mental ill health having an impact on children's mental health.

2.8.3 Presence of mental illness amongst parents attending CAMHS

Given the genetic and environmental influences of parent's mental health difficulties impacting on their child developing a mental health difficulty, it is reasonable to assume that

parents who bring their children to access mental health support are likely to have a mental health difficulty themselves. This is consistent with the findings of research studies, as Campbell et al. (2021) conclude in their review of the research literature. Campbell et al. (2021) carried out a literature review of English language peer-reviewed studies that investigated the mental health of parents accessing CAMHS. Campbell et al. found 18 studies that used different methodologies to assess parental mental health. The results from the studies varied in terms of the number of parents who were found to have mental health difficulties ranging from 16% to 79%.

Campbell et al. (2021) also found that parent's and child's mental illnesses were associated with additional adversities affecting the family which is consistent with the studies mentioned above. Campbell et al. concluded that it is a frequent occurrence for children who attend CAMHS to have a parent who also has a mental illness. Therefore, parental mental health should be an important factor to consider when offering treatment to the child, which could affect their recovery trajectory. This review focused on current parental mental health difficulties and not on whether the mental health difficulties were present when the parent was a child and continued into adulthood and parenthood.

2.8.4 Intergenerational impact of Adverse childhood experiences (ACES) on mental health

Other situational factors aside from the biological determinants or environmental impacts of parents mental health exist which can lead to both parental and child mental illness. This covers a wide range of sources including; being a refugee, homelessness, poverty, incarceration of parents, bereavement and domestic violence. The link between adverse childhood experiences (ACES) and subsequent mental health difficulties, is well established by research. Parents with their own history of deprivation, neglect or abuse have been found

to encounter problems later in life, including psychiatric problems in their own children and relationship problems with family members (Rutter et al. 1983).

Research has also grown regarding the intergenerational link between the impact of caregiver's history of childhood ACES and trauma on their child's psychosocial outcomes (Hughes, et. al. 2017). For example, Bodeker et al. (2019) studied the impact of maternal early life maltreatment and maternal history of depression on offspring's mental health. Murphy et al. (2018) also found that adults who had a parent with a mental health illness were more anxious in their parenting as adults. The intergenerational link present in different populations and ethnic groups is also emerging. For example, Leslie, Walsh and Sullivan (2023) studied the relationship between caregiver's exposure to ACES and their child's depression and PTSD symptoms amongst an African-American urban population in three under-resourced urban communities in south-eastern US. Caregiver ACES were found to be significantly associated with their child's PTSD symptoms but not depression. They concluded that the distinct intergenerational consequences of caregivers with ACES on their child's psychosocial wellbeing warranted further study.

2.8.5 Neuroscientific research - Trauma passed through from parent to child

In a recent neuroscientific study, Uy et al. (2023) used a prospective longitudinal design to look at the impact of early maternal childhood trauma (abuse and neglect) and maternal prenatal and postnatal mental health (anxiety and depression) on children's frontoamygdala functional connectivity at 6 years old and emotional health at 7-8 years old as measured by parent and child self-reports. Uy et al. found that greater maternal neglect was associated with higher maternal anxiety and depression. Worse maternal postnatal mental health was associated with more negative child frontoamygdala functional connectivity. This study

provides neuroscientific evidence for the existence of intergenerational influences of parental childhood exposure to trauma on childhood risk in the next generation of developing a mental illness.

Uy's neuroscientific study seems to support earlier psychoanalytic theory, (e.g. Fraiberg et al. (1975), Kestenberg, 1982) that suggested parent's experience of trauma in childhood may be passed in unconscious ways to the next generation, and locates where the impact of trauma in the brain. For example, Fraiberg et al. (1975) highlighted how parents conflicted past can impact on their relationship with their child and lead to a repetition of past relational patterns in the present. It is therefore likely that many parents who experienced mental health difficulties as children or adolescents due to trauma may return to CAMHS for support with their child. This supports Campbell's (2021) review study mentioned above which identified that a large number of parents attending CAMHS had a mental health difficulty. Further studies are needed to explore the prevalence of intergenerational trauma as the reason for children attending CAMHS.

2.8.6 Impact of intergenerational trauma on attachment and mentalisation

Fonagy et al. (1993) carried out an empirical study to measure the 'ghost's in the nursery's (Fraiberg, 1975) experience through looking at the relationship between mental representations of parents' childhood experiences and their internal objects and their infant's security and attachment. Fonagy et al. (1993) used the Adult Attachment Interview and strange situation test with 100 prospective mothers and fathers. They found security of infant's attachment to care-givers at 12 and 18 months could be predicted based on parents accounts of their own childhoods collected before the child's birth. This study confirmed Fraiberg's observations of parent's childhood conflicts re-emerging when they have children.

One mechanism for this is in how accurately parents make mental representations of their infant's internal world. If a parent's own attachment as an infant to their parent was poor their ability to accurately reflect on their infant's mental world was diminished.

Barrows (2004) presented a case example highlighting how 'ghosts' (using Fraiberg's term) in the father's history can also impact on the relationship between the parents that the child is born into. Barrows attempts to address the balance in research that had primarily focused on the mother's history and mother-baby dyad and help maximise therapeutic impact by paying attention to this.

Over the last few decades interventions to support parent-child attachment and enhance parent's ability to mentalise with their child has grown, as has the development of parent-infant psychotherapy. Fonagy, Sleed and Baradon (2016) commented on the now strong evidence base for psychoanalytic parent-infant psychotherapy (PIP), thus supporting the impact of early intervention. The focus of this work is on building a solid foundation for good mental health outcomes for developing infants. Fonagy, Sleed and Baradon carried out a randomised control trial to investigate the outcome of PIP for parents experiencing mental health difficulties as well as high levels of social adversity. They found favourable outcomes for maternal mental health, parenting stress and parental representations of their baby and relationship with PIP compared to the control group. This research points to the positive impact of early intervention with parents, in supporting accurate interpretations of their child's internal world, which as result help support the child's attachment. My literature search did not generate many results exploring the effects of parent work carried out by child psychotherapists with older children; therefore this gap in research requires addressing.

2.9 Summary – what has been learnt so far?

The research base for parent work carried out by child psychotherapists has been small since this type of work began around the 1960s. Research into the lived experience of child psychotherapists and parents engaging in parent work remains limited, although the field is growing. No studies were found in the literature search that explored parents or child psychotherapists' experiences of engaging in parent work following the parent's previous experience as a mental health service-user themselves as a child or adolescent.

The research evidence interlinking parental and child mental health is strong. My literature search found studies covering the various ways in which parent's mental health difficulties and adverse life experiences can lead to their child developing a mental health difficulty. These include genetic, environmental and unconscious factors. In particular, research is growing that focuses on the transmission of intergenerational trauma and its impact on children and parent's ability to accurately empathise with their child, thereby impacting their child's attachment and mental health.

Some empirical studies found high numbers of parents who bring their children to seek mental health support also have a mental health difficulty themselves. The strong research base regarding the relationship between parent and child mental health also suggests that many parents bringing their child for mental health support, (who may be engaging in parent work) are likely to have experienced mental health difficulties themselves as children. These parents may or may not have accessed professional child mental health services or support for themselves as children. The experience of carrying out parent work with this group of parents who may have received mental health support as children and how this may impact on the parent's engagement in the work remains unknown.

2.10 Current study

This study aims to combine the aspects of; parent work, experience of professional child mental health services/support and mental health difficulties passed through families. I hope this study will add to the growing body of research regarding parent work carried out by child psychotherapists and in particular the lived experience of these child psychotherapists.

Not much is known about the frequency or experience of work with parents returning to child mental health services following previous service-users involvement themselves as children or adolescents. The literature review indicates the need to see how frequently child and adolescent psychotherapists encounter parents returning to a mental health service for psychotherapy for their child having been themselves a service-user as a child or adolescent.

This study, therefore, aims not only to add to the growing body of research regarding psychoanalytically informed parent work carried out by child psychotherapists, but also to address the particular gap in research regarding work with parents who had mental health difficulties as a child and were previous child mental health service users themselves; it aims to explore how this may impact on parent's engagement in psychoanalytically informed parent work for their child.

Chapter 3: Methodology

3.1 Overview

In this chapter I aim to outline the methodology for this study and explain the rationale for the chosen approach in addressing the research aims set out in the introduction and further outlined in the section below.

I will begin by discussing the underlying epistemological position and ontological stance for my research. I will then discuss possible alternative approaches before presenting the chosen methodology taking into account the theoretical underpinnings, rationale for this approach and its limitations. The procedures for participant recruitment, data collection and analysis will be outlined along with a discussion of associated ethical considerations for the study. I will end with a discussion of the validity and quality of the study.

3.2 Research aims

The purpose of this research study is to explore the experiences of child and adolescent psychotherapists carrying out parent work with parents who had previously accessed mental health treatment when they were a child or adolescent.

The aim is to gather quantitative information about the frequency in which child and adolescent psychotherapists work with parents who have previously accessed mental health services as a child or adolescent through a profession wide audit in the UK. Moreover, I aim to reach a deep understanding of the nature of the lived experience of child and adolescent psychotherapists when encountering these parents in their clinical work by interviewing a small sample of professionals through semi-structured interviews following the Interpretative Phenomenological Analysis (IPA) method (Smith, Flowers & Larkin, 2022).

The main areas to be explored are:

1) The frequency in which child psychotherapists carry out parent work with parents who have had previous service-user involvement as a child or adolescent.
2) The reasons why the parents accessed mental health support as children or adolescents.
3) The type of professional mental health support the parent had received when they were a child or adolescent.
4) The lived experience of child psychotherapists engaging in psychoanalytically-informed parent work with parents who have previously accessed mental health support when they were a child or adolescent.

Originally a further aim was to hear the voices of parents to explore their lived experience of parent work after previously accessing mental health support as a child or adolescent. Ethical approval for this was received (see appendix A).

However, in the operational phase of the research, including a second set of interviews proved to be difficult due to the limitations of the doctoral project size. Furthermore, clinicians who were approached about the potential of recruiting parents reported reluctance to contact parents beyond the end of treatment. In many cases it was felt to be too painful to ask parents who fell into the category of having had mental health treatment themselves as children, about their experience. Therefore this original part the study focusing on interviewing parents was not carried out.

3.3 Epistemological and ontological frame

This research aligns itself with a contextual epistemological position, taking the view that we can only learn and gain knowledge about reality through individuals in their particular context

and unique way of relating to the world. This fits with the ontological position of critical realism that Larkin et. al. (2006) explain in the following phrase; ‘what is real is not dependent on us, but the exact meaning and nature of reality is’ (p.107). An objective reality already exists without humans being present but this reality can never be separated from the subjective accounts through which we are able to access it.

In choosing IPA as the method of qualitative data analysis, this research aligns with its epistemological position. As is explained by its name IPA has interpretive, phenomenological and hermeneutic aspects (Smith, Flowers & Larkin, 2022). Moreover, IPA has an idiographic focus meaning that it focuses on the particular rather than being concerned with making group claims, which fits well with exploring the individual experience of each participant undertaking parent work. The focus on detail and depth is also an aspect that fits well with gathering an in depth understanding of clinicians lived experience working with this particular group of parents in the context of psychoanalytically informed parent work. The hermeneutic aspect of IPA examines how a phenomenon appears and how the participant makes sense of it but also how the researcher makes sense of it, in what is defined as a hermeneutical cycle. As researcher making sense of the participants’ experiences, I bring a psychoanalytic lens in understanding and interpreting the results.

3.4 Research design

This study had a mixed-methods design including a quantitative and a qualitative part methodology. The first part of the research was quantitative involving a profession-wide audit in the UK about parent work. The aim of the audit was to gather quantitative data from across the child and adolescent psychotherapy profession about the frequency of providing parent work to parents who were mental health service users as children or adolescents.

The second part of the study was more immersive and used a qualitative approach with the aim of further exploring and providing a deeper understanding of the experience of child psychotherapist's work with parents who had previously accessed mental health services as a child or adolescent and are returning to seek support for their child. This was carried out through semi-structured interviews with child psychotherapists who had recently engaged in parent work of this kind.

In line with the aims of the research and through discussion with my research supervisor, it felt important to first attempt to gather quantitative descriptive data about this phenomenon, including how many parents are typically seen by child and adolescent psychotherapists who had accessed previous support from mental health services as a child. The aim was to provide a baseline of the frequency of parent work with parents who were previous mental health service users as children, before then exploring on a deeper level the nature of the experience of child psychotherapists in working with this group of parents.

3.5 Interpretive Phenomenological Analysis (IPA)

The rationale for Interpretative Phenomenological Analysis (IPA) (Smith, Flowers & Larkin 2009) being chosen as the methodology for the qualitative interview data was that it provides a way of examining closely how people make sense of their life experiences. IPA has the advantage of allowing for an in-depth and detailed exploration of phenomena that aren't easily quantifiable. Analysing the data using IPA enables the opportunity for rich data to be gathered to understand more about clinician's experience of their interactions with parents during parent work. A further advantage of IPA is that it can allow for unanticipated findings to emerge which fits with the exploratory stance of the research (Barker et al. 2002).

Other approaches such as grounded theory (Glasser & Strauss, 1967), narrative analysis (Bruner, 1990), and discourse analysis (e.g. Potter and Wetherell, 1987) provide analysis of data in a functional way. However, IPA focuses more on the phenomenological aspect of the experience being studied. Moustakas (1994) comments on how IPA can help explore the impact that experience has had on the participant's life. Smith et al. (2022) explains that IPA aims to avoid premature generalisations about populations. IPA therefore seems suited to this study in capturing the voices of child psychotherapists in sharing their accounts of what may be very delicate and painful work, particularly if there is a history of trauma within the family.

Analysis of the interview data using IPA also involves engaging in a 'double hermeneutic' process (Smith and Osborn, 2003). This means the analysis not only gathers how the individual subjects make sense of their experience but also the analyst's critical questions about what the subject is trying to convey and may be more under the surface of what is being said. This allows for richer and more comprehensive interpretations of the interview data and seems suited to the psychoanalytic psychotherapy stance of the child psychotherapists carrying out the parent work.

3.6 Participants

3.6.1 Audit

The first part of the research involved a cross-sectional quantitative profession-wide audit of child psychotherapists. Indeed, this part of the research study was open to all working ACP members in the UK, with the aim of including data from as many working members as possible across the UK. This therefore aimed to include child psychotherapists from a wide range of cultural and ethnic backgrounds, as well as encompassing different areas of the UK including a diverse range of ages, socio-economic and cultural backgrounds for parents who

may have been engaging in parent work following their own previous experience of child and adolescent mental health services for themselves as patients.

Inclusion criteria:

- Participants needed to be either a full-member or a trainee registered with the Association of Child Psychotherapists, who are currently working in the UK (at the time of the research)

Exclusion criteria:

- ACP members who were not-working or retired
- Overseas ACP members

A total of 31 child psychotherapists took part in the audit, out of 971 working ACP registered child psychotherapists.

3.6.2 Semi-structured Interviews

The second stage of the study involved carrying out semi-structured interviews with child psychotherapists about parent work.

The inclusion criteria:

- The clinician was a child psychotherapist and member of the ACP including both qualified and trainee members.
- The clinician needed to have been or currently providing parent work with one or more parent/parents who disclosed having previously received support from a mental health service when they were a child or adolescent.

- The clinician's experience needed to focus on a parent who has attended a minimum of a face-to-face assessment appointment as a child or adolescent prior to becoming a parent.
- There is no maximum limit to the length of the intervention as a child or adolescent, although this episode of care must have ended before returning as a parent.

The exclusion criteria were:

- Clinicians who are retired/no longer working and cannot recall enough of their experience of parent work to be able to engage in a detailed conversation about the work.
- Overseas clinicians

The research panel and my supervisor agreed that 4-6 participants for semi-structured interviews were a reasonable number for an IPA doctoral research study (Smith, Flowers & Larkin, 2022). One of the requirements of IPA is to have a small and fairly homogenous sample (Smith, Flowers & Larkin, 2022).

Invitations to take part in interviews were sent electronically and all interviews took place online using Microsoft Teams.

3.6.3 Recruitment processes

The research study had two stages of recruitment: the first stage entailed the recruitment of participants for the online child psychotherapy profession-wide audit and the second one for the semi-structured interviews.

Stage 1:

An advertisement for recruitment for the online audit was sent via the Association of Child Psychotherapists (ACP) newsletter in January 2024 and then monthly with the ACP's job

newsletter correspondence to all members for the remainder of the year, up to December 2024 when the audit was then closed to responses. According to the ACP register, in this time frame, there were 971 working members (including full and part-time working members and 220 trainees). Full breakdown of the membership for the year the audit was open is available in Appendix B.

In order to maximise recruitment, with permission from the ACP, I emailed members directly (with blind cc.) with an invitation to complete the short audit regarding parent work. Due to the large number of ACP members meaning it was not possible to email all members, direct emails were sent to a proportion of members using a systematic process. This involved emails being sent to the first 10 members of each letter of the alphabet. Where there was less than 10 members for that letter, e.g. for x and z then all members for that letter were contacted and then I moved on to the next letter to start selecting 10 again.

Stage 2:

The audit was anonymous and therefore a final question on the audit asked members to provide their contact details if they would like to be contacted to take part in the interview stage. All child psychotherapists that volunteered (5) to participate and met the inclusion criteria were invited to participate in an interview. Participants who sent me their contact details were contacted within 3 months of the audit. I then provided each volunteer participant with a participant information sheet and consent form which was sent via email (see appendix C and D).

I also emailed some ACP members who fitted the above inclusion/exclusion criteria directly to ask if they would like to take part in an interview in order to reach the target number of participants and to gather rich data from experienced subjects as fits with IPA methodology.

I was glad that five participants agreed to be interviewed. One interview was later excluded as it transpired during the interview that the parent work discussed did not meet the inclusion criteria due to the parent being in their twenties when they first accessed mental health support before attending CAMHS later as a parent. The initial support was also accessed through a perinatal service as they were already pregnant at the time of first accessing mental health support; therefore the child-to-be was already present in the work. The service also falls under adult mental health services rather than an adolescent mental health service. It was therefore discussed and agreed with my research supervisor to exclude this interview from the data set to meet the requirements for IPA of having a homogenous sample and to clearly fit with the aims of the research.

The four participants were given the pseudonymous of Sophie, Tom, Ellen and Mary. Table 1 summarises their professional characteristics and parent work discussed in their interviews.

Participant Name	**Background summary**
Sophie	Sophie has been qualified for a few years. She works in a CAMHS service in an urban area. She discusses her work with a young single mother and her baby. The parent had previously attended the same CAMHS as a child around age 9-10.
Tom	Tom has been qualified for over 10 years and works in an urban CAMHS. Tom discusses two parent work cases both single mothers whose sons around the ages of 3 and 11 were in parallel individual work. Both mothers had attended the same CAMHS in their adolescence but disengaged from the service at that time and were now returning as parents.
Ellen	Ellen is a third year trainee in CAMHS. She discussed a case of parent work for a parent whose son (around age 10) was in parallel individual work. The parent had previously attended CAMHS as a young adolescent.
Mary	Mary had been working for over 20 years and works in private practice in a part rural part urban area. Mary discussed a parent work case with a parental couple (both female) but focuses particularly on one of the parents who had previously received mental health support as an older adolescent whilst at university.

Table 1: Summary of interview participants

3.7 Data collection

3.7.1 Quantitative descriptive data

The recruitment advertisement and invitation emails sent for the online audit contained the link to the audit for clinicians to click on and complete online via Google forms (see Appendix E). Participants were advised that the audit would take approximately 10 minutes to complete. The audit contained 11 questions with set responses to choose and one final question to gather any other comments and invite participants to provide their contact details if they would like to take part in the interview stage of research.

3.7.2 Qualitative data

Once participants had agreed to participate in an interview and the signed consent form was returned, I then sent the participant further information about the interview topics to help them prepare (see appendix F). This was sent to each participant at least 1 week and no more than 2 weeks before the interview date.

The semi-structured interview was devised following Interpretative Phenomenological Analysis (IPA) principles (Smith, Flowers & Larkin, 2022) in order to facilitate a discussion which answers the research question and can be analysed effectively. See interview question schedule (appendix G).

The time for the online interview was agreed according to the time that worked best for the participant in order to have the time and space to reflect on their experience. Each interview lasted approximately 1 hour and 15 minutes and no longer, and participants were reminded of this at the start of the interview so they knew what to expect. They were also advised that if at

any point they needed to stop the interview or pause they were free to do so. This was not requested in any of the interviews that took place.

All interviews were carried out online through Microsoft Teams in order to keep the setting consistent. All interviews were audio-recorded via Microsoft Teams and then transcribed at a later date. Participants were sent a debrief sheet after the interview on the same day. This included information about confidentiality and data storage as well as support services if needed following the interview (see appendix H).

3.8 Data analysis

3.8.1 Quantitative data analysis

Descriptive statistics were used to analyse the data received from the online audit using Google forms. The figures from the audit on were inputted manually into Excel and graphs created. The graphs were chosen to best reflect the data visually, (e.g. using pie chart or bar graphs) and the axes were adjusted manually to clearly demonstrate the findings.

3.8.2 Qualitative data analysis

Transcripts were made of the four audio-recordings of the semi-structured interviews collected. The transcripts were checked several times for errors including wording and speech markers, (e.g. pauses) were added. The four transcripts were then analysed using the principles and following the stages of IPA as outlined by Smith and Flowers (2022). The stages of data analysis are outlined below:

1. Immersion in the data – The transcripts were read three of four times before then underlining/highlighting key words, phrases that stood out in the text.

2. Coding the data – I devised a table template to help in coding the data using three columns to gather three types of exploratory comments; firstly descriptive comments, secondly linguistic comments and thirdly conceptual comments (see table template, appendix I).
3. Developing emergent themes – The margin to the left-hand side of the transcript on the template was used to note down emergent themes that came from re-reading of the exploratory comments collected in the previous stage.
4. Developing superordinate themes (Personal Experiential Themes) – Once the emergent themes were gathered these were cut out as strips of paper and organised into clusters of themes. When I was satisfied with the clusters after approximately three periods of looking at these and time spent away from the data and then returned to I then titled each cluster to form super-ordinate themes.
5. Moving to the next case – Once I had completed the superordinate themes for the first interview I followed these same 4 steps outlined for the next interview until each interview had been analysed.
6. Looking for patterns across the interviews – This involved laying out each table of themes from the 4 interviews analysed and looking for patterns across them to develop a final master table including the themes for the group (Group Experiential Themes).

3.9 Ethical considerations

This research project was conducted following the code of professional conduct and ethics provided by The Association of Child Psychotherapists, (2023). Ethical approval was received from the Tavistock and Portman Trust Research Ethics Committee (See appendix A). There were no ethical dilemmas raised.

3.9.1 Consent

I sought and received consent from The Association of Child Psychotherapists to contact members via email through the contact list provided on the member's directory to request completion of the research audit and invite members to take part in a research interview.

All participants were provided with information about consent as part of the Participant information sheet (Appendix C). This document clearly explains key information about the study including the research purpose, involvement required of participants, who would have access to the research data and how it would be stored. Potential participants were provided with the information sheet prior to the interview so they could take as long as they needed to consider the information and make an informed decision whether or not they would like to contact me to take part.

Before the interview took place I made sure participants had read and understood the contents of the participant information sheet and had the opportunity to ask me any questions they might have. All participants were given a consent form to complete and sign (see appendix D). One copy was given to the participants and one copy was kept in the research file.

Participants were informed that they were free to withdraw from the study without needing to give a reason for doing so up to three weeks following the interview date. There were no withdrawals from the study. Participants were given a debrief sheet following the interview on the same day which gave advice on contacting the ACP for further supervision or well-being support if needed. The website for MIND charity was also given to clinicians if they were stirred up by the interview and required mental health support.

3.9.2 Confidentiality

Participants were fully informed about the confidentiality of information shared and the limits of the study. They were made aware that I would transcribe the interviews and although all names and places would be changed some quotations may be identifiable. They were informed that my research supervisor would have access to the anonymised transcripts if requested. Data was anonymised before being analysed and all personal and setting identifiable information was changed or blanked out in the transcripts to ensure confidentiality was maintained when discussing findings with my research supervisor.

3.9.3 Data storage

The audio recordings of all the interviews were transcribed and anonymised (using pseudonyms for participants/patients) and all place specific information was removed from the transcripts. The interview recordings and transcripts will be destroyed a maximum of 2 years after the date of the interview.

Participants were given an ID number and transcriptions of the interviews were stored securely using a password protected file. The audio-recorded interviews were deleted after they had been transcribed to enhance date protection.

3.10 Validity and quality

Smith et al. (2022) recommend Yardley's (2000) guidelines of four principles to follow to help maintain validity of the data. The four principles are:

1. Sensitivity to context – IPA was chosen with the idea of recruiting participants who shared a particular lived experience of carrying out parent work with parents who had accessed mental health services when they were a child or adolescent and were

returning as parents. This IPA approach meant data collected was as close as possible to clinician's lived experience. I attempted to support participants to feel at ease as much as was possible by conducting the interview at a time and location best suited to them where they could be comfortable to speak freely about their experience. Using empathy as a researcher allowed participants to feel safe and at ease to speak freely. Both these factors therefore aimed to enable for as rich a data set as possible to be collected therefore staying close to the context of parent work being studied.

2. Commitment and rigour – This involved in depth engagement with the topic being studied and developing competence and skill in the method used. I read a number of IPA studies to familiarise myself with the method and conducted a previous analysis using IPA and learnt even more about this method through conducting this study.

3. Transparency and coherence – I have attempted in the design and recruitment sections above to outline as clearly as possible the processes of the research.

4. Impact and importance – The impact of the study and the usefulness of the research were thought about from the outset. Clinical recommendations are in the final chapter.

3.11 Limitations

This research project is a small scale mixed-methods project. Findings are based on voluntary participation from ACP members for the audit and four interviews. The number of interviews is a large enough sample for the chosen methodology of IPA. However, the audit and interview data cannot be representative of the lived experience of the whole child psychotherapy profession.

Another limitation is my pre-existing relationship with some of the interviewees, which may have impacted on their readiness to take part in an interview, which in some ways could skew the data and impact on the discussion of the findings.

3.12 Reflexivity

This thesis is a requirement for being awarded with a Professional Doctorate in child and adolescent psychoanalytic psychotherapy with the Tavistock and Portman NHS Foundation Trust and University of Essex. I trained at the Tavistock and was on placement in a generic CAMHS service. I was therefore aware of my duality as a psychotherapist working with parents and as a researcher.

I knew two of the participants professionally and two I had not met prior to the interview which may have impacted on the flow of the interview. One of the participants was a colleague and the two cases that were presented during the interview were cases known to me; two years before the interview I was the one providing psychotherapy to the children, while my colleague carried out the parent work. This work happened before my maternity leave and the cases had since been closed. At the time of the interview I was no longer involved in the case since the last 2 years.

I conducted the research with a psychoanalytic stance in mind and was mindful of my relationship to the interviewees and possible transference. I was also mindful of my theoretical orientation in terms of psychoanalytical thinking.

With the support of my research supervisor I engaged in a reflexive process during my research. I kept a research diary in order to engage in this process and note down thoughts and reflections as they came to mind whilst conducting my research.

Chapter 4: Findings

4.1 Overview

The findings from both the quantitative audit and the qualitative semi-structured interview parts of the research will be presented here. The audit results will be presented first using descriptive statistics with the aim of conveying clearly and visually what was found. This will be followed by a description of the findings from the analysis of the interview data from the four semi-structured interviews using IPA.

4.2 Audit data

As outlined in the methodology section, out of the 971 working ACP members; 31 completed the audit, which represents only 3.2% of ACP members. The sample size was therefore too small for the results to be generalisable. Attempts were made to look at how representative the results were of the ACP membership as a whole, however these are limited.

4.3 Audit Results

There was a wide range in the number of years' experience participants who completed the audit had of practising child psychotherapy, ranging from 1-30 years illustrated in Figure 1. Eight trainees made up 25.8% of the total participants. Among the remaining 74.2% of qualified participants, there was a fairly even spread in terms of the different number of years participants had been practising. This included clinicians with 1-5 years' experience (7 participants), 6-10 years' experience (also 7 participants) and 11-20 years' experience (6 participants). As expected, the number of participants with over 21 years' experience was smallest (3 participants), which may reflect the tendency for psychotherapists to train later than in other professions so may not have been working for as long before retirement.

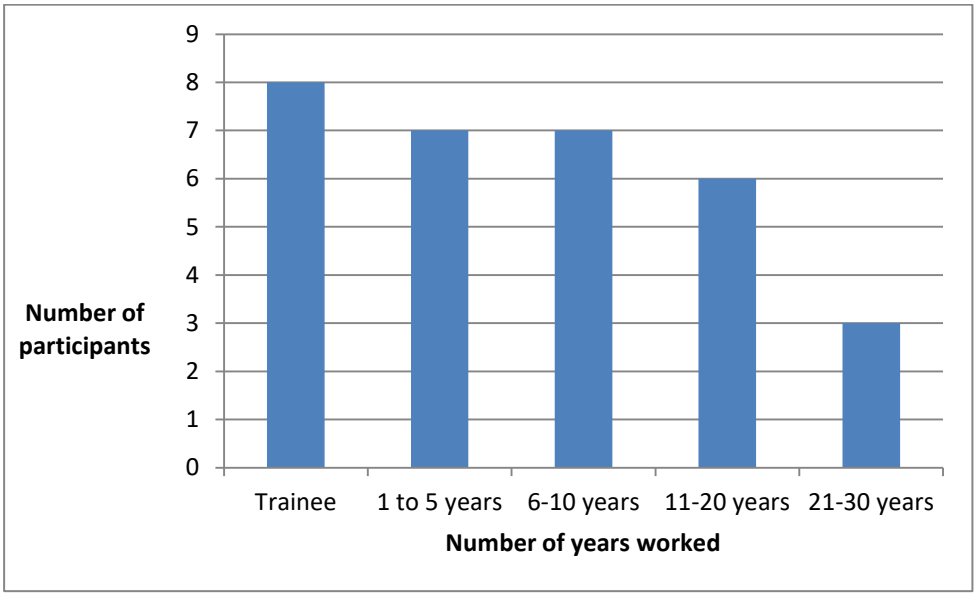

Figure 1: Bar chart to show the number of years participants had been working as a child and adolescent psychoanalytic psychotherapist

As shown in figure 2, 26 of the 31 participants had worked with at least one parent who disclosed having professional mental health support as a child or adolescent at some point in their career and five participants had not worked with any. These five participants included two third year trainees and three qualified psychotherapists with between 5-14 years' experience, therefore this latter 5 participants encompassed the experience of clinicians with many years working post qualification. The majority of participants (this being 11) had worked with between 1-3 parents in total (see figure 2). The results are variable, as in contrast to the majority of responses, 3 participants reported having worked with more than 20 parents. This suggests that overall it is not a common occurrence for child psychotherapists to work with parents who have accessed mental health support as a child or adolescent. Alternatively, it could be argued that prior mental health support parents received when they were children or adolescents may not always be disclosed during parent work.

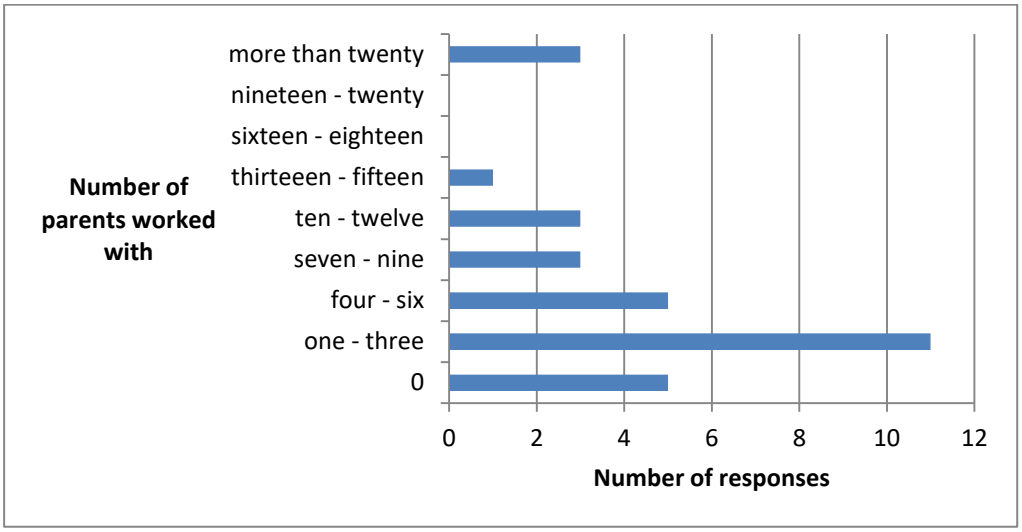

Figure 2: Bar chart to show how many parents child psychotherapists have worked with over their career so far who have accessed mental health support as a child or adolescent

Focusing specifically at child psychotherapist's work with parents over the past 12 months, out of the 26 remaining participants, 21 had worked with at least one parent who had accessed to mental health support as a child or adolescent. As illustrated by table 1 below, the majority of these participants (10) had worked with only 1 parent in the last 12 months. These figures are in line with the data gathered across the span of child psychotherapist's career with the majority of participants reporting having worked with 1-3 parents across their career and either 1 or no parents in the last 12 months.

However, the mixed picture remains over the last 12 months as it had with the results from across clinician's careers, as one participant reported having worked with 10-12 parents in the last 12 months. This brings the total number of parents worked with over the past 12 months - for all the 31 participants who took part in the audit to be between 59-61 parents as shown in table 1 below. It is unknown why the frequency of work with these parents has such a big variation from 1-12.

Number of parents worked with	**Number of participant responses**
0	8
1	10
2	3
3	0
4	2
5	5
10-12	1
N/A	2
Total number of parents seen = 59-61	

Table 2: Representing the total numbers of parents worked with over the past 12 months who had previously accessed mental health services as a child or adolescent

Figure 3 shows that the most frequently provided type of parent intervention was parent work alongside the child's psychotherapy, which represents the typical offer of parent work carried out by child psychotherapists and reported by 14 participants (34%). The second most reported support type was regular therapy review meetings, which was reported by 11 participants (27%). Nine of the participants reported seeing parents both for parent work and in regular review meetings. Six participants reported seeing parents for parent work without the child being seen (12%). Interestingly, 3 participants were seeing the parents while their child attended another child treatment other than child psychotherapy but these treatments are unknown. Four participants were carrying out dyadic parent-child or parent-infant work. One parent was not receiving any parent intervention but the reasons are unknown.

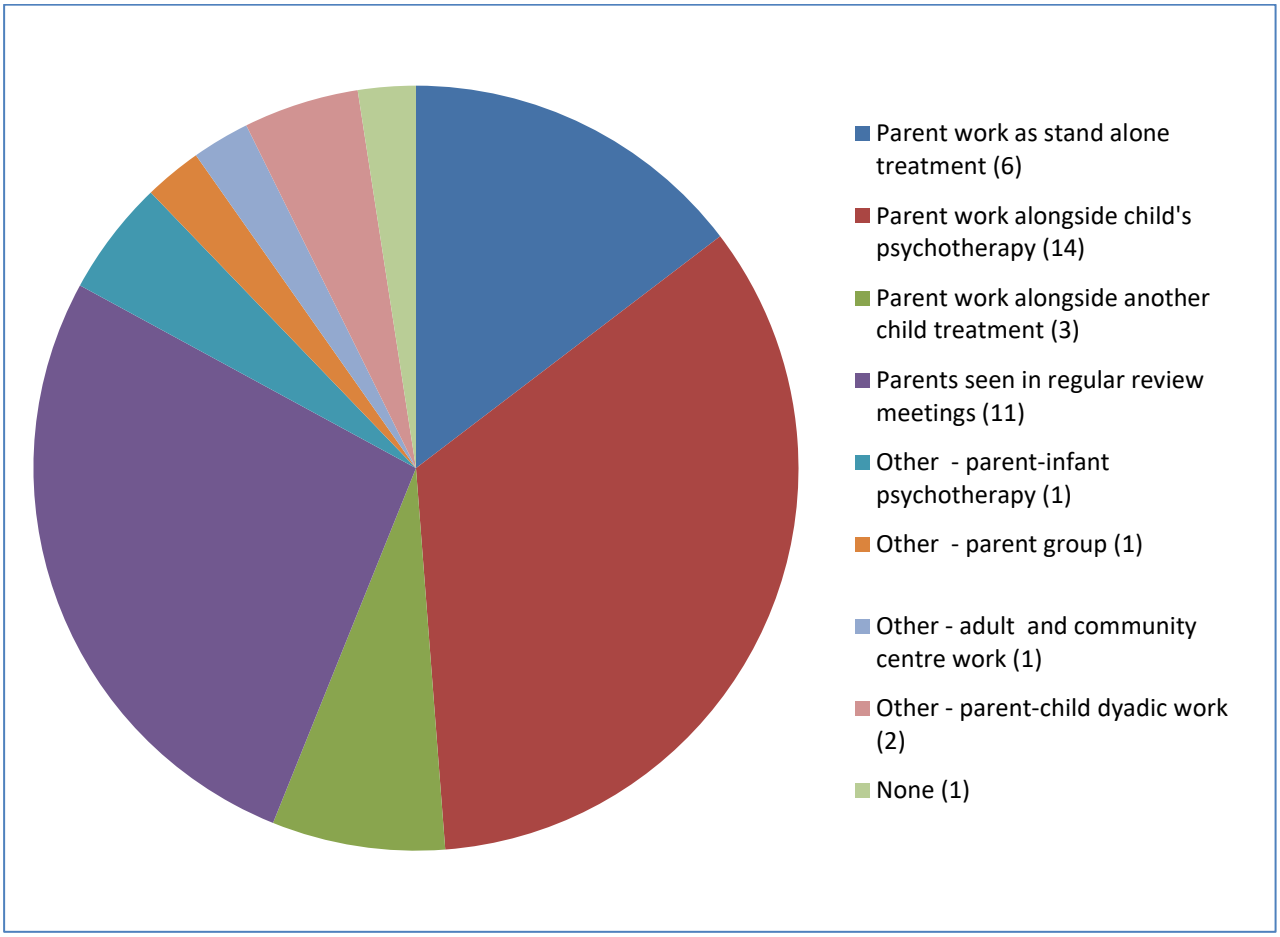

Figure 3: Pie chart to show the different types of parent support provided over the last 12 months

Figure 4 conveys that the majority of parents (with 19 (24%) of the responses) had accessed support due to trauma related mental health difficulties. The second highest category of need, with 17 responses, making up 22% of the parents, was for depression/low mood. This was followed by family issues and anxiety both with 12 (15%) each of the responses. Ten parents (13%) had accessed mental health support as a child or adolescent due to their challenging behaviour. Five responses reported 'other difficulties' which were then all specified. There was also a large cross-over with 15 participants reporting both trauma and depression/low mood symptoms.

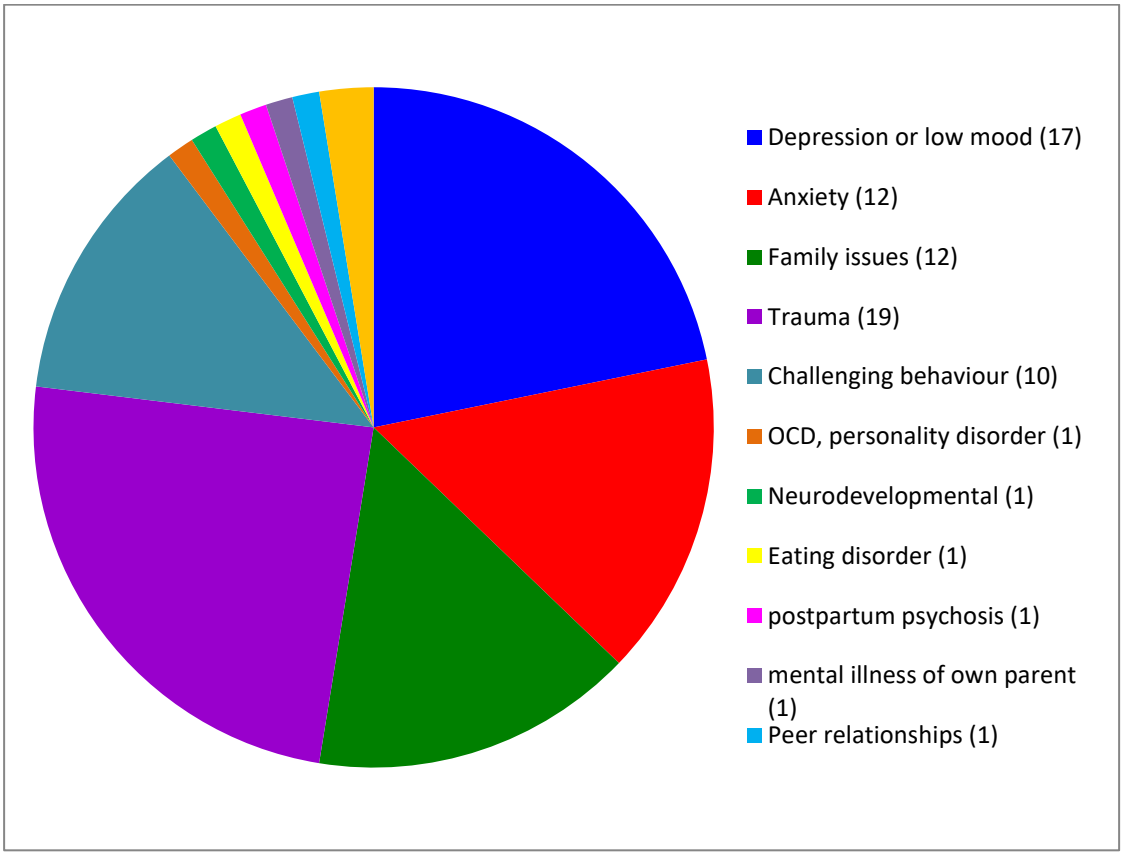

Figure 4: Pie chart to show the reasons parents had accessed mental health support as a child or adolescent

Unfortunately, the types of treatment interventions received by parents who had previously accessed mental health support as a child or adolescent were not always known by clinicians, indeed 39% of responses were 'don't know' (which made up 12 of the 31 responses), as seen in Figure 5. The intervention type most reported by clinicians that did know from parents what support they had received was medication for anxiety and depression (with 11 responses), followed by strategies or advice for managing emotions (with 8 responses) and then individual psychotherapy as the third highest treatment received (with 7 responses). Counselling and mental health assessment both received six responses. One parent received treatment as an in-patient and 2 parents had received CBT as a child or adolescent. These results fit with the results of the previous audit question suggesting that the majority of

parents had received medication and strategies/advice to manage depression when they were a child or adolescent. It is unclear what treatment or support was offered for the 24% of parents reported who were accessing support due to trauma related mental health difficulties.

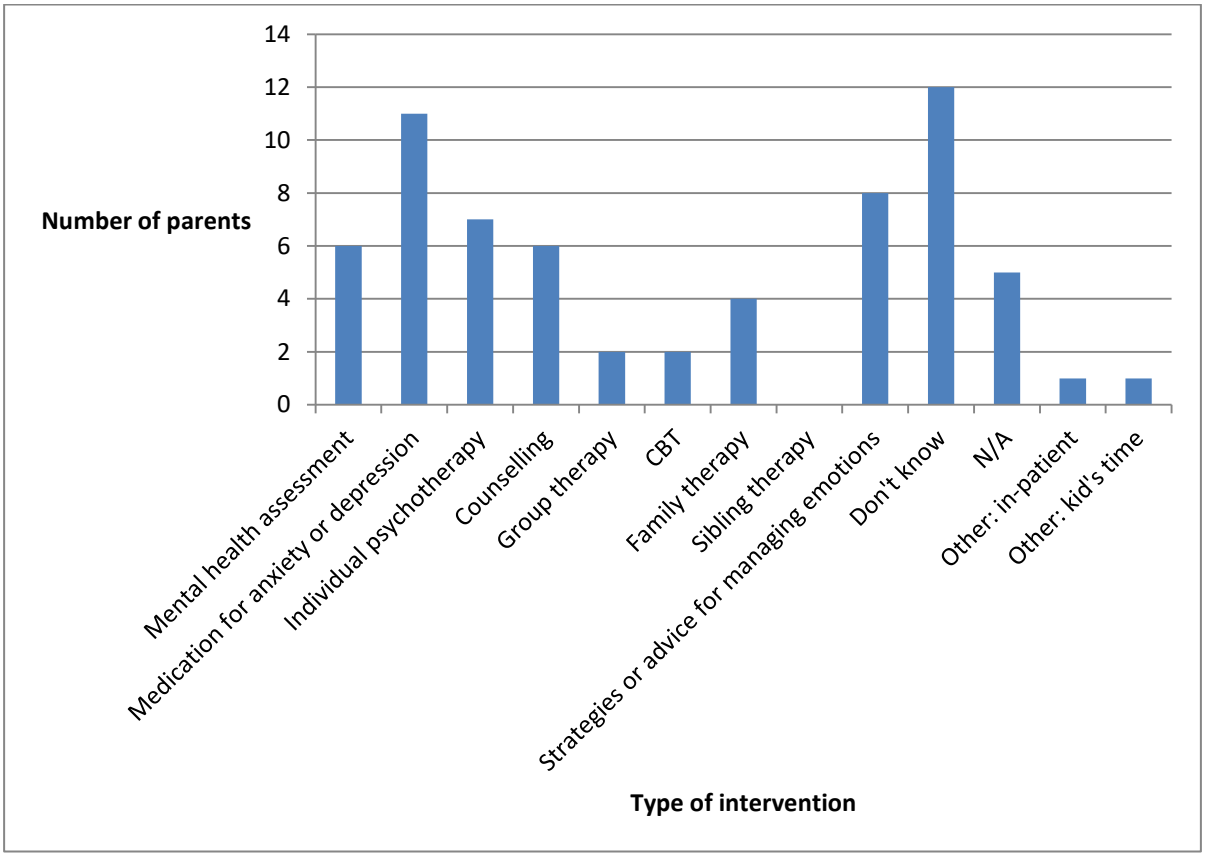

Figure 5: Bar chart to show the types of mental health support previously received by parents as children or adolescents

The most commonly accessed service for mental health support was CAMHS with 16 (38%) of the 59-61 parents mentioned in the audit having accessed their mental health support as a child or adolescent from CAMHS (see Figure 6). Five parents (12%) had accessed support privately. None of the parents disclosed accessing support through a charity and there were 10 responses (24%) that stated they did not know where the parent had accessed the support.

This reflects the general population with CAMHS being the main service where children and young people can access free mental health assessment and treatment through the NHS.

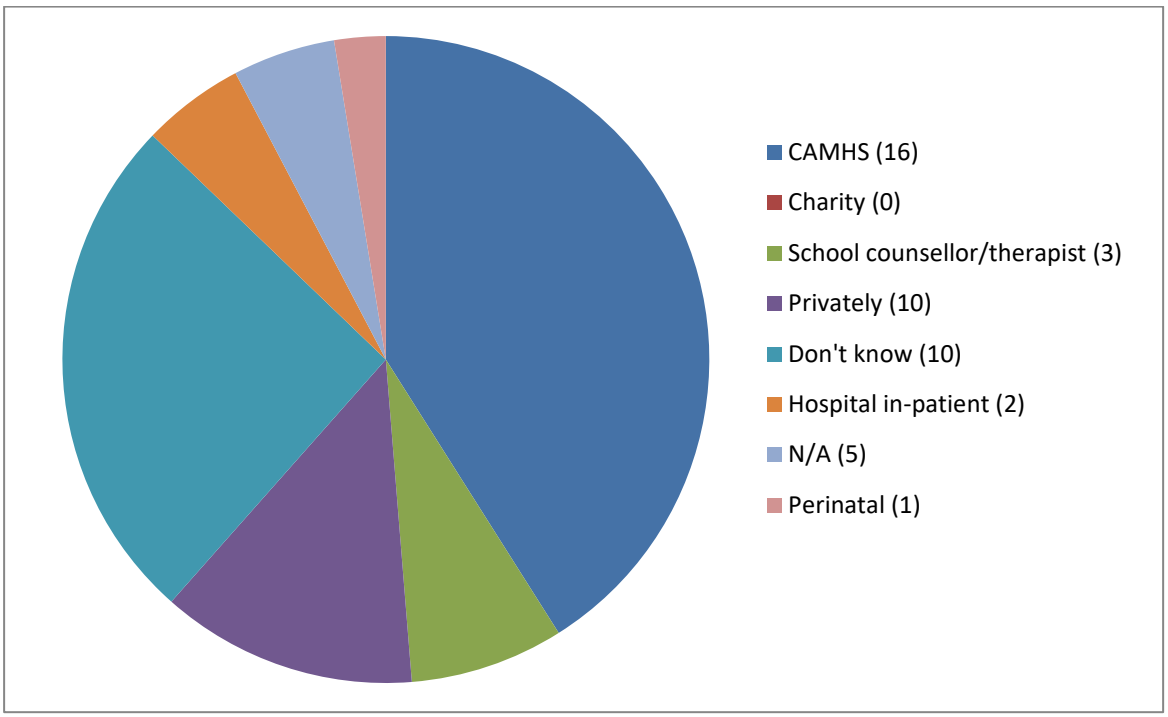

Figure 6: Pie chart to show where parents had accessed mental health support as a child or adolescent

Questions 8 and 9 of the audit aimed to capture data for any parents who participants may know of who had accessed mental health support as children but were not working with directly and investigate the reasons why. The majority of parents who had disclosed to the clinician that they had accessed mental health support as a child or adolescent were being seen for parent work with the clinician completing the audit (see Figure 7). However, eight of the parents were not being seen for parent work, the reasons for this are captured in table 3. There are a range of reasons why parents were not attending parent work including being seen by another clinician. One response highlighted the need for a stable enough home environment before parent work can commence. Two responses expressed that the parent declined the parent work offered but the reason is unknown.

Reasons for clinician not seeing parent for parent work
Parent seen by a different (psychoanalytic) colleague and in family therapy
Family situation is currently too uncontained/unsafe for work to begin
Neither parent or child wanted to go forward after the assessment
Parent is seen for weekly psychotherapy as an adult.
Parent did not take up offer for them or their child
parent work was not indicted
Seen by different clinician
Parent did not want to

Table 3: Table to show the reasons why the parents encountered were not being seen for parent work

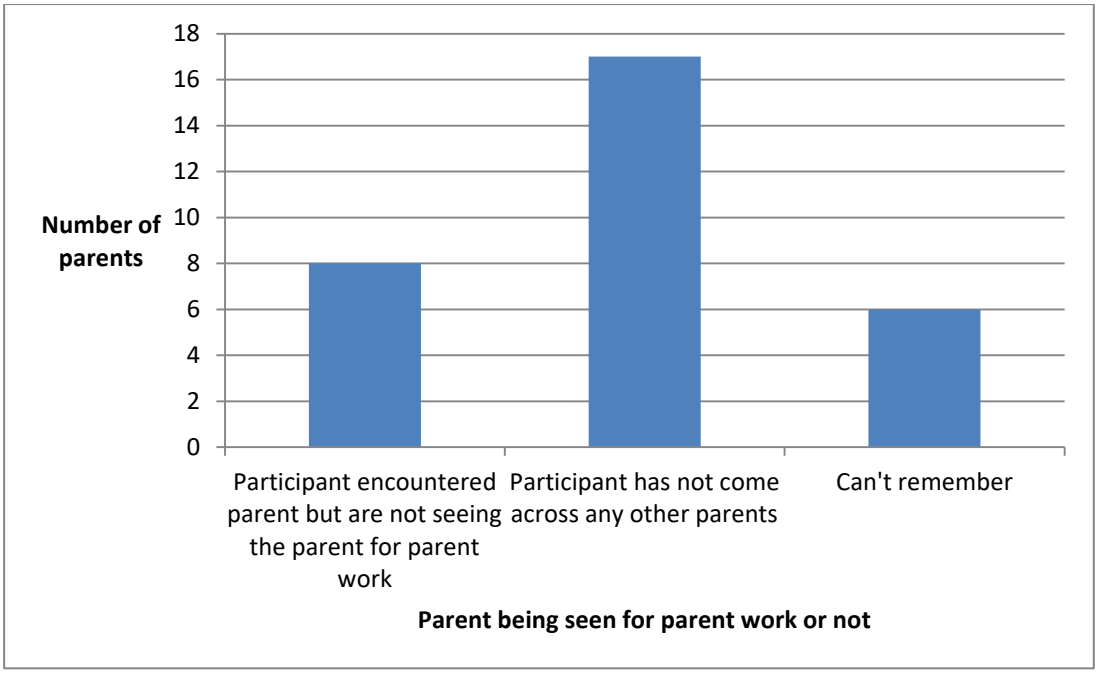

Figure 7: Bar chart to show the numbers of parents clinicians have come across who have accessed mental health support as a child but are/have not been seen by the participant for parent work in the last 12 months

The final audit question (focusing on all parents clinicians had encountered), clinicians were asked to rate the impact they perceived the parent's previous experience of mental health

support as a child or adolescent had had on the parent work (see figure 8). The impact rating with the highest response was for the previous experience perceived to have a 'moderate negative impact' with 13 parents rated under this category. In contrast, the second highest response was for the parent's previous experience perceived to have a 'significant positive impact,' with 5 parents rated under this category. No participants rated the previous mental health experience of the parent as a child or adolescent as having either 'no' or 'little positive impact.' This suggests participants within the small sample recruited felt that the parent's previous experience of mental health support as a child or adolescent either impacts positively or negatively on subsequent parent work in a moderate to significant degree. Two participants of the 26 who had reported working with a parent at some point in their career did not answer this question but the reasons are unknown.

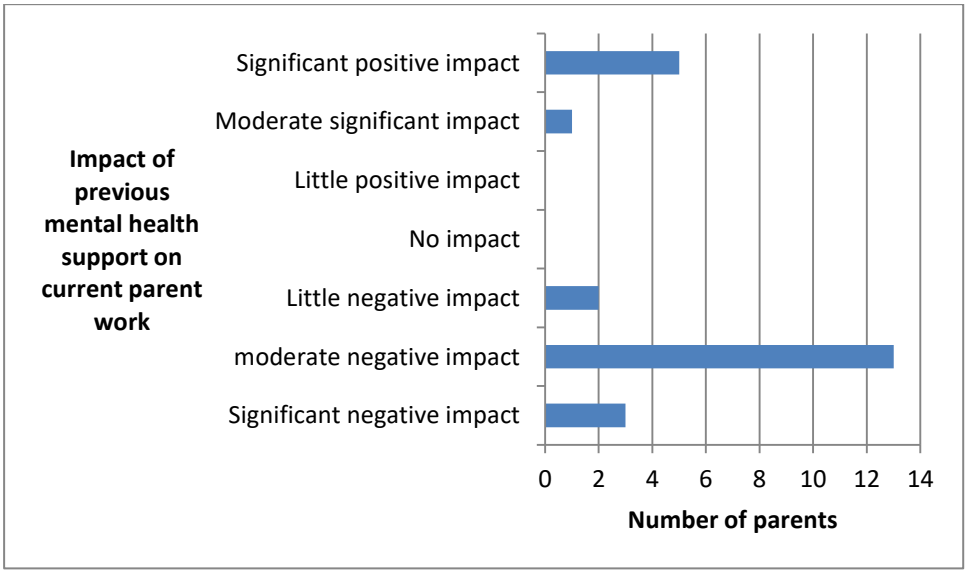

Figure 8: Bar chart to show the perceived impact by clinicians of parent's previous experience of mental health support as a child or adolescent on their engagement with parent work

The final question of the audit asked participants to share any comments they had about their work with parents who had previously accessed mental health support as a child or adolescent. Five comments were shared shown below in figure 9.

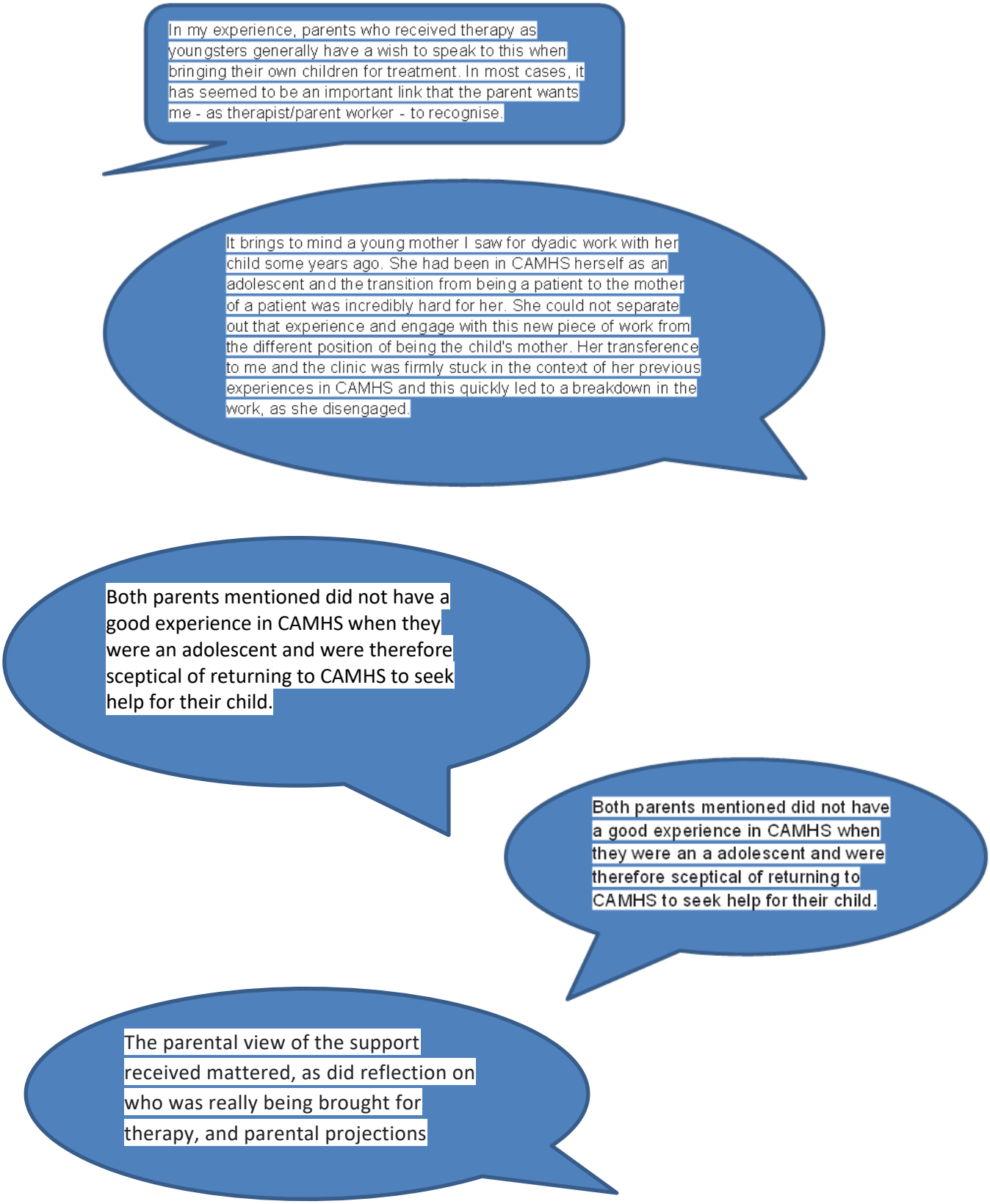

Figure 9: Comments gathered from clinicians in regards to working with parents who have accessed mental health support as a child or adolescent

4.4 Summary of audit results

In summary, 31 participants completed the audit representing 3.2% of ACP members working in the UK. Although the sample size is tiny and therefore not representative of the whole of the ACP membership; the participants did however encompass members with a range of experience from trainees to over 20 years' experience, therefore giving some indication across the profession of the frequency that child psychotherapists work with parents who previously accessed mental health services as a child or adolescent. Out of the 31 participants, 26 worked with at least one parent at some point in their career who disclosed having accessed mental health support when they were a child or adolescent; 21 participants worked with one of these parents in the past 12 months. The majority of these encounters were in parent work alongside the child's individual psychotherapy and in regular review meetings.

The most common reason parents disclosed for having mental health support as a child was trauma, followed by depression, family issues and anxiety. The majority of parents received medication for anxiety or depression if the treatment type was known by the participant. The most common service where parents had accessed support was CAMHS as expected. The majority of clinicians reported parent's past experience of mental health services to have a moderate negative impact on parent work as the quotations above capture and will be explored further in the interview findings.

4.5 Results from the semi-structured interview data using IPA

From the analysis of the individual interviews, four Group Experiential themes (GETs) emerged:

1. The parent work environment: What it stirs up for the parent

2. The influence of past experiences of accessing mental health support as a child or adolescent on the parent worker – parent relationship

3. Working on trans-generational issues, across the family system and creating a support network

4. When the past gets in the way: Ending parent work in light of the parent's previous experiences of accessing mental health support as a child or adolescent

Table 1 below gives a summary of the four GETs identified with their subordinate themes. A more detailed table with personal experiential themes associated to each group theme can be found in appendix J. Indeed, the GETs across participants are drawn together but detailed specifically to each individual. Each GET will be further explored using direct extracts from the interviews to illustrate how each theme manifested with each participant and provide evidence for the interpretation of the data. These extracts are narrated with comments to show how they were subjectively interpreted to support the GET that came to light from the analysis. Links will be made across the four interviews to identify connections, similarities and differences in the transcript data.

GETs	Subordinate themes
1. The parent work environment: What it stirs up for the parent	Sub-theme 1: A sense of having 'been here before' and the feelings stirred up by this.
	Sub-theme 2: Parent's phantasies or expectations of what is on offer based on their previous experience as a child or adolescent.
	Sub-theme 3: Feelings of anger and resentment for what the parent had not received from mental health services as a child or adolescent and the impact of this on the parent work.
2. The influence of the past experiences of accessing mental health support as a child or adolescent into the parent worker – parent relationship	Sub-theme 1: Holding the parent, the child and the 'child within the parent' in mind.
	Sub-theme 2: Building a trusting and safe working relationship for parents who have previously accessed professional mental health support as a child or adolescent.
3. Working on trans-generational issues, across the generations and family system and creating a support network	Sub-theme 1: Past mental health difficulties and experiences of accessing support from childhood re-surfacing and needing resolution.
	Sub-theme 2: Helping to separate past childhood experiences from the present.
	Sub-theme 3: Working across the generations and family system and creating a support network.
4. When the past gets in the way: Ending parent work in light of the parent's previous experiences of accessing mental health support as a child or adolescent	

Table 4: Group experiential themes and subordinate themes

4.6 GET 1: The parent work environment: What it stirs up for the parent

GET 1 illustrates how all participants spoke about what the setting stirred up for parents upon bringing their child for mental health support and commencing parent work having accessed

mental health support as children or adolescents. This group theme is divided into three subordinate themes to analyse the different emotional responses stirred up.

4.6.1 GET 1, Sub-theme 1: A sense of having 'been here before' and the feelings this stirs up

The first sub-theme explores memories and associated feelings triggered upon re-entering a mental health service. In three interviews, the parent discussed by the clinician was returning to the same CAMHS. Therefore the feelings and memories evoked and the environmental transference to the clinic were strong, although they differed in how readily available the memories were.

In the case Sophie discussed, there appeared to be a visceral feeling in the parent who had previously attended the clinic as a child around age 9 when returning as a 17-18 year old parent. Her experience was fairly close in time and memory and the setting triggered memories that gave her the sense of needing to place where she had been previously in relation to the present. Sophie helped orientate the parent by locating the rooms she had used as a child and where they were now, as illustrated below:

> 'As soon as I met her…she was saying, oh, I've been here before. I used to come here a lot to this clinic. I've not actually been in this room before, but, and then would start naming other people she'd worked with…making these connections'
>
> (Sophie)

As well as supporting to orientate the parent in physical space, Sophie describes the need to help orientate them in 'psychological space.' Sophie described helping orientate the parent in her new identity as a parent in CAMHS. Sophie spoke about helping the parent to make connections with their past experience. The parent seemed to need to acknowledge and

connect to her previous self but also feel different and separate. Sophie commented on there being 'uncomfortable feelings' that the parent names as 'weird' and wanted to get rid of in relation to the setting.

> 'She began telling me about her experience, saying it feels really weird being here. I don't know if I liked coming back then. I was just listening and helping to orientate her.'
>
> (Sophie)

After orientating the parent in physical and psychological space, there was a question of when they had arrived in the service. Sophie comments; 'starting work with somebody who had an experience of another team that I hadn't had before I joined the service…It's like ohh you got here first.' These perhaps competitive feelings contrast to the experience of welcoming a parent (with no prior associations) into the clinic. There seemed to be a question about whose setting it was.

The theme of environmental transference was also present in the parent's arrival in the second interview where Ellen speaks about the parent needing to orientate herself as the CAMHS building had moved. The feeling present with this parent appears to differ from Sophie's parent as Ellen feels unable to ask more about this initially:

> 'The first time I met her, she made that comment about the buildings, so it was not clear to me then, but it was like at first, just so you know, I've been here before when I was younger, but I did not know what for and did not ask at the time because we had just met.'
>
> (Ellen)

Ellen talks about the parent not only wanting to let her know but also warn her that she had a difficult history connected to the setting. This suggests anxiety stirred up in the parent by the setting and perhaps needing to test if the parent worker can manage what they may hear.

> ‘The comment about the building had me thinking maybe she was warning me. I think with Jess I always felt like there were a series of warnings like I'm about to tell you something really awful. Are you ready for this? Can you take it? Are you going be able to tolerate it? Can you bare it? I always felt with Jess there was this sense of not knowing what to expect. You just knew you were going be expecting a lot.’
>
> (Ellen)

Tom speaks about the intense feelings that can be stirred up in the experience of waiting and not being the one seen. This experience may mirror experiences as a child or adolescent and trigger difficult feelings associated with the memory of not receiving the help they wished for that their child is receiving.

> ‘I think we learned a lot from her. As though there is a particular way we need to explore how to talk with those parents. If you purely talk to a parent like this without knowing about their experience of CAMHS you might miss a lot about the intensity of the emotions that got stirred by waiting in the waiting room. As though it was not just the parent that is expected to wait for her son, this was something about herself not being seen and listened to.’
>
> (Tom)

Mary states that almost 50% of parents she worked with over her career disclosed having accessed mental health support as a child or adolescent. She talks about her previous work in CAMHS and, like Tom comments on feelings stirred up in parents through waiting but focuses on the often long wait patients have before receiving treatment. Mary talks about feelings of envy that can be stirred up. This particular feeling will be explored further in the third sub-theme.

> ‘One of the things that can be quite difficult, I think for parents who've had their own difficulties earlier in life. Is a sense of; I also needed something and I've been waiting. And also sometimes whether it's conscious or not, envy of what might have been when they were children that might have been very helpful, but was not available.’
>
> *(Mary)*

The recent case Mary focuses on differs in many ways from the other three interviews as she describes a parent work case through her private practise. Also she saw the parental couple not a single parent. Both parents were present in sessions but she focused particularly on one of the parents who had accessed mental health support as an older adolescent whilst at university and also later as an adult. These experiences remained with the parent and Mary describes how these memories were stirred up when the parent attended her consulting room for parent work. These memories were not disclosed until later in the work. Once the experiences had been shared it helped Mary, as parent worker, to make sense of the feelings stirred up earlier on, which had been felt in the countertransference but not yet possible to make sense of as shown in the quotation below:

> 'I often felt at the end of sessions, really perplexed and helpless, rather frustrated actually in not being able to reach the child. I was worried about the child, not in terms of safety, but in terms of emotional development and impairment and wondered when we might be able to get closer to that and I suppose also what would that take or would I be utterly powerless'
>
> (Mary)

4.6.2 GET 1, Sub-theme 2: Parent's phantasies and expectations of what is on offer based on their previous experience as a child or adolescent

Different factors can influence parent's phantasies and expectations of services but the focus in this sub-theme is on the particular influences participants related to the parent's past experience of mental health support as a child or adolescent.

Sophie and Tom mentioned parents having particular phantasies about what work or clinicians would be like in CAMHS based on their previous experience. For example, as mentioned in the first subtheme, the parent Sophie worked with mentioned something 'weird'

about the clinician they had seen in CAMHS. This memory was present when the parent returned and impacted on the parent's expectation of how *all* clinicians in CAMHS would be. Sophie spoke about the need to separate the past from the present and help the parent to locate the 'weirdness' and negative experience in a separate room in order to continue the work.

Sophie also talks about the parent coming as 'a different person' to the child they were when they previously attended and needed to see their clinician as different too. Sophie spoke about the fact she was older than the clinician seen previously and a different gender, which helped to separate past experience and locate the weirdness 'over there.'

This idea of phantasies was also illustrated by Tom in speaking about parents having expectations of what CAMHS would be like for their child based on their memories. There is emphasis on this being a phantasy and having to take into account the fact that the service and staff had changed significantly over time as he describes below:

> 'She thought she knew. Maybe what she knew and was clear, she did not want what she got. But CAMHS was, perhaps 15 years or 20 years later. The clinicians changed. The way we work as a team changed… I think there had been different spells of CAMHS interventions so she felt quite familiar with what kind of CAMHS input she was expecting for her son. She felt she knew how CAMHS should respond to what she thought her son needed.'
>
> (Tom)

Ellen spoke about the assumptions parents bring to appointments based on previous experience of mental health services. Again, these assumptions may interfere with parent's ability to view the current help available and assess its own merit. Ellen spoke about the parent she worked with often being aggressive in tone and angry towards 'professionals and people in her life who hadn't picked up' on her difficulties. These feelings impacted on the

parent's phantasy of clinicians not being helpful, and she was suspicious of anyone working for the NHS and in particular what Ellen would be like as shown in the quote below:

> 'I think at the very beginning she was very suspicious of me. There was an undertone of, you're very young. Are you sure you can do this job and she would ask me a lot of personal questions. She wanted to know whether I had children, whether I could understand what it's like.'
>
> (Ellen)

On the other hand, Sophie mentions parents who had a positive experience of mental health services, as a child or adolescent, then know where to access help for their child. As described in the quote below, in Sophie's parent work case the parent's positive experience of attending CAMHS appeared to support the continuity of the parent worker as a clinician (also in CAMHS) who the parent could accept and trust.

> 'I felt there was something positive she brought from her previous experience that enabled her to engage with me, because it's rare that adolescents that become parents will engage in a service because of all the emotional complications about the conception and their sexual activity, but for her it seemed actually that previous experience helped to feel that she could trust the work we were doing. It was like she'd already had an attachment to CAMHS and was coming back in.'
>
> (Sophie)

On another note, Sophie mentions parents who may have phantasies about clinicians they saw as an adolescent and whether they are 'still around and still know about them' and these may be erotic in nature, e.g. 'do they want me back?' Sophie talked about parents who may 'bring' these phantasies unconsciously into parent work and may be deeply buried and need teasing out and understanding as they could impact on the current work.

4.6.3 GET 1, Sub-theme 3: Feelings of anger and resentment for the mental health support the parent hadn't received as a child and the impact of this on the parent work

The third sub-theme explores specifically the feelings of anger and resentment from parents about what they hadn't been offered as children, upon accessing a mental health setting for their child and was experienced in the parent work by all four participants.

Ellen and Tom talked about parents who hold resentment for what they had missed out on which becomes apparent when they witness their child receiving help, as the quote below highlights.

> 'Where there is a lot of deprivation you clearly see a lot of resentment when they feel their child is being listened to, or I would like to believe nurtured in some way when there is a resource available that they did not have.. You hear at times parents say when they get psychotherapy intervention; 'I wish I had this,' which is what we clearly got with the second case... We were offering something to her son, that she was still holding on to the idea she should have had.'
>
> (Tom)

Tom comments on the experience feeling at times unbearable for the parent and for the parent worker in their countertransference. This can impact on the parent worker's role making it complicated as they are not only supporting the parent to understand their child, but also need to be wary of what is stirred up for the parent. This can feel unsettling, unbearable and may be too painful at times for the parent, and therefore needs careful consideration on the part of the parent worker.

> ‘I had a few cases that once the therapy started, and clearly you saw that the child or young person will develop a relationship with the therapist, the parents felt were very unsettled. It's not because they did not have a space, or because there was not a colleague to offer parent work but because it was unbearable.’
>
> (Tom)

Ellen spoke about the anger parents may have felt towards their clinician in the past when they were a child being projected towards the parent worker in the present.

> ‘She was extremely angry towards professionals and people in her life who hadn't picked up on this. She felt she was not understood, that the bullying and everything she experienced in secondary school could have been avoided.’
>
> (Ellen)

Ellen spoke about the experience of what this can be like in the room with the parent and described struggling to say anything in sessions resulting in feeling ‘deadened.’ Ellen spoke about the importance of parent’s previous experience being acknowledged to facilitate the parent work and help them think about their child.

> ‘My mind was just kind of dead, it just failed. Bombarded with all this information and it was really difficult to think.’
>
> (Ellen)

Mary spoke about the reaction of the parent when she suggested accessing adult psychotherapy. This enabled the parent to talk about their past experience of adult psychotherapy and the anger for the female psychotherapist who had retired and therefore the work was time-limited. Once it was spoken about in the sessions:

> ‘It became something that could be thought about. The anger and contempt for yet another motherhood; for another mother that had failed her.’
>
> (Mary)

Although Mary’s example of the anger experienced is towards losing a therapist as an adult, it is mentioned here as it could reflect similar experiences as a child if their therapist leaves, which would require further investigation.

4.7 GET 2: The impact of parent’s previous experiences of accessing mental health support as a child or adolescent on the nature of the parent worker to parent relationship

The second GET focuses on the nature of the parent worker to parent relationship and is broken down into two sub-themes to explore different aspects of this working relationship which all participants discussed. These encompass child psychotherapist’s work with all parents; however the nuances are explored here in relation to how parent’s history of accessing professional mental health support as a child or adolescent becomes interwoven into the parent work relationship.

4.7.1 GET 2, sub-theme 1: Holding the parent, the child and the ‘child within the parent’ in mind

All participants spoke about parent’s previous experiences of mental health support and associated feelings being carried into adulthood and their role as parent worker to hold this in mind. All participants commented on there being ‘something about this parent that stays in mind’ suggesting there was something shared among clinician’s experience of working with a

parent who had previously accessed professional mental health support that made them stand out.

Sophie's parent case was going through her late adolescence, still growing up whilst also developing an identity as parent. The use of the word 'holding' came up many times in different ways throughout the interview. Sophie said the particulars of CBT the parent received from CAMHS as a child was difficult for the parent to retain but what was important was that she had been in CAMHS before, perhaps providing some continuity.

> 'It was much more to do with the sort of environmental transference that triggered something about I've been here before.'
>
> (Sophie)

Sophie talks about 'holding the parent through pregnancy and delivery' as well as having 'the baby-to-be' in mind. Sophie also talks about holding in mind this parent as adult in her own right and giving space in sessions to think about what it means to be 18 as the following extract illustrates:

> 'She did a lot of work with me thinking about how it would feel to separate from her baby and becoming an adult. She thought about what she'd lost in her adolescence and the things she wanted.'
>
> (Sophie)

There was much for Sophie to hold in mind as parent worker; the parent as a separate person, the baby, and the parent-baby relationship. This kind of psychological holding contrasted to practical holding received from family members. Sophie reflects on what the patient may be 'holding from that time' when they were in CAMHS and keeping this in mind as parent worker.

Tom also talks about there being the child referred and the ‘child within the parent’ to keep in mind. Similar to Sophie, Tom talks about the needs of the child being carried into adulthood and therefore requiring attention and support by the parent worker as described below;

> ‘The understanding of why psychotherapy was offered to their children is important. I think at that point you get the parents cooperation into the intervention and they also offer themselves and their experience of CAMHS and of needing help… there is a dimension of bringing themselves in their own right as children to CAMHS. Either the child that has been seen in CAMHS or the child that was not seen, or the child that was seen but in a particular way, that was not listened to.’
>
> (Tom)

Tom goes on to reflect on how moments of realisation can occur in sessions when the parent, (as well as the child), are held in mind as the following extract illustrates.

> ‘The moment we offer intensive psychotherapy to her son, I think immediately she said: ‘you know I should have had that’. I don't think she blamed anyone because perhaps there were a range of reasons…you could imagine she was not in the parents, in the mother's mind. There was so much domestic violence and so much feeling dropped. The idea of anyone keeping her in mind was not there… I don't think she was saying that in regret of being a parent, but it was a moment of realisation.’
>
> (Tom)

Tom describes how he stayed with the parent’s difficult feeling of not having had therapy which allowed the parent to reflect on their experience of needing help and not feeling held in mind growing up. This encouraged her motivation to engage with CAMHS, in getting her child the help she needed and hadn’t had.

Similar to Tom, Ellen spoke about the parent she worked with needing her to hold in mind her experience in adolescence as she states; ‘it was very important for her to let me know there

was a history here.' Ellen talks about the experience of hearing the parent talk about this history as described below;

> 'What I found really difficult about the sessions was she would share all this information and then feel terribly exposed and worried about what I would think or do with this information…She wanted me to know and my understanding. But then think I was going to criticize her, persecute her, and often she would say you probably think I'm a terrible mother.'
>
> (Ellen)

Ellen describes having to set boundaries which she hadn't anticipated, as the parent wanted to know if she had children. This relates to the parent's uncertainty about how safe they were with the clinician and if they could help. Ellen reflects on her experience in that session thinking, 'you're not with a parent. You're more with an adolescent.' Perhaps it was the adolescent part of the parent that was present in this moment.

Ellen reflects on the nature of parent work with a child psychotherapist being one that enables the parent to be held in mind similar way to in therapy. Ellen commented on how some parents may need this kind of holding due to their difficult past as she described for her parent work case;

> 'Supporting her in network meetings, reaffirming her position as a mother capable of making decisions in the best interests of her child…I think I did become a bit of a substitute parent, but most of it really was holding her.'
>
> (Ellen).

Defining the parent worker role, setting and maintaining boundaries are part of all parent work; however the participants' experiences indicate how this may become more complicated if the parent has a history of accessing services as a child or adolescent.

Mary and Tom are qualified adult psychotherapists; they both spoke about the need to hold the 'child within the parent' in mind being familiar to their role as adult psychotherapists.

Mary reflects that as an adult psychotherapist she may have a particular approach which enables parents to share more readily their childhood experiences. This enables the parent work to go deeper than other more behavioural types of parent work. Mary suggests:

> 'I'm accustomed to looking for and hearing from the child in the adult. Maybe there's something in me that… makes it possible for them to talk about it or to know.'
>
> (Mary)

Tom comments on the complexity of holding the 'child within the parent' in mind during the parent work in order to support their child as the following quotation illustrates:

> 'You are working with the parent because you need to monitor the child. But in that you need to hold the parent, the adult and understand how they communicate, how they think and take on board the young child in that adult. So that is something not that simple'
>
> (Tom)

This highlights the many levels of holding the parent worker has to do in keeping the child referred and 'child within the parent' in mind. Parents who come with their own previous experience of accessing mental health support bring with them a past childhood experience that needs attention in the parent work in order to support their child who has been referred.

4.7.2 GET 2, sub-theme 2: Building a trusting and safe working relationship for parents who have previously accessed professional mental health support as a child or adolescent.

This sub-theme illustrates how all participants experienced the parents need to trust them and feel safe enough to talk about their childhood. This often includes painful experiences, which led to mental health difficulties and need to seek help as a child or adolescent.

Sophie commented on how it can be 'hard to know' how many parents clinicians have worked with as 'we might have seen a lot of parents who have been to CAMHS, but never spoke

about it in the work.' This can be complicated for parents to divulge due to fear of judgement or what implications may come from sharing their history. Moreover, Mary commented on how parent's difficulties may not be apparent at surface level upon meeting parents; their disclosure of past mental health support being complicated. As Ellen highlighted, this can take time to come up in the work. Mary commented on the need for the parent to feel safe and comfortable with their parent worker in order to speak freely and reveal their vulnerabilities.

> 'Particularly when I was working in quite deprived areas. I think there's an anxiety about how much it's safe to tell you, the question of is there going to be somebody questioning their parenting, particularly with children who are perhaps still young enough to be potentially removed... Maybe it's the sense of being in the system. I think that in private practise people seem more likely to tell you earlier on about their own difficult experiences, including having some help or some therapy. Whether it was or was not helpful.'
>
> (Mary)

Mary touches on feeling frustrated, lost and powerless in the parent work as getting to know the child is dependent on parent's openness. This can lead to a feeling of not knowing what the child's problem is and needs time to unfold. Mary used the metaphor of a 'log jam' to describe the child being stuck developmentally, only once there was understanding taking into account the parent's history, the log was removed and the child flourished. Mary spoke about the parent work being very emotional in hearing the parent's difficult childhood experiences.

> 'It was difficult initially to get Emma to speak more freely about her own early life. When she did, after that session, I needed about half an hour to sit down'
>
> (Mary)

In contrast, Sophie describes how the positive projections the parent already had, thanks to a positive experience of CAMHS supported the work as Sophie comments;

> ‘Fortunately with the mum I’m thinking of it was helpful, the projections. She was already familiar with the clinic… that previous experience meant she could trust the work we were doing to make that attachment’
>
> (Sophie)

The continuity of the positive attachment also appears present in the way Sophie acknowledges the parent with a maternal sounding pride having done ‘beautifully’ and ‘was able to use the work.’

Tom spoke about ‘meeting the parent where they’re at’ in order for parents to engage. Tom spoke about parents’ experience of being listened to enabling them to be open in sharing childhood experiences.

> ‘When she was able to tell me, I think when we were in regular parent work where she felt listened to, her son was being listened to, the school was implementing a support plan. I think then she identified there was a place for her to talk about herself’
>
> (Tom)

Ellen worked with the parent she discusses in her interview for nine months and describes the parent work relationship being ‘a gentle process’ needing time to develop. Ellen talks about the first session with the parent where the parent ‘talked nonstop for a whole hour and it was difficult to get any word in, the parent perhaps feeling ‘threatened of what could potentially come out of my mouth and what I was making of her.’ This fear of judgement on their parenting abilities fluctuated in sessions and it was important for Ellen to be mindful of the parent’s tendency to feel judged which may be based in their own history including a harsh superego.

Ellen spoke about the parent work relationship allowing for the opportunity for the parent to experience a different and compassionate relationship and reflects on the variation in timing of the parent's disclosure of their past experiences perhaps linking to the point they feel safe enough with the parent worker. Ellen spoke about the parent's past traumatic experiences and resentment towards clinicians who she felt had missed things when she was a child, now made the parent prone to difficulties trusting the parent worker.

> 'There was quite a lot of anger and responsibility placed on clinicians who saw her at the time. Who couldn't see that the problem was really her family, that her mother was equally groomed by this man, although that happened after. But I think in her mind it was like how could no one see that this man was dangerous'
>
> (Ellen)

The clinicians had also not picked up on the parent having ADHD, which she was diagnosed with as an adult.

> 'She said she was not honest with her therapist, she was very quiet, and at the time she did not know she was autistic or had ADHD. So the therapy was not tailored to her neurodiversity. She really struggled with that therapist and lost complete trust that anything or anyone could help her.'
>
> (Ellen)

Given the parent's previous experiences with CAMHS, Ellen commented on the parent's need to test their parent worker's resilience to hear the painful experiences of their past and be able to help as she hadn't received the help needed in the past.

> 'There was an undertone of testing, what kind of a person I am. You know, I've been here before. And are you going to be able to help me? Because they clearly did not help me.'
>
> (Ellen)

4.8 GET 3: Working on transgenerational issues, across the family system and creating a support network

The third GET illustrates how all participants experienced transgenerational aspects in the parent work, and is divided into three sub-themes to convey the different ways clinicians applied a transgenerational lens to their work.

4.8.1 GET 3, sub-theme 1: Past mental health difficulties and experiences of accessing support from childhood resurfacing and needing resolution

This sub-theme addresses the participants' accounts of parents who shared past childhood difficulties that were unresolved. Sophie spoke about birth triggering mental health difficulties from the parents' childhood to resurface upon stepping into parenthood. Sophie spoke about unresolved difficulties needing to be thought about, providing continuity of work started in childhood or adolescence:

> 'I'm wondering whether the work the parents did previously in CAMHS hadn't been properly resolved. There was something about needing to come back. Which is why I'm just picking up on being able to discharge which suggests something became resolved.'
>
> (Sophie)

Focusing on the specific case reported; Sophie developed her thinking around transgenerational trauma and the cycle of repetition when things are not resolved, as she explains clearly here:

> 'As she settled into the relationship and started opening up more about the transgenerational trauma and what brought her into CAMHS before. It was very helpful for the work we were doing to get an idea of what was being transmitted through from her parents that she needed support on and what might still be impacting on her. It was very much a 'ghosts in the nursery' type experience and actually it was important from that respect for her to prevent the cycle again with her infant. For her to be able to talk about her experience

> of being parented which had caused her to feel suicidal and self-harm …To enable her to think about what sort of parent she was becoming and how different that was to her own.'
>
> (Sophie)

The two parents Tom focused on were older but the theme of difficulties continuing from childhood was just as alive as in Sophie's young parent. Tom comments on the impact of parent's past experience of adults and authority figures such as CAMHS professionals 'getting in the way.' This was something carried from childhood and became a stumbling block that needed working through in parent work to enable them to accept help and work with services to achieve the outcomes they wanted for a better future for themself and their children, as explained by Tom here below:

> 'I felt in this mother CAMHS and social care got really tangled up at times. We needed to work alongside a child in need plan, because she was living in a risky drug dealing area. She felt very vulnerable. It was a world that she had known and felt under pressure she was going back to and wanted rehousing…A practical solution also had to be contained within a very psychological dilemma; about wanting to be a good parent and something getting in the way. Authority, being one. The idea of CAMHS working with social care, suddenly, she felt that CAMHS would gang up and remove the children from her, which is what she probably experienced when removed from her family.'
>
> (Tom)

In another case example, Tom talks about the parent's own parents having prevented them as a young person from receiving help and this situation being repeated in trying to stop their child (now parent) from getting help for her son (their grandson). This brings up painful feelings from the past but this insight allows for the parent to respond differently and not be prevented from getting the help she is seeking for her own child and herself as parent.

> 'Because of that previous experience where she felt mainly the parent was heard. She was clear that it was the mother who disengaged following the

> crisis intervention. That actually re-enacted in the treatment at one point when she needed support for child care from her mother. I remember her reporting to me ‘she's encouraging me to disengage. That's what she used to do when I was a child.’ Almost as if she was given a script about what to say in those CAMHS conversations because actually there was a lot going on at home.’
>
> (Tom)

Tom spoke about the idea that parents come seeking reparation about something needed in their past experience as a child that ‘the system was not very receptive to but by the time they come as parents they feel more able to articulate what they thought was the matter that needed addressing. Parents may feel bringing their child is a kind of second chance.’

Tom mentions how the parent’s past experience fuelled the parents to seek something better for their children as he describes below.

> ‘There is always a reparation attempt when they bring their children. In those particular cases they wanted something different from what they experienced and if we engage with that it was not just fighting or controlling. I think there was in both cases the readiness to support the therapy because they’ve been there before and they did not have it.’
>
> (Tom)

The parent work case Mary spoke about focused on understanding the child’s difficulties with separation. Through the parent work which involved understanding the parent’s own separation difficulties relating to their past and difficulties carried through from childhood. This enabled the parents and the child to move on and become able to manage separations that had felt impossible before this understanding and link to the parent’s history was made. Similar to Tom, Mary spoke about addressing difficulties carried into adulthood by the parents that are interfering with parenting:

> ‘There hadn't been any unusual events or traumas, until finally it seemed when I was trying to get a better understanding of why it was so hard for Tilly to separate from Emma. I suddenly thought, actually I think it's Emma who can't separate from Tilly.

As she was on the cusp of going to school, you know, really beginning a separation, something had kicked in and absolutely frozen Tilly. It was very difficult initially to get Emma to be able to speak more freely about her own early life.'

(Mary)

Ellen also spoke about difficulties being 'unresolved' and difficult to separate from the present, as the following quote illustrates;

> 'There were quite a lot of comments and feelings that I had in the room with Jess that indicated to me that there was something very unresolved. There was something about what had happened to her and her body as a young adolescent that she was still carrying and projecting onto her developing, preadolescent child.'
>
> (Ellen)

4.8.2 GET 3, sub-theme 2: Helping to separate past childhood experiences from the present.

The second sub-theme looks at difficulties re-surfacing in a particular way which makes it difficult to disentangle past from present.

Sophie refers to this being a 'ghosts in the nursery' type experience which occurred with the parent case she describes as there were fears of what was being projected onto the baby in utero. Sophie describes how parent's past trauma needed thinking and talking about in parent work to support her parenting.

> 'There was some merging going on in her mind. We had to think about what the difference was from being a child then to being a parent coming into CAMHS…There's something about would that impact on her, coming in previously very unwell mentally as a child and then speaking to a healthier part of her to enable her to develop a good bond with her son.'
>
> (Sophie)

Sophie describes a 'full circle' as parents who accessed CAMHS as children return 'bringing their babies. This is positive if parents know where to access help and work can continue. On

the other hand parents with negative experiences may form a negative attachment which may interfere later when accessing help for their children. One way past experiences become muddled with the present relates to GET 1; indeed the feeling stirred up of grievance towards the service for not providing the help they needed as a child. This grievance can result in "locking horns" between parents and clinicians and can be unconscious and become attached to the present. In this event the past prevents the parent from trusting and accepting present support offered, as Sophie describes:

> 'I was supervising a trainee psychiatrist working psychodynamically with the daughter of a mother who had been in CAMHS. It caused a lot of problems. The consultant psychiatrist received a lot of complaints, but they weren't really upheld because it was not really clear what the complaint was. But there was something very messy.'
>
> (Sophie)

Tom spoke about how fear of history repeating itself can cause parents to build defences, which may interfere with engagement as he describes here:

> 'She was a bit at home in CAMHS. So long as you sustain a relationship with her that was based on how committed she was to make a difference to her son. And not repeat the same history she had with CAMHS. I think, in the moment we managed to unpack that she became less belligerent. Once we were able to not be defensive and try to understand what the belligerence was about I think she engaged well and actually part of that belligerence was how defiant and belligerent she had been as a teenager.'
>
> (Tom)

Mary spoke about what belongs to the child and what belongs to the parent becoming muddled. The child's separation difficulty mirrored the difficulties of the parent and Mary talks about the anger she felt from the parent when 'putting it as gently as possible that it was, at the very least, a shared difficulty.' The muddle then comes into Mary's narrative as she confuses the names perhaps tripping up in trying to be so careful.

> ‘As the work proceeded and particularly when I was trying to talk about, obviously being very careful and sensitive that actually it was not so much that Tilly was stuck, but that Emma couldn't let her go. And the parallel with her mother, who couldn't let her go. Now she really couldn't let Tilly go because no amount of thinking about how could we begin to encourage Emma, Tilly to, oh muddled up in my mind…. ‘
>
> (Mary)

4.8.3 GET 3, sub-theme 3: Working across the generations and family system and creating a support network

The third sub-theme follows the previous two as once parent’s difficulties re-surfaced, were listened to, understood, and separated from the present; then all participants talked about it following naturally in the parent work to focus on the family system.

Tom spoke about parent work being cross-generational; involving ‘understanding how therapy works across generations and family systems.’ Tom spoke about his work in hospital where focusing on the family allowed parents to disclose their own mental health difficulties and history in an organic way. Individual work, Tom explains, did not happen until family conversations had explored the difficulty within the family.

Mary spoke about intergenerational trauma interfering with children’s emotional development, which seemed to occur with the case she shared. Mary reflects on the parent’s separation difficulties linking to their parent’s history and struggles separating. The parent addressed these difficulties in the parent work to some degree in thinking about trauma in the family system with losses going back three generations. Mary spoke about supporting the parent to separate from her mother. Thought was given to buying the grandmother a separate house to support this but; ‘there was the emotional separation between Emma and her mother that still remained to be done’ (Mary).

Sophie spoke about CAMHS acting like a family supporting the different generations of parents and children, as she states; 'you get a sense that CAMHS on some level has been a family to them. They're familiar with it and then bring their own babies.' Work with parents also focuses on the family system around the parent, as she describes here:

> 'I'm thinking about constructing a family system with the perinatal service, so we combine and it's linked up for the parents that they see they're well held within both parents, you know, PMHT and CAMHS that we're doing kind of collective parental or quasi parental thinking which is quite similar to LAC'
>
> (Sophie)

Sophie also commented on her need to find a new professional home. This highlights the need as clinicians to belong to a professional family and support structure. This is reflected in the parent work as Sophie links with other services and professionals to support the parent forming a wider family structure. This also comes up in Ellen's interview as she talks about needing a supervisor in working with a very troubled parent.

Sophie talks about helping the parent to integrate their experience and connect with family members.

> 'The abuser in her family was her father, over there. I needed to think about how to integrate things and she did that work really well…She was back in touch with him and he was doing a really good job as granddad.'
>
> (Sophie)

Ellen also spoke about the parent reconnecting with her sister during the parent work.

> 'For her it was very difficult to let people see how much she was struggling. However, I think there was also a part of her that really made sure people knew how much she was struggling.'
>
> (Ellen)

There seemed to be a discussion within each participant's work of pulling others in to create a wider support network, which was initiated by the parents. This may be the case with many parent work cases. However, may be more crucial if parents have a difficult history which led them to accessing CAMHS as a child or adolescent, with difficulties that go back generations.

4.9 GET 4: When the past gets in the way: Ending parent work in light of parent's previous experiences of accessing mental health support as a child or adolescent

The final GET demonstrates the variation of parent work endings participants described, which seem interlinked to parent's history of accessing mental health support as children or adolescents. These ranged from complicated and premature to good endings with contained good byes.

The ending of Sophie's parent work case crosses over slightly with the theme above, as Sophie mentioned how, once past difficulties were resolved, the parent was able to 'stop and end.' However, Sophie also comments on the ending in light of the parent's mental health difficulties as being 'good enough,' as 'this baby is being kept alive and is thriving and has potential to develop and grow.'

The theme of 'when to stop' came up several times in Sophie's interview. Sophie talks about community groups linked to CAMHS that provide continuity of care for parents and babies after finishing work. Parents can then decide when they're ready to end and stop attending.

At the other end of the scale, Sophie spoke about the ending of the parent work case she supervised that may reflect the ending the parent experienced as an adolescent in CAMHS. The parent's difficult past experiences continued to be present and couldn't be worked

through. These feelings interfered with the parent's ability to approach parent work and made the work impossible.

> 'Something felt resentful, that fear of failing their child. It was obstructive to the work and it ended prematurely because they just couldn't feel comfortable. The mother couldn't stop, couldn't leave it alone and let her daughter be seen. Very unhelpful projections…the young person my supervisee was seeing just disengaged and we thought, is this telling us something about what happened for her mother?..
>
> (Sophie)

Ellen's parent work case also ended prematurely, however this was because adult therapy became the primary need, as illustrated below;

> 'The case ended prematurely as she became unwell mentally, which makes me wonder about her own experiences in adolescence and when she was a child. There is a lot of intergenerational trauma and a very complex history of mental health in the family. The case broke down…She was really collapsed…It was left as we're not ending with you as a family. You are still with CAMHS. We are just trying to find a way to help you at this point. Your needs have changed and we are adapting to that and I honestly think she was quite relieved.'
>
> (Ellen)

Back to the other end of the scale, Tom shared two cases where parents were able to have a different ending than they had experienced as adolescents. Tom speaks about the importance of a 'contained good bye' to the service unlike previously, when they were discharged or disengaged without feeling satisfied with the support offered.

> 'She never missed a session... It was interesting that experience with that particular parent. It was possible once all these things were addressed, to have a kind of discharge that was a very contained goodbye.'
>
> (Tom)

The parent work case Mary discusses had a good ending too once the parent's difficulty with separation had been understood as described in the above theme. The child progressed and the

parents felt able to end. However, Mary makes the point that we often do not know the long term impact of work.

> ‘We ended and they felt very happy with the way the work had gone... As is often the case, I'll never know whether they actually managed to extricate themselves from their dependence on their children.’
>
> (Mary)

The idea of longer term outcomes of parent work was briefly mentioned by Tom too as being hard to measure and unknown. As Tom comments; the parent’s understanding of their son’s aggression and challenging behaviour diminished by the end of the parent work but we ‘don't know about the long term we need to go and ask them.’

Chapter 5: Discussion

5.1 Overview

This research project set out to explore the experiences of child psychotherapists engaging in parent work following the parent's previous involvement with mental health services as a child or adolescent. A mixed methods approach was adopted to investigate this experience at two levels. The quantitative audit part of the research aimed to gather data on the frequency of this experience and the qualitative interview part of the research aimed to explore the nature of the lived experience of child psychotherapists engaging in this work.

This chapter includes an in-depth interpretation of the research findings and discussion regarding how well these have answered my research questions. I will reflect on how the audit results and themes that emerged from the interview analysis fit or contradict with existing research and theoretical knowledge. This will include evaluation of the reliability and validity of the research and reflections on the study's limitations, before then outlining the conclusions drawn. I will end by suggesting recommendations for clinical practise and future research.

5.2 What is the frequency that child psychotherapists carry out parent work with parents who have had previous mental health service-user involvement themselves as a child or adolescent?

5.2.1 Low audit response rate

Despite the audit being sent to all ACP members and methods employed to maximise the number of responses received; only 3.2% of members completed it. This is a major weakness meaning results cannot be representative of parent work that child psychotherapists are

engaged in across the profession as a whole in the UK. The findings will therefore be discussed with this very small sample size in mind and the reasons for the low uptake in participation reflected upon.

5.2.2 Range in years of experience

Although small in sample size overall, clinicians who participated covered a broad range in terms of years they had been practising from trainees to 30 years. This is a strength of the audit results as despite being small in sample size overall; the audit captured data about parent work from child psychotherapists with a wide range of experience.

5.2.3 Few parents who were previous service-users have been encountered

Very few parents had been encountered by child psychotherapists who completed the audit, both over their careers and within the past year. This suggests that overall it is rare child psychotherapists work with parents who have accessed mental health support as a child or adolescent. Another interpretation could be that parent's past mental health difficulties may not always be known as this is not something clinicians routinely ask.

There was large variability in the numbers as in contrast to most responses, three participants reported work with more than 20 parents who had accessed mental health support when they were a child or adolescent. This was an unexpected finding and does not fit with the overall reported prevalence. This high number may be due to the situational factors such as working in deprived areas where mental health difficulties may be more prevalent. Or perhaps relates to the therapist's approach enabling parents to disclose their past difficulties more readily which requires further investigation. The audit data is anonymous so it is unknown but this finding could link with the interview of one participant who is an adult psychotherapist and

these skills may support parents to disclose their childhood experiences including having accessed past mental health support as children.

Taken together the low response rate overall and the range in years of experience of participants, (covering many years in total of parent work) links with the low numbers of parents clinicians reported to have worked with who had previously accessed mental health services as children. One possible reason for the small uptake in the audit was those who had experience working with this group of parents were the clinicians who tended to complete the audit. This in some way fits with the literature search results in that no other studies had investigated work with parents who had been previous service-users themselves as this may not be a common occurrence in child psychotherapist's work with parents so not considered a worthy topic for investigation.

On the other hand, given the strong research base found in the literature search linking parent and child mental health it poses the question of why parents may not have accessed support or had not disclosed their past experience during parent work. The numbers of parents who accessed mental health services for their child who had mental health difficulties as a child themselves remains unknown.

A common type of parent work reported in the audit was in therapy reviews. It may be less likely that parent's disclose their own past mental health difficulties in a review setting which is different to the private and dedicated space provided in parent work sessions. This may reflect current pressures on the NHS where the child's therapy is given priority in circumstances where there may not be a separate worker for parent work or limited time available to offer sessions to the parent despite evidence supporting the need for parent work in maximising the child's progress in therapy.

5.3 What were the reasons for parents accessing mental health support as a child and what type of professional mental health support did the parents receive when they were a child or adolescent?

5.3.1 Reasons for accessing mental health services as a child

The majority of audit responses identified first trauma and secondly depression as main reasons for accessing support. The sample is too small to identify any patterns in the types of difficulties parents had accessed mental health for when they were a child. However, the findings support research into the inheritability of mental health difficulties such as anxiety and depression (Campbell et al. 2021).

The specific types of trauma the child was accessing support for are not known so could also account for a range of traumatic experiences which may be due to a traumatic event unrelated to their family history. However the results appear to align with the growing evidence base for the presence of intergenerational trauma.

5.3.2 Type of support received as a child

The majority of clinicians did not know the mental health treatment parents who disclosed having accessed mental health services as a child had received. If known the most common reason was medication for anxiety and low mood. As mentioned above, the support received as children may not be something spoken about in reviews where the main focus is on the child's difficulties. Parents may not know or remember the specific intervention received, but it is likely they would know the general area of support, (e.g. medication or therapy) even if couldn't recall the specifics. It could be that medication was offered more frequently than therapy but the sample is too small and data depends on parent's memories from childhood so may not be very reliable.

The majority of parents mentioned in the audit had accessed support previously from CAMHS. Campbell et. al (2021) concluded that it is a common occurrence for children attending CAMHS to have a parent with a mental health difficulty. Campbell et al.'s review focused on current mental health difficulties in parents not on parent's history of mental illness. It could be that onset of parent's mental health difficulties was in childhood and carried through into adulthood. However, a longitudinal study would be needed to assess this hypothesis. Three parents mentioned in the audit did not take up parent work. Whether their past experience had impacted on this decision is not known. One parent was attending adult therapy which suggests their mental health difficulties continued into adulthood. While further information would be needed, it fits with Campbell et al.'s (2021) findings of parents who access CAMHS also having mental health difficulties themselves.

5.4 Did the parent's previous experience impact on their engagement with parent work?

The highest response for impact of parent's previous experience of child mental health services on parent work engagement was a 'moderate negative impact' and the second highest response rate was a 'positive significant impact.' This suggests that within the small sample gathered, participants felt clearly that the parent's previous experience either impacts positively or negatively on subsequent parent work in a moderate to significant degree, and did not have a mild or neutral impact. This leads into the interview findings which explore in more detail the experience of parent work from the clinician's perspective and how previous experience impacted on the parent's engagement as discussed below.

5.5 What is the lived experience of child psychotherapists engaging in psychoanalytically-informed parent work with parents who have previously accessed mental health support when they were a child or adolescent?

The analysis of the rich interview data gave insight into the lived experience of four child and adolescent psychotherapists who had engaged in parent work with a parent/s who had previously accessed a mental health service when they were a child or adolescent themselves. The following Group Experiential Themes were retrieved:

1) Parent work environment: What it stirs up for the parent
2) The influence of past experiences of accessing mental health support as a child or adolescent into the parent worker – parent relationship
3) Working on trans-generational issues, across the family system and creating a support network
4) When the past gets in the way: Ending parent work in light of the parent's previous experiences of accessing mental health support as a child or adolescent

5.6 Parent work environment: what it stirs up for the parent

5.6.1 A sense of having 'been here before' and the feelings stirred up by this.

The findings illustrate how the parent work environment is influential in evoking memories and associated feelings from the parent's past experience of mental support as a child or adolescent. These were evoked upon entering the clinic or setting and commencing parent work. All four clinicians interviewed spoke about the experience of these feelings coming in to the parent work. This suggests the memories and associated feelings stirred up in parents who were previous service-users may be important for clinicians to be aware of and consider in parent work.

For three participants the CAMHS clinic the parent had attended as a child was the same one they were attending as parents, therefore enhancing the experience of a "return". This indeed

may have made the feelings arise more strongly or readily. It could be argued that this only occurs when parents return to the same service. However, for the fourth participant who illustrated the work with a parent who accessed a different setting as a child, the past journey into mental health services still came to the parent's mind when engaging in parent work many years later. This indicates that it may be more about the therapeutic dynamic or what the mental health service symbolises and puts parents in touch with internally/ emotionally than the specific setting itself.

The results show how the strength of these feelings may lead to a certain dynamic in the parent work where the parent tests the parent worker's ability to tolerate their past experiences. Borrowing the word of one of the participants, there seems to be a need to orientate the parent in 'psychological space,' thereby helping the parent to locate what belongs to their past experience and orientate them to the present setting and clinician. The intensity of parents' feelings were also lived in the countertransference of participants; countertransferential responses of feeling 'perplexed,' 'helpless' and 'frustrated' needed to be located and understood within the experiences of parents returning to a mental health setting.

The techniques used to support parents in managing feelings stirred up, e.g. in psychological orientation or talking to the parent in a different way to acknowledge the child in the parent - would not be possible if the parent's previous experience had not been disclosed. Therefore, when such knowledge is available, the results indicate the importance of the parent worker keeping it in mind and adapting accordingly.

5.6.2 Parent's phantasies or expectations of what is on offer based on their previous experience as a child or adolescent.

The results show how the experiences and expectations of returning to CAMHS as parents were reported to be highly influenced, either positively or negatively, by their childhood experience. In particular, expectations parents had of the clinicians being the same as they were years earlier when they attended the clinic. This has some sense of going back in time and the past influencing the present. For example, it was reported of parents being angry at the parent worker for what they hadn't picked up on when the parent was a child. On the other hand, it was also reported of parents who had a good experience in CAMHS and positive transference to the service, which helps them in engaging in parent work.

The findings link to Henri Rey's concept of the 'brick mother,' which describes patients feelings towards the building where they are treated and which provides a place of safety, stability and continuity for them. Henri Rey developed this concept in relation to patients at the psychiatric unit within the Maudsley Hospital, (Henri Rey, 1994). However, this concept could also apply to the CAMHS building itself and what it represents in parent's minds. For some patients who have accessed the service at different times in their life, perhaps as children and then later as parents, it may be perceived as a place of continuity and providing stability for families across the generations.

The findings from the interviews conflict in some ways with the findings by Bone et al. (2014) who studied the perceptions and expectations of parents accessing CAMHS. Bone et al. (2014) identified a theme of 'fear of the unknown' as parents do not know what to expect. The results in this study seem to conflict with the findings of Bone et al. as parents appeared to have clear expectations of CAMHS based on previous experiences. However, it could also be that where there is fear of the unknown, this leads to anxiety; the space for the unknown in the parent's mind then becomes filled with thoughts and feelings from their past experiences as a way of managing the anxiety. If parents had had a negative experience of CAMHS as a

child, they may be more likely to put up defences to prepare themselves for accessing the service again. With negative experience in mind, along with the wish for a better experience and support for their child, the defences could be quite strong and a parent worker may need slow and thoughtful understanding to aid engagement.

5.6.3 Feelings of anger and resentment for what the parent had not received from mental health services as a child or adolescent and the impact of this on the parent work.

The results show how child psychotherapists experienced feelings of anger and resentment stirred up in parents for the support they had not received as a child upon witnessing their child receive support. This can be painful and unbearable for parents and these feelings were lived by the participants in their countertransference.

On a more extreme level, one participant experienced a feeling of 'deadening' as perhaps the anger and resentment were so strong the parent cut-off from any engagement with the parent worker making their mind and source of helping unusable. The findings illustrate how parent work treatment could be discontinued when the feelings stirred up become too unbearable, even leading parents unconsciously to sabotage their child's treatment. This could be seen at face value as envy for treatment the parent did not have. However it may also relate to Klein's notion of envy and gratitude (Klein, 1957). Parents who hadn't received the attention and support needed as children from their care-giver, and mental health services could become resentful and envious of the support their child may be receiving. This envy may manifest as an attack on the good object (represented by the parent worker) who is trying to provide therapeutic help to the parent. If parents are able to work through their difficult feelings relating to what they had not had, as was described in the interviews, they will be able to express gratitude for the work and have a good ending. This in turn may lead to a greater

understanding of themselves and their child. As a result this will improve their relationship thereby helping to prevent the repetition of trauma through the generations.

This finding from the interviews links with the audit data where clinicians rated the parent's previous experience with child mental health services as either having a positive or negative impact on parent work engagement. The interview findings suggest that feelings stirred up upon re-entering a child mental health service play a part in the parent's ability to engage with parent work. Furthermore, depending on whether the parent had a positive or negative experience as a child may then determine the types of feelings that are stirred up upon returning to a child mental health service setting.

5.7 The influence of past experiences of accessing mental health support as a child or adolescent into the parent worker – parent relationship

5.7.1 Holding the parent, the child and the 'child within the parent' in mind.

The results illustrate the capacity of parent workers to hold in mind the parent's experience of childhood and of accessing mental health support as a child during parent work. This links with psychoanalytical theories about the aims and process of psychoanalytically informed parent work. For example, Green's (2000) notion of the child in the parent's narrative being a mixture of the child in reality and the parent's own internal history. A parent's experience of mental health difficulties and accessing mental health support would be part of this and impact on the parent's view of their child and needs space to be understood. This finding also supports Fitchie's (2023) parent study which concluded that parents feeling 'held in mind'

helped them to wait with their child during the therapy process and enabled them to better understand and support their child.

The experience described by clinicians of keeping 'the child within the parent' in mind also relates to Rustin's (2009) work who noted the capacity of child psychotherapists to understand the intensity by which infantile difficulties within the parent are stirred up. All participants commented on there being something about the parent they discussed that 'stays in mind,' suggesting there was something about this group of parents that makes an impact on the parent worker. Perhaps, this is an infantile need within the parent that makes an impression on the parent-worker just as an infant projects feelings into their care-giver to ensure their needs are met (Klein, 1952). This links with Holmes (2018) study that found the common aims of parent work by child psychotherapists to focus on containing anxiety, which may come from different levels, including early infantile anxiety that the parent holds internally.

Aspects of the previous patient-clinician relationship may arise in the parent-parent worker relationship. Indeed, going from being a patient as a child to being the parent of the patient may be complicated. This came through in the audit comments as one clinician mentioned a parent who had been a patient in CAMHS and 'could not separate from that experience and engage in work as the child's mother.' It links to the first theme as a clinician mentions the parents 'transference to me and the clinic was firmly stuck to her previous experiences in CAMHS.' This relates to Stapley et. al's (2017) notion of 'stuck parents' who value the idea of help for themselves and their child but do not view CAMHS as helpful and often includes parent's with their own mental health difficulties.

5.7.*2 Building a trusting and safe working relationship for parents who have previously accessed professional mental health support as a child or adolescent.*

All participants spoke about the need for the parent to be able to trust the parent worker to share often painful childhood experiences. This fits with the description of psychoanalytically informed parent work that Rustin (2009) gives of creating a reliable setting for parent work, which enables the infantile feelings aroused to be contained in a safe setting. It would therefore be interesting to investigate if parents are more likely to disclose their past experience as a child within psychoanalytically informed parent work compared to other parent work approaches.

It could be that many parents do not feel they can trust the parent worker enough to disclose more about themselves as children and mental health difficulties experienced as a child. The results show that factors that might impact on trust are not feeling comfortable, feeling exposed, suspicious and a tendency to feel judged. Interestingly, one of the participants reflected on how private practise may help parents to trust the parent worker more as they have less tendency to feel judged as they are not 'part of the system.'

5.8 Working on trans-generational issues, across the family system and creating a support network

5.8.1 Past mental health difficulties and experiences of accessing support from childhood re-surfacing and needing resolution

The results indicate experiences of transgenerational transmission of trauma; as all participants included accounts of difficulties from the parent's childhood that were yet to be resolved that re-surfaced within parent work. One participant commented on this being a 'ghosts in the nursery' experience (Fraiberg, 1975); as difficulties from the parent's parents were transmitted leading to mental health difficulties in the parent's adolescence. It was illustrated how pregnancy might trigger past difficulties to re-surface, leading to concerns around attachment as shown in Fonagy's (1993) study, which demonstrated how infant's attachment could be based on parent's accounts of their childhoods. However, the re-surfacing of difficulties was just as alive even in situations where the children and parents were older. This theme of difficulties re-surfacing is in line with the research base regarding the intergenerational transmission of trauma (Fraiberg, 1975; Fonagy, 1993). It also aligns with the audit findings where the most common mental health difficulty reported by clinicians was trauma related.

5.8.2 Helping to separate past childhood experiences from the present.

Borrowing the words of one of the participants, the results show how parents were coming 'full circle'; the parents came as children and now bring their children to CAMHS. It is becoming clear how complex such a circle this can be, and how the first stage of the circle- the parent's past – impacts and interferes at different levels with the child's development, their relationship with the child and the parent-parent worker's relationship. From the results an idea of the need to let go of aspects of the past arises.

The results indicate how psychoanalytic informed parent work is well suited to helping separate past from present in order to make progress within parent work, recognising how a

parent might build defences due to fear; once such defences are understood, they can be overcome and make change possible.

5.8.3 Working across the generations and family system and creating a support network.

This sub-theme followed the first two as once difficulties had re-surfaced and been helpfully separated from the present, work on the family system naturally followed due to the historic trauma. Trauma passed down through the generations could then be thought about and support offered going back up to the parent's relationship with their parents. The idea of connections and re-connecting with other family members to create a support network arose in the interviews. This provides support for Sutton and Hughes (2005) aim of parent work in understanding family function and supporting the wider network around the child and family.

5.9 When the past gets in the way: Ending parent work in light of the parent's previous experiences of accessing mental health support as a child or adolescent

Given the infantile feelings within the parents that were stirred up upon accessing a child mental health setting and commencing parent work spoken about by all participants, it is likely that ending work may also resonate with previous endings. All participants spoke about offering a different kind of ending to parents to the one they experienced from mental health services as children or adolescents which relates to previous themes of reparation.

One of the parents discussed in the interviews ended parent work as they went into adult therapy. This was also the experience of one parent mentioned in the audit who did not access parent work as adult therapy was needed. The audit and interview samples were small, so it remains a question as to how many parents of children who access mental health support may not actually be able to access parent work as adult therapy becomes the priority. This links

with Campbell's (2021) who concluded that it is a frequent occurrence for parents of children attending CAMHS to have a mental health illness and therefore needs to be considered in terms a child's treatment trajectory.

One parent in Fitchie's (2023) study on parent work was on the waiting list for adult therapy and commented on feeling held by the parent worker while waiting for their own therapy. This poses an interesting question about the role of parent worker for parents who have mental health difficulties that continue into adulthood and the potential of parent work, although not individual therapy in its own right, perhaps providing a link between CAMHS and adult services and helping a parent and their child to feel held.

5.10 Critical Appraisal

My aim here is to evaluate the research study with consideration given to the limitations of the method, quality of research and transferability. I will also share my personal reflections on the process of carrying out the project and self-evaluation of myself as researcher.

5.10.1 Reliability

I have detailed as clearly as possible in the method section the process by which I carried out the literature review, participant recruitment and data collection through audit and semi-structured interviews. Therefore, the method of research is reliable. The methods used for data analysis are also replicable as I detailed the descriptive statistics used to analyse the audit findings and followed closely the process of IPA set out by Smith, Flowers and Larkin (2022).

5.10.2 Transferability

Due to only 3.2% of the ACP members having completed the audit the findings cannot be generalised to the whole profession. It may have been the case that there is an over

representation of members who had direct experience of working with parents who had previously accessed mental health support as children in completing the audit and therefore is not representative of parent work carried out across the profession in the UK. The study only recruited ACP members working in the UK and therefore the findings cannot be generalised even if the sample was larger to work by child psychotherapists practising in other countries.

In relation to the participants of the qualitative part of the study, three were working in CAMHS and one in private practise; the results, therefore, may not be relevant to other settings. The four participants were working in different locations covering rural and city areas. Therefore, although small in size the sample did cover a range of populations. Nevertheless, the sample is too small for the findings to be generalisible.

Two participants interviewed were both trained adult psychotherapists and both mentioned being attuned to the 'child within the parent' as their adult training has enabled them to do more in their work with parents. This therefore raises the question as to whether the parent's previous history may not have come up in the parent work if the parent was being seen by a child psychotherapist who was not an adult psychotherapist.

The child psychotherapists interviewed included three female and one male therapist. This is fairly representative of the profession with the majority of ACP members being female. The parents spoken about in the interviews were also all mothers and no fathers were present in the parent work described in the interview data. One of the interviewees commented on her older age and gender perhaps aiding the work in making a maternal transference and grandparent role more accessible to the parent and helping the parent to feel contained and able to trust the parent worker.

Notably race and culture did not come up in the interviews and it could be that these may have also affected parents ability to feel similar or different to the parent worker and impact on trust and openness in sharing difficulties from their past. The characteristics of the parent worker may also have impacted on how easily or intense the memories and feelings stirred up in parents from their past experience of clinicians as a child or adolescent if similar to their past experience, however, further research would be needed to explore this.

5.10.3 Validity

I will now evaluate the validity and quality of the IPA part of the study using Yardley's criteria (2000) for assessing qualitative research. Yardley set out four broad principles for assessing qualitative research. The first is 'sensitivity to context.' The chosen method of IPA to explore the lived experiences of child psychotherapists fits the first criteria as it enabled in depth exploration of the nuances of the experience of parent work.

The second of Yardley's criteria is 'commitment and rigour.' This criterion was met as commitment to data collection and analysis was shown through ensuring the participant was comfortable at the start and during the interview when discussing difficult experiences. Close attention was given to subjects during interviews to gather rich data and through many re-readings and reflections on the data during data analysis. In terms of rigour, the sample of participants was selected to link closely to the research question and be homogenous. In order to maintain homogeneity and stay close to the research question one interview was excluded from the data set before analysis as it transpired in the interview that the parent discussed had accessed mental health support in their twenties through the adult mental health service and therefore did not meet the inclusion criteria.

Yardley's third criterion is 'transparency and coherence.' In this respect the process of recruitment and data collection for the audit and interviews have been clearly explained and are therefore fairly transparent. The process of creating the semi-structured interview schedule and audit questions was also explained in the methodology chapter so this is replicable. I have aimed to be coherent in the writing up the GETS and their subthemes and explain how the subthemes were often closely linked and followed from a previous one.

The last of Yardley's criteria is 'impact and importance.' I hope this study has added to the growing body of research for psychoanalytically informed parent work. Specifically, it provides insight into the frequency and lived experiences of child psychotherapists working with parents who have had their own mental health difficulties and bring with them to parent work the experience of accessing mental health support when they were a child. The study sheds light on an important factor to consider when offering parent work and how previous experiences of mental health difficulties and support can both help and sometimes cause barriers to engagement with parent work therefore impacting on the child's progress.

5.10.4 Authenticity and reflections

Although the audit was sent to all ACP members, as a practising child psychotherapist and member of the ACP those who may have known me may have been more likely to participate. This may have impacted to some degree on the participant sample being formed of certain locations, e.g. linked to my placement and the Tavistock as my training school.

As a practising child psychotherapist I carry out parent work and was therefore careful not to make assumptions based on my clinical knowledge and experience. Whilst mindful of this I also found analysing the interviews an enriching experience and formed my own questions and reflections on my lived experience of parent work. The process strengthened my

understanding of the importance of parent work in aiding children's progress and development and need to advocate for it particularly given current strains on NHS resources.

As mentioned in the methodology section I was familiar with the two parents Tom discusses in his interview as I had seen the children for individual work which ended two years prior to the interview. Despite this gap in time and the parallel parent work having been separate from the child's individual work, the potential for bias was still present. This was continually reflected upon throughout under-taking the project in order to maintain a neutral position as researcher whilst also staying close to the data particularly during the analysis stage. During the interview the focus was kept on the clinician's experience of the parent work keeping focused to the research aims. During the analysis stage I kept a diary where I noted thoughts, memories or feelings that arose. I reflected on whether these related to my experience of the child or to the interview; ones relating to my work with the child were kept separate from the analysis.

As well as being a child psychotherapist engaging in parent work I also too had the personal experience of becoming a parent during the course of this project. This experience I believe added to my interest and understanding of the intimacy of the parent-child relationship and how one's own history comes into the relationship with their child in both conscious and unconscious ways. I found it helpful to reflect on this aspect of my own experience as I was analysing the interview data and found it enriched my questioning and interpretation through the hermeneutic cycle of IPA (Smith, Flowers and Larkin 2022). Thoughts and reflections relating to my own experience as parent were also noted in the diary mentioned above and kept out of the analysis in order to stay as close as possible to the research data.

5.11 Conclusions

This project aimed to explore the frequency that child psychotherapists work with parents who have previously accessed mental health services as a child or adolescent, and the lived experience of child psychotherapists engaged in this parent work.

An audit was sent to all members of the ACP to gather information about the frequency that child psychotherapists work with parents who have previously accessed mental health support as children. Although attempts were made to look at how representative the sample was of the whole ACP membership only 3.2% of ACP members completed the audit and therefore the sample size is too tiny for the results to be generalised in terms of being representative of the discipline as a whole. The results confirm the presence of parent work with parents who had been previous service-users as children or adolescents but suggest it is not a frequent occurrence for parents to have disclosed this within parent work.

The audit indicates that the most common reason for accessing support as children was for trauma related difficulties, followed by depression and anxiety. For the majority of clinicians they did not know what kind of mental health treatment the parent had received as a child. The most common type of known treatment was medication for depression and anxiety. The most common setting the parents had accessed mental health support as children was in CAMHS. Finally, clinicians rated the parent's previous child mental health service experience as having a moderate negative impact on parent work. This suggests a potential barrier to engagement in parent work, however due to the very small sample size; this requires further research to confirm.

Four child psychotherapists provided rich accounts of their lived experience of parent work and the interviews were analysed using IPA. Four group themes emerged from the analysis which were:

- Parent work environment: What it stirs up for the parent
- The influence of past experiences of accessing mental health support as a child or adolescent into the parent worker – parent relationship
- Working on trans-generational issues, across the family system and creating a support network
- When the past gets in the way: ending parent work in light of the parent's previous experiences of accessing mental health support as a child or adolescent

In conclusion, the results of this study are not generalisable due to the small sample. However, the results indicate that even if the number of parents who disclosed accessing mental health support as children is small, when it does come in parent work it has an impact on parent's engagement in parent work. The interviews shed light into the nuances of this experience from the parent worker perspective including feelings stirred up upon entering the clinic and commencing work through to ending. The parent's past experience can also impact on the parent to parent-worker relationship and may require the parent worker to pay particular attention to transgenerational patterns in supporting the child, parent and family.

The idea of feelings relating to parental past experience being unbearable came up throughout the study at different points; in the lack of enthusiasm from clinicians to approach parents for recruitment, clinicians reporting feeling uncomfortable to ask parents about their experience of past mental health difficulties, through to clinicians experiences of seeing parents disengaging from the parent work itself. This notion of unbearable feelings requires careful

consideration and sensitivity when carrying out parent work as will be discussed in the clinical implications below.

5.12 Clinical Implications

The findings from this study have demonstrated the impact that parent's previous experiences of accessing child mental health services can have on the nature of the experience of later parent work. The themes that arose from the lived experiences of child psychotherapists engaging in parent work with parents who were previous service-users has several implications for clinical work including the following;

1. It can be helpful to know if a parent has previously accessed a child or adolescent mental health service for themselves as this can impact on parent's ability to support their child's therapy, the relationship with the parent worker, and engagement in the parent work. This indicates the importance of finding a way to ask parents about whether they had accessed mental health support when commencing parent work.

2. Memories and associated feelings are likely to be stirred up when parents return to a child mental health service. These may be positive or negative and unbearable and can arise at different moments within the parent's experience including entering the building, waiting for their child during therapy, in parent work sessions and network meetings. The findings support the importance of the parent worker using close observation of parent's behaviour, communication and interactions to understand how the parent may be feeling to allow the parent worker to support the parent accordingly.

3. The findings support the importance of creating a safe and predictable setting for parent work as child psychotherapists routinely provide for their child patients. The findings also highlight the need to pay attention to the 'child within the parent' who may need understanding and be thought about in order for parents to separate their past experience from their child's current experience and foster their relationship with their child without the past getting in the way.

4. Parents who have previous experience of accessing mental health treatments as children or adolescents may benefit from their parent worker using supportive techniques. For example, helping to orientate them in psychological space and separate their past from their current experience or their child's. Or using certain ways of communicating with parents who may hold anger or resentment for what was not offered to them as children, or are anxious based on their previous experiences and may require additional support to reduce any barriers to engagement and prevent treatment drop-out.

5. The findings support the notion of working with the family system and point to the importance of having a trans-generational lens to a child's treatment to support connections and relationships across the family network and prevent the cycle of transgenerational trauma.

5.13 Recommendations for future research

One way of potentially increasing the response rate for the audit could be to implement an audit in specific services across the UK to give a picture of the frequency that parents disclose

past mental health support within a given time frame. It could be a routine question in initial assessments as a way of gathering a measure from all parents accessing the service within a given year. It could then be measured how many of these assessments lead to parent work with a child psychotherapist and the engagement in the parent work can be measured.

Within an audit, it would be interesting to further explore whether the frequency of parent's returning to child mental health services varies nationally or occurs more in deprived areas as speculated in the interviews. This links with research around the higher occurrences of ACES in deprived areas and higher prevalence of associated mental health difficulties.

A further study could explore the lived experience of the parents engaged in parent work following their own experience of accessing mental health support as a child or adolescent. This would allow parent's stories to be heard directly and add to research about parent's experiences of child mental health services and psychoanalytically informed parent work. This could help improve and develop parent work, including how to support parent's engagement. Given the pressure child mental health services are under and complaints being a common occurrence it could provide insight into how to better support parents who may be triggered emotionally when returning to a child mental health service for their child following their own perhaps negative experience of accessing support.

One theme that emerged from the analysis was the intergenerational transmission of trauma. Positive outcomes were also reported in parent work for three of the four interviews who had experienced trauma. This may be difficult to implement practically due to discharge processes and families moving out of area but if ethical approval was gained, a longitudinal study of parent's experiences would be valuable. This could explore if positive outcomes of the child

psychotherapy treatment including parent work continued to have an impact over time, e.g. by interviewing parents a year after or at different developmental stages as the child grows.

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Appendices

Appendix A – Ethical approval letter

The Tavistock and Portman NHS
NHS Foundation Trust

Quality Assurance & Enhancement
Directorate of Education & Training
Tavistock Centre
120 Belsize Lane
London
NW3 5BA

Tel: 020 8938 2699
https://tavistockandportman.nhs.uk/

Sarah Birch

By Email

31 May 2023

Dear Sarah,

Re: Trust Research Ethics Application

Title: 'A qualitative exploration of the lived experience of parents and child psychotherapists engaging in parent work following the parent's previous service-user involvement as a child or adolescent.'

Thank you for submitting your updated Research Ethics documentation. I am pleased to inform you that subject to formal ratification by the Trust Research Ethics Committee your application has been approved. This means you can proceed with your research.

Please be advised that any changes to the project design including changes to methodology/data collection etc, must be referred to TREC as failure to do so, may result in a report of academic and/or research misconduct.

If you have any further questions or require any clarification do not hesitate to contact me.

I am copying this communication to your supervisor.

May I take this opportunity of wishing you every success with your research.

Yours sincerely,

Academic Governance and Quality Officer
T: 020 938 2699
E: academicquality@tavi-port.nhs.uk

cc. Course Lead, Supervisor, Research Lead

Appendix B – ACP membership figures for January - December 2024

	No of members in 2024
Full Members	654
Full Members - Newly Qualified	61
Full Members - Reduced Hours	33
Honoured Full Members	3
Not Working Members	95
Honoured Not Working Members	4
Overseas Members	46
Trainee Members	220
Friends'	42
Supervising Associates -	4

Appendix C – Participant information sheet

NHS
The Tavistock and Portman
NHS Foundation Trust

Clinician Participant Information Sheet

Research Project Title:

A qualitative exploration of the lived experience of child psychotherapists engaging in parent work following the parent's previous service-user involvement as a child or adolescent.

What is this research about?

The present study aims to gain insight into the nature of the experience of child psychotherapist's work with parents who are engaging in parent work for their child or adolescent having previously accessed a mental health service for them self when they were a child or adolescent either through CAMHS or another service.

It also aims through an audit to gain insight into the number of parents that child psychotherapists are working with or have previously worked with who have previous service-user involvement as a child or adolescent, and what kinds of professional mental health support they had received when they were younger.

Who is running the research?

My name is Sarah Birch and I am the lead researcher on this project. The research is being undertaken as part of my Professional Doctorate in Child and Adolescent Psychoanalytic Psychotherapy at the Tavistock Clinic, Tavistock and Portman NHS foundation Trust.

What will participating in this project involve?

Participating in the study as a child psychotherapist involves a first part which is an online completion of an audit which will be sent by the ACP to all its members. The audit focuses on past and current work with parents.

Following the completion of the audit, you can let me know whether you are available for the second part of the study, which involves taking part in a semi-structured interview lasting up to 75 minutes. Interviews will take place online using Microsoft teams. During the interview, you will be asked to reflect on your experience of carrying out parent work with parents who have previously accessed a mental health service when they were a child or adolescent. Interview topics will be sent beforehand to allow for some preparation and reflection prior to the interview.

What are the possible benefits of taking part in this project?

You may benefit from the opportunity to think about and make sense of your experience of working with parents who had been previous service-users and how this may have impacted on the parent work. You may gain some personal satisfaction from knowing that their involvement in this project could contribute to the body of knowledge and understanding in the field of mental health and help to improve mental health services.

Are there any risks involved in taking part in this project?

There are no direct risks to taking part in this study. However, I am aware that each individual will have a personal relationship to the topics being discussed and as such may stir up strong feelings. Anyone taking part in the study will be given a debrief letter in which they will be provided with details of how to access a confidential service which they could use to reflect on the experience of the interview and what it may have stirred up.

What will happen to the data collected?

All data collected during the course of the research will be handled in accordance with the Tavistock and Portman's data collection and handling policies, please see https://tavistockandportman.nhs.uk/about-us/governance/policies-and-procedures/.

Data from the audit will be completely anonymous and used as a group format and not linked to the individual participant who answered the audit.

Each interview will be audio recorded and transcribed for data analysis purposes. It is hoped that up to 4 clinicians and 4 parents will participate.

The transcription will be made anonymous through using pseudonyms. All interviews will remain confidential unless there is a disclosure of any imminent risk to harm oneself or another, then this will be shared with the relevant bodies as part of safeguarding procedures.

Any personally identifiable information from the interviews will be de-identified so that they cannot be identified in the study's write-up.

Electronic data will be stored on a password protected computer and paper copies will be kept in a locked cabinet and will be kept for no more than 3 years after the end of the study, they will then be destroyed in line with the University's Data Protection Policy. All audio recordings will be destroyed after completion of the project.

During the data analysis from the interviews some direct quotes may be used. Because the group is a small number of people it is possible that you may be recognised from your direct quotes although every effort will be made to prevent this through anonymisation such as changing names and particularly identifying details.

What will happen to the results of the project?

The results of this study will be used in my Professional Doctorate thesis. It may also be used in future academic publications and presentations.

Who is sponsoring this study?

This study is being sponsored by The Tavistock and Portman NHS Trust.

Disclaimer

You are not obliged to take part in this study and are free to withdraw from the project for up to three weeks after your interview.

I will be using information from participants in order to undertake this study and will act as the data controller for this study. This means that I am responsible for looking after their information and using it properly. I will keep identifiable information about participants from this study for not more than 3 years after the study has finished.

Your rights to access, change or move your information are limited, as I need to manage your information in specific ways in order for the research to be reliable and accurate. To safeguard your rights, I will use the minimum personally identifiable information possible. I will use your name and the contact details you provide only to contact you about the research study. I will be the only person who will have access to information that identifies you. I may be assisted in the analysis of this information by my research supervisor and/or senior colleagues, but they will not be able to identify you and will not be able to find out your name or contact details.

You can find out more about the legal framework within which your information will be processed by contacting the sponsoring Trust's Clinical Governance and Quality Manager, Irene Henderson: IHenderson@tavi-port.nhs.uk

This research has been formally approved by the Tavistock and Portman Trust Research Ethics Committee.

If you have any concerns about the conduct of the researcher or any other aspect of this research project, please contact The Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk).

If you would like to discuss any of the above with me further before making your decision or if you have any questions, concerns or would like more clarification please do not hesitate to contact me on the email or phone number below and I can arrange a time to speak with you. You can also contact my research supervisor Dr Lucia Genesoni (luciagenesoni@gmail.com).

Contact details:

Sarah Birch

Child and Adolescent Psychotherapist in Training

Tavistock and Portman NHS Foundation Trust and University of Essex

Sarah.birch16@nhs.net

Appendix D – Participant consent form

NHS
The Tavistock and Portman
NHS Foundation Trust

Participant Consent Form

Research Project: A qualitative exploration of the lived experience of child psychotherapists engaging in parent work following the parent's previous service-user involvement as a child or adolescent

Researcher: Sarah Birch

Please read each statement and tick the box of you consent:

I confirm that I have read the participant information sheet (Version number 1, date 15.02.2023), which provides details of the nature of the research and how I will be asked to participate. I have had the opportunity to consider this information and ask any questions that I might have.	
I understand that this is research that will lead to a professional doctorate and may be published.	
I understand that I am being asked to take part in a semi-structured interview with the researcher and that my interview will be audio recorded, transcribed and analysed for the purposes of the study.	
I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researchers involved in the study will have access to the data. It has been explained to me what will happen once the research programme has been completed.	
I understand that although all efforts will be made to ensure confidentiality, due to the small sample size of this study there is a small chance I may be identifiable to others	
I understand that any identifiable information linked to my participation in the research will be de-identified and held securely by the researcher.	
I understand that should any disclosures about the risk of imminent harm to myself of others is shared in the interview then this will need to be passed on to the relevant services in line with safeguarding procedure.	

I understand the results of this research may be published in the form of a thesis, journal article, academic publications or presentations with no personally identifying details included within the write-up.	
I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the research without disadvantage to myself and without being obliged to give any reason.	
I understand that I have 3 weeks from the date of my completion of the interview to withdraw and that after this time I cannot withdraw from this research project	
Participant's name: _____ Signature:_____	

Thank you for agreeing to take part in this study. Your contribution is very much appreciated.

Appendix E – Audit recruitment invitation and audit questions

Invitation to take part in a research project regarding parent work

Dear ACP member,

I am writing to invite you to take part in my research project.

I am a child and adolescent psychotherapist in training at the Tavistock. I am researching child and adolescent psychotherapist's experience of working with parents who have previously accessed a mental health service when they were a child or adolescent, and the impact this may have had on their engagement in parent work for their child.

I would be grateful if you could please complete the following online audit questionnaire.

Please copy and paste the link below into your internet browser to take you to the questionnaire:

https://forms.gle/1BCYXNsZurXd1gmt6

It should take you approximately 10 minutes to complete.

Thank you very much for your time and consideration.

Kind regards,
Sarah Birch

Child and Adolescent Psychotherapist in Training
Tavistock and Portman NHS Foundation Trust and University of Essex
sarah.birch16@nhs.net
Work mobile: 07436027683

Parent work audit

A questionnaire to investigate the frequency and experience of child psychotherapist's work with parents who have previously accessed mental health support for themselves when they were a child or adolescent.

1.	How many years (including your training), have you been working/worked as a child and adolescent psychotherapist? If you are a trainee then please can you state this and give which year of the training you are in, (e.g. trainee - 3rd year). If you are retired then please state this.
	———
2.	Thinking back over your career (including your child psychotherapy training), approximately how many parents in total have you worked with who have mentioned having accessed mental health support from a professional for themselves when they were a child or adolescent? *Please note this audit does not include parents who are under the age of 18. (This figure includes parents seen for; parent-work as a stand-alone treatment, parent-work alongside individual child psychoanalytic psychotherapy, parent work alongside another child treatment, (such as art therapy, group therapy, CBT) and parents seen in regular review meetings).
	o 0 o 1-3 o 4-6 o 7-9 o 10-12 o 13-15 o 16-18 o 19-12 o More than 20
3.	From the figure given in question 2, how many of these parents have you worked with in the last 12 months? (As in the last question, this includes parents seen for; parent-work as a stand-alone treatment, parent-work alongside individual child psychoanalytic psychotherapy, parent work alongside another child treatment, (such as art therapy, group therapy, CBT) and parents seen in regular review meetings).
	___
4.	For the parents mentioned in the previous question, what was the nature of the support they were provided as parents? Please tick any/all that apply.
	o Parent work sessions as stand-alone treatment o Parent work alongside their child's psychotherapy o Parent work alongside another child treatment o Parents seen in regular review meetings o Other
5.	Do you know the *reason* for the mental health support the parents you identified in the previous

	questions (if any) received when they were a child or adolescent? (Please tick any/all that apply)
	○ Depression or feeling low ○ Anxiety ○ Peer relationships ○ Family issues ○ Problems with attention or focusing on activities ○ Trauma ○ Challenging behaviour ○ Other
6.	Do you remember what *type of mental health support* the parents you mentioned in the previous questions said they received as a child or adolescent, if any? (Please tick any/all that apply).
	○ Mental health assessment ○ Medication for anxiety or depression ○ Individual psychotherapy ○ Counselling ○ Group therapy ○ CBT ○ Family therapy ○ Sibling therapy ○ Strategies or advice to help manage emotions ○ Don't know ○ Other
7.	Do you know *where* the parent/s you mentioned in the previous questions accessed the mental health support they received as a child or adolescent?
	○ In CAMHS ○ Through a charity ○ School counsellor/therapist ○ Privately ○ Don't know ○ Other
8.	Have you worked with any parents in the last 12 months who have mentioned they had accessed mental health support as a child or adolescent but you are <u>not</u> seeing or have seen for parent support sessions?
	○ Yes ○ No ○ Cannot remember
9.	If you answered 'yes' to question 9, please can you give a reason why you did not carry out parent support sessions? (e.g. parent was seen by a different clinician, parent did not take up the offer of parent work).
	_____
10..	If you have carried out parent work sessions either in the last 12 months or prior to this, with parents who had previously accessed mental health support as a child or adolescent, then please can you answer the following question: How much do you think the parent's previous experience of mental health support when they were a child or adolescent has had an impact (either positive or negative) in facilitating the way the parents have engaged with the parent work with you for their child? Please give an impact rating from -3 to +3 on the scale below. If you think the parent's previous

	experience had both positive and negative impacts on the parent work then please give 2 ratings. (If you mentioned more than one parent above, then please give separate ratings for each of these cases).

	Significant negative impact	**Moderate negative impact**	**Little negative impact**	**No impact**	**Little positive impact**	**Moderate significant impact**	**Significant positive impact**
Parent 1							
Parent 2							
Parent 3							
Parent 4							
Parent 5							
Parent 6							
Parent 7							
Parent 8							
Parent 9							
Parent 10							

11.	Do you have any other comments?
	_____
12.	Are you happy for me to contact you about taking part in an interview about this topic? If so please can you give your email address below and I'll send you the participant information sheet which includes further information about this study.
	_____
	Thank you very much for you time in completing this audit.

Appendix F – Semi-structured interview preparation sheet

The Tavistock and Portman
NHS Foundation Trust

Semi-structured interview topics for clinicians

Thank you for agreeing to participate in the interview stage of my research project. I look forward to meeting with you and hearing your thoughts on the topic.

Before attending the interview you may wish to reflect on your experience of working with parents as a child psychotherapist, and perhaps revisit some of your clinical notes from relevant cases if possible. Alternatively, you might prefer to attend the interview without any preparation to see what thoughts and memories come to you spontaneously during the course of the discussion. This is entirely your choice.

Please see below a list of the topics which I hope to cover in the interview:

- Information about your job role and the types of parent work you usually offer
- Experience/s you've had in your career so far of encountering parents who have been previous mental health service-users as a child or adolescent.

In relation to a particular parent you have worked with or are currently engaging in parent work with who has been a previous mental health service-user as a child or adolescent…

- How this family arrived at your service and commenced parent work
- When and how you found out that the parent had accessed a mental health service for themselves as child or adolescent
- How the parent understood their own previous mental health difficulties as a child or adolescent
- How you think the parent understood the difficulties their child is currently facing in relation to their own prior mental health difficulties as a child or adolescent
- How you think the parent viewed the parent work they were engaging in and your role
- In what ways you think the parent's previous experience of mental health services may have helped or hindered the parent work they were engaging in with you
- Whether the knowledge of the parent's past mental health difficulties and experience accessing support shaped the nature or course of the parent work you were doing
- In what ways if any did the case relate to the concept of intergenerational trauma

Thank you for your time in thinking about the above and look forward to the interview with you.

Appendix G – Interview schedule prompt sheet

Semi-structured interview questions for clinicians

1. **Please can you tell me about your job role and the types of parent work you usually offer?**
   Prompts: What does parent work usually look like in your service, e.g. how long does it usually last? Is the child usually seen alongside the parent work or does parent work take place without the child attending therapy?

2. **Please can you tell me about the experience/s you've had in your career so far of encountering parents who have been previous mental health service-users as a child or adolescent?**
   Prompts: Can you tell me about the frequency of these cases that have been referred to you? How do they usually get referred to your service/s you've worked in?

Thinking of a particular parent you have worked with or are currently engaging in parent work with who has been a previous mental health service-user as a child adolescent…

3. **Can you tell me how this family arrived at your service and commenced parent work?**
   Prompts: Can you tell me more about how they were referred? How was the decision for parent work as an intervention made?

4. **Can you tell me about when and how you found out that the parent had accessed a mental health service for themselves as child or adolescent?**
   Prompts: How did you feel when they disclosed this information? At what stage in the therapy did this information come up?

5. **Can you tell me about how the parent understood their own previous mental health difficulties as a child or adolescent?**
   Prompt: How did you understand the parent felt about their past difficulties and experience of mental health support. How did you feel upon hearing about the parent's experiences?

6. **How do you think the parent understood the difficulties their child is currently facing in relation to their own prior mental health difficulties as a child or adolescent?**
   Prompts: Were any comparisons made by the parent with their child's difficulties? Did the parents perception of their child's difficulties in relation to their own change at all over the course of the parent work?

7. **How do you think the parent viewed the parent work they were engaging in and your role?**
   Prompt: Did their views change at all over the course of the intervention?

8. **In what ways do you think the parent's previous experience of mental health services may have helped or hindered the parent work they were engaging in with you?**

Prompts: In what ways may it have helped them engage in the work? Can you tell me about any challenges that arose in the parent work and how these were overcome?

9. **Do you feel the knowledge of the parent's past mental health difficulties and experience accessing support shaped the nature or course of the parent work you were doing?**
   Prompt: In what ways did you have to adapt the work if any in light of their disclosure?

10. **In what ways if any did the case relate to the concept of intergenerational trauma?**

Appendix H – Participant debrief letter

Post interview debrief letter

Dear Participant,

Thank you very much for taking part in my research project, your contribution is very much appreciated. I hope you found the opportunity to reflect on your experiences useful. I hope also that your contribution as part of this research project will help to improve the support offered by mental health services to children and their families.

I'd like to remind you that all information collected during your interview will be stored securely and that any information from the interviews about you, your child or patients will be anonymised so that they cannot be identified in the study's write-up. All audio recordings will be destroyed after completion of the project.

I will hold on to your contact details so that I can let you know when the research is published, in case you'd like to read it.

If you would like an opportunity to discuss any concerns about your participation in the interview or have any questions, please feel free to contact me: sarah.birch16@nhs.net or my supervisor, luciagenesoni@gmail.com. If you have any concerns about the conduct of the researcher or any other aspect of this research project, please contact the Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk).

I understand that it is possible that the interview may have stirred up difficult or complicated feelings for you related to your life as a parent, work or own mental health. Below are some sources of information and support that may be useful.

- The charity Mind offers information and advice to anyone experiencing a mental health problem. Their website is www.mind.org.uk
- If you would like to speak to someone about your care in CAMHS you can contact The Patient Advice and Liaison Service (PALS). PALS is a confidential service that offers support to patients, relatives or carers who can help problem solve any issues you have about your care in the NHS. The PALS team can be contacted as follows FREEPHONE 0800 783 4839 or Email: elft.pals@nhs.net
- For clinicians - The ACP website can offer support in accessing supervision and support related to your work. https://childpsychotherapy.org.uk/resources-professionals

Thank you again for your time and participation.

Kind regards,

Sarah Birch

Child and Adolescent Psychotherapist in Training

Tavistock and Portman NHS Foundation Trust and University of Essex

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Appendix I – IPA coding table example

Emergent themes Capture/reflect understanding of participant's words and analyst's interpretation. Not explicitly alluded to but connected to what was said	**Transcript source data**	**Exploratory comments**		
		Descriptive Describe content of what was said, key words, phrases, sound bites, explanations, assumptions, acronyms, emotional responses (participant and analyst), thoughts, experience at face value, what matters to participant	**Linguistic** Language use - try and interpret this, e.g. emphasising, sense of... How the content was presented. Laughter, pause, fluency/hesitation, repetition, metaphors, tone, pronoun use, tails off, sigh, emotional moment	**Conceptual** More interpretive. Could be interrogative –prompts questions, countertransference Understanding of participants overarching understanding of the matters discussing e.g. feeling particular relationship to sense of isolation common to all
Parents feeling under threat can stop clinicians from being able to think in sessions, deadening the clinician's mind.	E: Something that really struck me from the start is how she described herself and P_ as twins as identical, that she understood her son better than anyone because she has the same diagnosis because she knows what it's like. And and I thought at the time it was a bit of a warning for me as well, you know, like don't don't think that you're gonna tell me anything I don't know. I'm the expert of my child and I think from the start I found her quite challenging to just even to to be with her. Umm to be present. Umm, I kind of my mind was just like kind of dead, you know, kind of it just failed. Bombarded with all this information and he was really difficult for me to to think really.	Mother described herself and child as twins, as identical. She said she understood her son better than anyone as they have same diagnoses, she knows what it's like. Parent appeared to be giving a warning she is expert on her child. Felt challenging to be with the parent. E felt her mind 'was kind of dead' 'it failed' 'bombarded with information' and 'difficult to think'	Understood her son 'better than anyone' emphasis on parent's authority of her son and how well she knew him as they were 'twins' parent warning parent worker. Feel sense of attack on thinking in description used – 'bombarded,' 'dead.' 'Difficult for me to think' Hesitation 'to to think' conveys the stuckness in being able to get her thoughts going/use her mind	Parents may feel threatened by the thought that someone else knowing their child better than they do. Parents have need to communicate this which can make work very difficult and stop the clinicians mind from working as they communicate this.

Appendix J – Table of Group and Personal Experiential Themes

Group experiential theme 1: The parent work environment: What it stirs up for the parent	**Group experiential theme 2:** The impact of parent's previous experiences of accessing mental health support as a child or adolescent on the nature of the parent worker to parent relationship	**Group experiential theme 3:** Working on trans-generational issues, across the generations and family system and creating a support network	**Group experiential theme 4:** When the past gets in the way: ending parent work in light of the parent's previous experiences of accessing mental health support as a child or adolescent
Sub-theme 1: A sense of having 'been here before' and the feelings stirred up by this	**Sub-theme 1:** Holding the parent, the child and the 'child within the parent' in mind	**Sub-theme 1:** Past mental health difficulties and experiences of accessing support from childhood re-surfacing and needing resolution	Being able to stop and end the work. Not require referring on as things have resolved Ending of work with child may share features of ending of work parent had as a child **Ending parent work can feel painful** **Parent work may not turn out how the clinician expected.** Success of parent work intervention may be difficult to measure. What may appear small signs of progress or change may make a big difference to a parent's daily life **Long term outcomes of parent work can be unknown and**
Environmental transference triggers memories of having been here before *Orientation in both physical and psychological space* *Sense of having 'been here before' in an environment transference to the service* *Unclear whose setting it is and who 'got here first'* *Wanting to get rid of an uncomfortable feeling* Parent already has an attachment to CAMHS *Waiting involves not being seen or listened to which can stir up difficult memories and intense feelings*	*Therapist holding parent as their own separate person as well as a parent* **Something about this patient stays in mind** *Baby known and held in mind despite not yet being seen* ***Two children being focused on in parent work the child referred to CAMHS and the child within the parent*** ***Parents bring themself and their experience of needing help as well as themselves as a parent needing help for their child*** ***Needs of the child can continue into adulthood and parenthood*** ***Moments of realisation occur in parent work conversations when parents as well as the child are held in mind*** ***It's important for some parents that their experience as a child is recognised***	*Unresolved difficulties coming back in needing continuity of the work* *Birth of baby may trigger mental health difficulties in parent to re-surface* *Transgenerational trauma may affect the bond with one's baby as difficulties relating to trauma re-surface.* *Desire to be a good parent and something getting in way* ***Parent difficulties with separation can be passed onto their child*** *Making links to parents history can help things to move on* *Parent work can involve understanding and removing what has caused development to become stuck, allowing the child to move on.* Parent difficulties with separation can be passed onto their child	

	Parent work may involve holding the parent. ***Parent work enables the parent to be held in mind in similar way to the child being held in mind by their therapist. Some parents may need this more than others.*** Mental health support can be provided at different levels some addressing deeper levels than others. ***Parent workers who are also trained as adult psychotherapists may have a certain valency for parents sharing information about their childhood, or the child within them.***		**difficult to gather.** **Letting go can be extremely painful** **Parent work can involve understanding and removing what has caused development to become stuck, allowing the child to move on.** **Possible to have contained goodbye and discharge** **Need to investigate if effects of understanding parents gain during the work is sustained over time.** **Parent work can bring about an opportunity for a second chance of reparation** **Past negative experience can lead to persecutory projections that can impede on-going work** **Restless and uncomfortable hard to let past go**
Sub-theme 2: Parent's phantasies and expectations of what is on offer based on their previous experience as a child or adolescent	**Sub-theme 2:** Building a trusting and safe working relationship for parents who have previously accessed professional mental health support as a child or adolescent.	**Sub-theme 2:** Helping to separate past childhood experiences from the present.	
Parents may have phantasies of what their clinician and work will be like when they return to the service *Weirdness and negative experiences can be located somewhere over there away from here* *Parent knows where to look for help as received help there previously* *The setting the parent attended as a child may have changed in reality over time but not in the mind of the parent* *Previous experience of child mental health services can lead to assumptions parents bring to future appointments*	*Grandmother status can facilitate parent-infant work* ***Parents not always comfortable to share whether they have accessed mental health services themselves as child or adolescent*** ***Disclosing prior mental health difficulties and support is complicated for parents*** ***Parent needs to be met where they are at for engagement to follow*** ***Feeling listened to allow for disclosure of previous experience and their story as a child*** Amount and type of work	*Difficult to separate differences between past and present experiences.* *'ghosts in the nursery' experience* *Concerns of what may be projected onto baby in utero* *Trauma in parent's past needs understanding to help the parent with their parenting* *Help:* *A full circle sense of completeness in parent bringing their baby after coming themselves* *Complaints and grievances may belong to an earlier time when parent was in CAMHS themselves as a patient*	

The nature of the parent work may not be what was expected.	with parents depends on the receptivity of the setting ***A parent's history can affect their ability to trust the receptiveness of the psychotherapist*** The gender of the parent worker matters and can affect the work in ways that relate to the parent's history and life experience ***Building a relationship with a parent is a gentle process that needs time.*** ***Parent worries about being judged on their parenting abilities.*** ***Parent worker can take up different positions in the parent's mind, may be seen as judgmental.*** ***Parent work allows for opportunity for a professional to take a different position one of compassion.*** Parents may feel threatened by the thought that someone else knowing their child better than they do. ***A parent's past experience and trauma may determine how easy they are able to feel safe with the parent worker.*** ***Feels extremely exposing for parents to share their past*** Clever strategies may be needed to support engagement and get to deeper levels of understanding to help parents go beyond surface level problem. ***Timing of disclosure from***	**'locking horns' between parent and clinician over who has parental authority** *Emotional difficulties of child may mirror emotional difficulties of the parents.* *What belongs to parents and what belongs to child can get muddled.* *Intergenerational confusion* ***Fear of history repeating itself can lead parent to put up defences.*** *Anxiety can lead to problem being misplaced and can lead to risk of wrong intervention being offered if not explored first what belongs to whom.* *Parent work requires exploration of the problem and projections separation of what belongs to whom.*	
Sub-theme 3: Feelings of anger and resentment for the mental health support the parent hadn't received as a child and the impact of this on the parent work		Sub-theme 3: Working across the generations and family system and creating a support network	
Feelings of resentment evoked when child listened to in a way the parent had not experienced *Opening up what may feel unbearable for parents* *Parents who had mental health service involvement as a child or adolescent may hold resentment about what was missed and what they missed out on when they were a child that their child may now be receiving*		***CAMHS can act as a family supporting the different generations of children and parents.*** *Lots of professionals can be involved in linking up with them around the parent and child* *CAMHS helps link services together to construct a family system around the parent and child* ***Parent work is cross***	

Anger at what clinicians missed in the parents childhood may be projected into anger towards the parent worker in the present *Parent worker can feel deadened at times during sessions* *It's important for some parents that their experience as a child is recognised*	***parent about their mental health difficulties varies depending on parents' readiness to share their past experience.*** ***Parent may need to test parent worker's resilience and how much they can tolerate knowing about the parent's difficult past.*** ***Parent mental health difficulties may not be easy to recognise at a surface level*** ***Parents need to feel comfortable in order to speak freely and share vulnerabilities*** *Parents disclosure of mental health support when they were a child or adolescent is complicated and different factors are involved.* **Parent work through a private therapist may free parent's anxiety about being in a system.** *It can take time for parents to disclose their own mental health difficulties of the past or present, may not be known at the start of parent work* ***Parent work can be frustrating and power imbalance when it's difficult to get to know the child through the parents as it depends on parents openness*** ***Emotional and can take time to process hearing about parents difficult experiences as a child. Parent worker may feel maternal affection for the child within the parent*** ***Feeling safer in private***	***generational, it involves 'understanding how therapy works across generations and family systems'*** ***Focusing on the family as a whole and exploration can allow for disclosure of parent's previous mental health difficulties to arise organically in the conversation.*** Work with parents can trigger the opening up of memories covering various difficult experiences *Parent work can involve addressing some of the issues carried from the parents childhood that may be interfering with parenting ability* *Intergenerational trauma can lead to difficulties with emotional development in a child* **Asking for help is complicated:** Trying to get help from services for one's child can feel like a battle Parents can have a way of mobilising the network Finding a home? Professional home Home for baby and mother	

	practise to disclose p.8 transcript. Less anxiety about being in the system. **Parent work through a private therapist may free parent's anxiety about being in a system.** Countertransference of parent worker can provide understanding of emotional state of the parent **Role of parent worker can involve taking up different roles.** **Parent work is different from adult therapy for a parent** **Parent work requires boundary setting** **Parent worker may need to reach out to seek therapeutic help for parent in their own right as an adult outside remit of parent work.** CAMHS clinic as a co-parent Linking up with the parent and including parents in the therapy process is key		