Fight, flight, freeze, (for)give: what do we hear when we listen to child psychotherapists talk about parents and parent work in the context of their daily practice

Fight, Flight, Freeze, (For)give:

What we hear when we listen to child psychotherapists talk about parents and parent work in the context of their daily practice

Roni Bor MA

A thesis submitted in partial requirement for the DPsych in Child and Adolescent Psychotherapy

Birkbeck, University of London

May 2020

Declaration

I, Roni Bor, declare that the work presented in this thesis, ‘Flight, Fight, Freeze, (For)give – What we hear when we listen to child psychotherapists talk about parents and parent work in the context of their daily practice’, is entirely my own, except where otherwise referenced or acknowledged. It was supervised by Prof. Lisa Baraitser.

Signed: Roni Bor

Abstract

This thesis presents the results of a qualitative research project aimed at exploring the place of parents and 'parent work' in child psychotherapy theory and practice through the way in which it is talked about by child psychotherapists in the UK. The rationale for the project emerged from the researcher's own experience as a child psychotherapist trainee in a Child and Adolescent Mental Health Service where a range of supportive and therapeutic work with parents was often done by other clinicians alongside the child's therapy. There seemed to be great variety amongst professionals, including child psychotherapists, in the way and manner in which they practiced this parent work. Some exploration of the literature drew attention to a lack of resources for parent work in Child and Adolescent services, and a lack of conceptual support in both the theoretical literature and in training schools.

In order to explore this gap in literature and practice, a qualitative narrative research project was designed to address the question of how child psychotherapists understand the place of parents in their work, and how they make sense of the work they do with parents in their daily practice. 11 senior child psychotherapists agreed to participate in the study, and 7 of the interviews were chosen for full analysis. A linguistic approach to Narrative Analysis was chosen as the preferable methodology to analyse participants' accounts. Narrative Analysis is a powerful tool for revealing the stories we tell about personal experiences, and the ways these stories shape and produce experience. The aim was to learn about parent work through listening to the stories that child psychotherapists construct when they talk about their work with parents. It was also hoped that we would be able to deepen our understanding of the professional identity that child psychotherapists portray when they talk about this subject.

The analysis revealed three main narratives: a story of 'threat' that revolves around a sense of heavy responsibility and burden, and the construction of the therapist as taking a serious and careful approach in response to various challenges and external constraints on the work; a narrative about 'wobbly' therapeutic space where parents seem to come in and out of focus and the attitude towards them alternates between distance and closeness; and a story of 'identity in action' in which child psychotherapists construct themselves as active, assertive and solid in order to facilitate development and change.

A discussion about possible underlying reasons for these particular narratives is discussed, as well as the counter-narratives that run through the interviews, such as therapists' passion to help their patients and make a difference in their lives. The discussion includes issues of reflexivity and the process and development the researcher went through over an extended period of ten years of engaging with this project.

Table of Contents

Acknowledgements

Thank you, **Jill Wilson**, for setting up the doctorate programme as part of the child psychotherapy training at the BAP (now IPCAPA). Thank you also for all of your generous support along the way.

Thank you, **Laura Paynter**, for, together with Jill, taking care of so many aspects relating to the doctorate, including the formalities relating to my own situation and status as a doctorate student, long after I finished being a student at the BAP.

Thank you, **Janine Sternberg**, for continuing to provide support to me along the way.

Thank you **Conor Byworth, Dan Alexander, Matthew Banham** and **Richard Abbott** from Birkbeck for helping me sort out all the formal, financial and technical aspects of being a student.

Thank you, **Teresa Bailey,** my inspiring service supervisor during my child psychotherapy training, for providing a truly unconditional deep trust, support, love and belief in me. This support has, during and since my training, influenced many professional and personal steps I took forward.

Thank you, **Wendy Shallcross,** my tutor during my pre-clinical studies at the Tavistock, for being an important inspiration and support to me and for providing unique, valuable insights at different times along the way.

Thank you very much **Pamela Bartram**, my clinical supervisor, for always willing to listen, read, comment and support different aspects of my work journey and my transition from a trainee to a qualified child psychotherapist.

Thank you to my dear, close friend, **Maaike Engelen,** for your support, care, listening, interest, love and understanding of me and for many, many hours of discussion, exploration, sharing and processing of our ideas.

Thank you to my family: my **dad** and my **mum**, for a lot of encouragement, for always being available and incredibly patient to engage with hours of conversations, which allowed me to process both my thinking and struggles along the way as well as feel stronger and readier to engage with them. Thank you for believing in me, when I didn't. Thank you to my mother-in-law, **Elaine,** for her good spirit, her exceptional unconditional support and trust in me and my way. Thank you to my husband **Shimon**, for putting up with my journey, and all the uncertainties and unknowns embedded within it. Thank you to my **brother** and **sister** for always being there for me and accepting me the way I am. A special thank you to **Dan** and **Yotam**, for helping me grow into becoming a mother, for surviving my mistakes, and for teaching me a lot about Love and what it means to be a mum to you.

A big thank you to my editor, **Emily Steadman**, who not only put a lot of attention, effort and rigour into editing my work, but also approached the subject with genuine care and interest. She was the main person 'outside' the community of therapists who read my work, and her feedback and our mutual exchange was immensely valuable and rewarding.

Thank you to my **participants**, for volunteering to take part in this research, for being so kind, welcoming and generous with your time and with your sincere attempts to share your thoughts and experiences, and for all of your thoughtful and encouraging feedback after the research was done. This research would not have existed without you.

And last but not at all least, THANK YOU **Lisa Baraitser**, for your generous feedback and encouragement, valuable guidance, for being there, for making the effort to understand not only my doctorate topic but also me – my way of thinking, processing and working. Thank you for respecting yet helping me put aside many irrelevant ideas along the way. Thank you for passing on an enormous amount of knowledge, for all the teaching, direction, the help in developing my ideas and for being immensely supportive and SO patient with my very slow and not straightforward journey!

With much gratitude and appreciation, Roni

Chapter 1
Introduction

What we hear when we listen to child psychotherapists talk about parents and parent work in the context of their daily practice

This research project arose out of my wish to explore the work done with parents by child and adolescent psychotherapists (CAPTs) and the place it occupies within child and adolescent psychotherapy (CAP) practice. When I was a CAPT trainee at an NHS Child and Adolescent Mental Health Service (CAMHS), seeing children for individual therapy, it was common for another professional, either from the CAPT team or another discipline, to see the parents. This, I found, didn't always go smoothly. I realised there was no accepted view about parental involvement on both a practical and an emotional level. I found great variation in the way other professionals carried out this parent practice, from the frequency of sessions with parents, the contact with parents between sessions, confidentiality issues, the approach to parents, and perspectives of and aims for the therapeutic work. Above all, there seemed to be no clear guidance for this type of work, nor clear theoretical reasoning for the various ways of working.

An initial look at the available literature in this area confirmed that research was indeed lacking and the literature itself identified that theoretical resources were scarce. As early as 1974, for instance, John Bolland stated that he was not the first to be interested in 'the problem that was kept quiet' (1974, p.14), referring to parent work. More recently Pasqual Pantone has discussed 'new child therapists' strong reluctance to involve themselves intensively in therapeutic treatment with the parents …' (2000, p.21).

In the empirical literature, there weren't many studies done specifically about parent work, but rather about parent work as one aspect of child therapy (e.g. Fonagy & Target, 1996). Research about CAPTs' experiences of working with parents was even less prevalent (Whitefield & Midgley, 2015, and Holmes, 2018 are an exception). In addition to the lack of theoretical resources available, in my own experience – four years of extensive training, comprising many theoretical and clinical seminars – there was little focus and space for thinking directly about parent work. There was also no specialist supervision offered for it, even though taking up a parent work case was one of the training requirements.

I became more interested in this gap in literature and practice – where did the avoidance come from? I wondered whether there was something particularly complex, difficult, perhaps even anxiety-provoking and uncomfortable about parent work that led CAPTs to avoid creating and allowing enough space for sharing experiences, talking and thinking about it. This research project is a response to these gaps. It involves a study designed to talk to CAPTs to hear about their experiences of parent work and try to understand and make sense of those experiences. It attempts to situate the findings of these conversations within the discipline of CAP and the context in which CAPTs are currently working.

1.1 **A 'Crisis' in Child and Adolescent Mental Health** (ACP Newsletter, August 2018)

The Association of Child Psychotherapy (ACP), the professional body for CAPTs in the UK, was founded in 1949 and CAP was recognised as an NHS core profession in the 1970s. As a professional body, the ACP governs members' professional training, accreditation, continuous learning and development. It functions as an internal regulator for the profession by developing and monitoring a set of high-quality standards of competency, ensuring they are maintained by members. In addition, 'It is registered with the Professional Standards Authority (PSA) and is responsible for regulating the training and practice standards of child and adolescent psychotherapy across the public and private sectors'. It has two main functions to maintain: 'protecting the public' and 'promoting the profession' (ACP, 2019).

On an external level, it engages with policy work with government and non-governmental organisations and campaigns to improve mental health services for children and young people. The ACP also produces the *Journal of Child Psychotherapy*. It aims to adhere to its long psychoanalytic tradition as well as keep up with changes in the environment. 'We are functioning in a different and changing environment and are a modernised organisation' (Pick, 2019, in ACP Newsletter, February 2019).

CAPTs work in NHS settings, third-sector settings and private practice. CAPTs often exercise their expertise in one (or more) of the following specialist areas: paediatrics, autism, eating disorders, working in schools, Under 5s, looked after and adopted children, peri-natal services, refugees and asylum seekers, and court work.

In the last few years, the ACP has recognised a growing mental health crisis in children and young people in the UK. In January 2018 they launched a campaign called 'Treat Them Right', explaining in their January/February newsletter that they were '… campaigning for all CAMHS services to have access to an ACP registered child psychotherapist, so that every child can benefit from our skills, expertise and experience as part of a truly comprehensive system of support'.

In June 2018, they then published a report, 'Silent Catastrophe: Responding to the danger signs of children and young people's mental health services in trouble', sharing it with CAPTs, 'key politicians, the media and supporting organisations' (Waggett, 2018, p.5). One of their biggest concerns is that 'many children and young people with more complex problems will be left without the specialised support they desperately need' (ACP Newsletter, January/February, 2018).

The ACP communicated to its members the risk of losing funding for CAPTs' training as well as raising the issue of '… the future of CAPT as a vital core profession within specialist CAMHS' (Waggett, 2018, p.5). Dr. Ruth Schmidt Neven, clinical psychologist and child psychotherapist, highlighted the issue of CAPTs being '… vulnerable in a cost-cutting environment and feel[ing] under pressure to provide 'evidence' of the efficacy of their treatments and services' (2018, p.13).

In light of the above, Nick Waggett, the ACP's Chief Executive, has reiterated that 'we need to regain the strong voice that we have had in the past in being able to represent the needs of patients and to share our deep understanding of what works … In order to do this the ACP needs to be a robust and sustainable organisation …' (2019, p.5). The ACP is thus recognising the somewhat vulnerable (or powerless) position of the child psychotherapy profession against external pressures and threats while at the same time asserting its unique role, value and contribution to child mental health on a national level ('powerful', but not necessarily 'in power').

Where does this tension in the profession between vulnerability and unique contribution leave parents? What is their place in our mind and practice? The name CAPTs – Child and Adolescent Psychotherapists – doesn't necessarily imply work with parents, and their main public working place, CAMHS, also doesn't seem explicit about the fact it's a service for

parents too. In the current 'crisis', it seems more important than ever that parents aren't left unseen, unrecognised and further neglected. Parents often seem to be taken for granted in debates about a crisis in child mental health services, and indeed in child mental health. It's as if parents easily fall into a 'non-position', one where we (rather omnipotently?) think 'they are always there anyway' and therefore they are '… there to be left' (Furman, 1982, p.15). Perhaps it's because we have all had parents (or those who have performed the role of parents) that we don't seem to see parents as separate, having needs and requiring attention.

We cannot afford, however, to collude with the idea that children's problems are 'out there' and parents have nothing to do with them. In other words, we have to acknowledge that parents suffer from a political crisis in child mental health services too and may well want to change things. They are an integral part of their children's world. How can they not then be an integral part of the fight for their children's mental health? Including parents in our thinking and reflections is a good way to start 'modelling' how to keep the context of the family as well as services cohesive, and how worries, responsibilities and concerns can be shared. Moreover, learning to 'parent' our professions' anxieties, tensions and ambivalence in relation to parent work practice would be a valuable model of how to 'parent' the parents in our society. Internally, attending this neglected area in our practice will naturally contribute to a more integrated profession, stronger both internally and externally.

For these reasons, research into parent work appeared to me to be both timely and valuable. In order to be helped, children need not only robust therapists, but robust parents. Though on a theoretical, empirical level we understand more than ever that parents are *needed* for child psychotherapy practice to be effective (e.g. Midgley, O'Keeffe, French & Kennedy, 2017); it's actually through opening up a space to understand what we, as CAPTs, w*ant* and really *feel* about it, that we may be able to approach this subject rather than avoid it.

I again wonder, what are we trying to avoid? What lies at the heart of the avoidance? What is it that we may be feeling uncomfortable or anxious about? As CAPTs, what are parents for us? How open are we to think, share and process possible complexities and tensions within the work and relationship with parents? How comfortable are we when it comes to having to exercise a more flexible practice? How much do we strive to enjoy our work? How comfortable are we in thinking about the ways in which the structure of our training, profession and discipline might affect the way we conduct and experience parent work?

As I began this research project, I was interested in the practicalities of doing parent work and some of my initial research questions were designed to address this. However, as I proceeded, it became clear that parent work's complexities went far beyond its practicalities and that CAPTs' professional identity was, in part, being constructed through those experiences. The main guiding question that emerged for the project thus became 'What is the place of parents in Child Psychotherapy?'. I aimed to find out how CAPTs made sense of parent work in their daily practice.

This thesis is structured as follows:

In Chapter 2, the Literature Review, I look at parent work and views of parents within the child psychotherapy discipline, based mainly on British literature (and some others).

In Chapter 3, Method, I present the design of this research and how it came about, detailing the size and choice of the sample and addressing ethical concerns. I explain my rational for using a Narrative Analysis methodology.

Chapters 4, 5, & 6, Findings, are a presentation of the in-depth analysis of the transcribed accounts of my interviewees. They present the three main narrative themes that have emerged from the analysis and integration of the material across interviews: Threat/Pressure, Wobbly Space and Identity in Action. Narrative segments are presented throughout the chapters to provide evidence and support for those themes.

Briefly, 'Threat' (Chapter 4) portrays a sense of burden in CAPTs' talk. The emphasis is on difficulties, obstacles and problems in the work, a sense of danger and a need to be careful when working with parents, as well as a sense of seriousness and need to convey that this work entails a lot of responsibility and obligation, as if there is 'no choice' in carrying it out.

'Wobbly Space' (Chapter 5) comes from the sense that parents were coming in and out of focus in therapists' talk, that there was a preoccupation with the boundaries of the therapeutic space in the therapist's mind and a sense of conflict in the relationship with parents between a more distant connection and a close one.

‘Identity in Action’ (Chapter 6) looks at the assertive, ‘active’ and categorical language therapists use in an attempt, it seems, to portray a solid, strong identity of themselves, which focuses on change and development.

In Chapter 7, the Discussion, I reflect further on the findings presented and link them with the theoretical literature. I concentrate particularly on the narrative of ‘power’ as an underlying reason for some of the anxieties and sense of danger in the relationship with parents. Other issues I look at are the way in which external stresses as well as the actual structure of training and discipline feed into the sense of danger. I reflect further on the possible restricting and persecutory experience of boundaries and how the way therapists manage those stresses within and outside the profession becomes in itself a catalyst for further stress, sense of obligation and responsibility in the work and a compromised free space to express real feelings, stay with tensions, and potentially enjoy a flexible and creative practice.

In Chapter 8, I conclude by saying that it seems the way we as a profession take care of and manage our anxieties, tensions and ambivalence towards parent work reflects the way we ‘parent’ these aspects within our profession. I argue that by being encouraged to talk freely and bravely among ourselves we can feel more supported and connected. Consequently, we might feel we can bring more creativity, freedom and fulfilment to our parent work practice, while relying on our inherent passion to ‘make change’.

Chapter 2
Literature Review

What we hear when we read what child psychotherapists write about parents and parent work in the context of their daily practice

2.1 Historical overview of the development of parent work in the UK

To place parent work in a local, historical context, I have decided to focus mainly on theoretical and clinical literature in the area of child psychotherapy in Britain, also drawing on literature from the United States (US). There have been some attempts to review the history of parent work within child psychotherapy (e.g. Baldwin, 2014; Novick & Novick, 2005; Horne, 2000; Siskind, 1997). Reviewing the literature reveals widely differing views on how parent work developed as well as how the child's and parent's mental worlds have been perceived over time. It makes outlining a narrative of 'parent work' across time quite complex in itself. My attempt in this chapter, apart from reviewing the history of parent work in the literature, is to catch the spirit, tone and narratives that come across in the writings about parents and parent work. This will, I hope, be a good way to set the scene and highlight the complexity of the topic.

Both Gvion and Bar (2014) and Novick and Novick (2000) identified the 'first analysis' as done 'by proxy', meaning via the parent. For example, Freud (1909) guided Hans' father in treating 'Little Hans' and Anna Freud very clearly included parents in her thinking about child analysis. Furthermore, it seems likely that she was grappling with what should be their position and role in the child analysis (e.g. Geissmann & Geissmann, 1998, p.105; Midgley, 2012, p. 63). Yet, even when Midgley describes how Anna Freud '… worked with Peter's [Peter Heller – her most famous child patient] parents to try to limit the degree to which he was exposed to the world of sexual sexuality'…. and 'supported a referral for Peter's mother to an analyst' (2012, pp.61-62), and other examples too, it's still not clear how frequently and in what form her interventions with parents took place.

Parents were, at that time, seen as largely responsible for their child's therapy, although opinions on the efficacy differ. 'Anna Freud's actual practice', claim Novick and Novick, 'revealed a sophisticated appreciation of parent work' (2000, p.57), whereas Gvion and Bar

view it as rather ‘invasive and exposing’ for the child (2014, p.59). It is difficult to pinpoint when ‘parent work’ as we know it began. Nancy Berlin suggests the roots of parent work – where the child’s therapist met the parents for occasional ’parent guidance’ sessions – lie in ‘Anna Freud’s (1965) child-guidance model’ (2008, p.337). However, Novick and Novick describe an earlier start, though for the whole field of child analysis (and not for parent work specifically); ‘… psychoanalysis as a method of treatment for children did not start until the 1920s with the work of Anna Freud, Melanie Klein, Hug-Hellmuth, and the Bornsteins …’ (2000, p.57).

Yet it’s hard to get a sense of the degree to which parent work was acknowledged. According to Novick and Novick, ‘in relation to parent work they [A. Freud and M. Klein] both had little to say’ (2000, p. 57). Moreover, ‘they [A. Freud, M. Klein, Hug- Hellmuth and the Bronstein’s] further reinforced denial of the pathogenic or constructive impact of the family’ (2000, p.57). However, the Novicks attributed the biggest neglect of the family domain (parents included) to Melanie Klein, ‘whose theory and technique ignored environmental effects’ (2000, p.57). Sorensen, however, disagrees with this view, arguing that ‘a close study of [Klein’s] work shows us how the richness and complexity of the inner world is in a continuous feedback loop with the external world’ (2005, p.159).

Lanyado and Horne describe how ‘in the 1920s the child guidance movement … reached the UK’ (2009, p.3). The first Child Guidance Clinics (later replaced by CAMHS NHS settings) occupied a central place in children’s therapy. Emanuel Miller, a psychiatrist, founded the first clinic in East London in 1927 and seemed to promote a view of the child being part of a larger family. ‘Experience has stressed the importance of understanding the role the family, the grandparents, and uncles and aunts play in the problems of the child’ (cited in Renton, 1978, p.311). Although the ACP was not founded until 1949, child therapists were already working in those early Child Guidance Clinics. The work was done within a multidisciplinary team and the social workers who carried out parent work had a ‘psychoanalytically based understanding of human development and family relationships …’ (Rustin, 1998, p.234).

The Hampstead Clinic opened in 1951 (Geissmann & Geissmann, 1998, p.161), where psychoanalytic treatments of children took place, as well as assessments, training and research and, of course, where Anna Freud’s work was based too. ‘In a few cases simultaneous mother-child analyses were carried out by two different analysts. Regular meetings were organised

with the mothers of young children in analysis' (Geissmann & Geissmann, 1998, p.162). Again, it's hard to decipher the manner and degree of those meetings, and how much they were indeed a form of 'classical' parent work as we know it. Novick and Novick aren't very optimistic, saying that, following World War II, many parents were referred to psychoanalysis themselves, while their children were in therapy, 'so the special nature of work with parents could be avoided' (2000, p.57). As we can see, disagreement and confusion still exist about how and when 'it all started'. What looks like 'parent work' may vary in the eyes of those who review and write about it, and parents seem to come in and out of focus in CAPTs' mind, work and writings.

In the 1970s, the child therapy field faced another shift. Changes in training and reduced funding meant social workers became less involved in the kind of parent work practice just discussed (of parent and child being seen separately by different therapists). The discipline of Family Therapy became more dominant, offering a new, alternative model of understanding relationship dynamics (Rustin, 1998). This left a gap in parent work practice that got filled yet again with the work of CAPTs themselves, facilitated perhaps, by the ACP gaining recognition by the NHS in 1974. Since then 'the supportive work with parents … is now more frequently undertaken by child psychotherapists themselves' (Rustin, 2009, p.213).

Within the different training schools of psychotherapy in London, a more informal overview of parents' place in therapy shows there used to be specialised supervision for parent work cases in some places, yet this is no longer the case. The Tavistock and Portman NHS Trust run two year-long seminars that focus on working with parents. While taking both seminars is recommended, it is only obligatory to take one. Students can choose which one they take (or they may decide to take both) and at what point they take it. Specialist supervision for parent work cases is available if needed. The Independent Psychoanalytic Child and Adolescent Psychotherapy Association (IPCAPA) also runs a workshop about parent work that every trainee has to take. They are shorter and run over five seminars, with a relatively short reading list.

2.2 More recent developments in the writings about parent work

Publications and writing about parent work waned between the 1970s-1990s, suggesting the thinking and appreciation of its importance and complexities were somewhat neglected during that time. However, parent work seems to have had a revival following a progression in infant

research (e.g. Brazelton, Koslowski & Main, 1974; Stern, 1974; Trevarthen, 1976; Murray & Trevarthen, 1985; Cohn & Tronick, 1988; Meltzoff & Moore, 1992; Reddy & Trevarthen, 2004) and developmental theories, which originally relied on attachment theory (e.g. Ainsworth, Blehar, Waters & Wall, 2015) and interpersonally-oriented psychoanalytic theories (e.g. Winnicott, 1960; 1965). In the US, this theoretical and clinical development was named the 'relational shift' (Jacobs, 2006, p.226). These developments offered a new and growing context for both thinking and working directly with parents (e.g. Jacobs, 2006; Pantone, 2000; Altman, 2000) to the degree that parent work was now acknowledged and rendered essential (e.g. Berlin, 2008).

However, as noted, no change is straightforward. Berlin is critical about the change in theory and claims that, in practice, CAPTs continue to marginalise parents. Indeed, when reviewing the writings about parent work, it seemed to be represented mainly in those areas that offer alternative models of working with parents, such as 'Under 5' work (e.g. Emanuel, 2006; Emanuel & Bradley, 2008), Berlin's (2008) 'Tripartite model of therapy', and Jarvis's (2005) consultation model for working with parents of adolescents.

The idea that parent work as an area – both in practice and in the theoretical thinking and writings – had become somewhat neglected in classical child psychotherapy came to the fore around the turn of the 21st century. Sutton and Hughes' 'experience is that it [parent work] no longer seems to occupy the same position, and may sometimes even be regarded as peripheral or optional' (2005, p.170). In the US, Novick and Novick argue this neglect may be due to the fact that child and parent work is thought of as 'second class psychotherapy' (Chethik, 1989, cited in Novick & Novick, 2000, p.59). Trowell, Rhode, Miles and Sherwood (2003) addressed this neglect in their research on childhood depression, and Tsiantis, Boethious, Hallerfors, Horne and Tischler (2000) published a collection of papers specifically on work with parents.

Another promising development was in 2005, when the *Journal of Child Psychotherapy* dedicated a whole issue to parent work. More recently, the Journal published two important papers on the subject – Claire Whitefield and Nick Midgley's 2015 paper and Joshua Holmes's 2018 study of parent work in his clinic. Both studies rely on interviews with child therapists to understand CAPTs' perceptions, views and experiences with parent work. Encouragingly, it appears the challenges and importance of working with parents are, once again, becoming more present in therapists' awareness.

Looking through the literature for relevant papers was an interesting and informative process in itself, revealing something important about the nature of this area. One of the characteristics of the parent work literature is that it relies on clinical examples writers use to illustrate different issues in parent work or to form conclusions and recommendations (and sometimes warnings) about this practice. The case study is an established research method in psychoanalytic and psychotherapeutic research, and using clinical examples seems to help form and construct views about parents and how to work with them, as well as recognising the challenges. These papers, however, lack an empirical research component as they contain very few systematic collections of views, ideas and experiences of parent work through the eyes of CAPTs, and across a larger sample of CAPTs, and there is a lack of systematic analysis of their experiences. My own research attempts to bring something different, interviewing CAPTs in a systematic manner about their experiences of parent work and analysing their narratives. Also, rather than relying specifically on clinical examples of working with parents, I invited therapists to talk and share their thoughts about the *topic* and *area* of parent work itself.

In my search for relevant papers, I identified six main categories where working with parents was discussed: Papers about parents who had to stay in a hospital/residential psychiatric unit due to their own mental health problems; papers about parents whose children/adolescents were staying in residential settings/psychiatric departments due to serious mental health problems (such as psychosis and eating disorders); papers concerned with work with children Under 5 (which contains quite rich material); papers focusing on the state of mind of mothers experiencing post-natal depression; and papers focusing on work with parents (mainly mothers) who have experienced – or their infants have experienced – some birth-related trauma. Another quite extensive category is parents whose children have some kind of neurodevelopmental disorder/atypical development, including autism (mainly), ADHD, psychosis, eating disorders and physical disabilities. Each of these categories offer a different angle to think about parents and the challenges involved in the work with them. Other disciplines where parent work has been discussed are Couples Therapy and Family Therapy.

For the purpose of this thesis, I have focused on papers written specifically about working with parents in the context of classical child psychotherapy (where the child is seen alongside parent work sessions, or parents are being seen prior to seeing the child or as an intervention in itself), and on those published primarily in the *Journal of Child Psychotherapy* (founded in 1960). There are both logistic and conceptual reasons for this. Logistically, other areas of parent work

are not included due to limited space and a need to focus on one aspect. Furthermore, some are vast areas of expertise in their own right, such as Couples Therapy, Family Therapy and Child Psychology, and rely on their own (often vast) literature. Conceptually, we can see that Under 5 work, for example, is seen as situated within both Brief Therapy and Family Therapy (e.g. Daws, 1999, p.267), and I would add, in Child and Infant Development research. Under 5 is also seen as a way of applying traditional psychoanalytic thinking (e.g. Daws, 1999, p.267; Edwards and Maltby, 1998, p.110) and expanding the clinician's work (Hopkins, 1992).

Expanding the analysis of parent work into Under 5 work and other disciplines would certainly add to the wider field, and further develop our knowledge of parent work. However, in order to keep my focus on child therapists, it felt imperative that this particular research relied on a more specific paradigm, which would provide a sufficient level of depth to best understand therapists' experiences and perceptions of parents.

By writing about parent work, I am trying not only to create a space for it, but to gradually understand what might be underlying the relative neglect and avoidance of engaging with and writing about parent work within the CAP field. Following a brief look at the definition of parent work, I will move on to explore its place in theoretical literature through what I have recognised as the conflictual views on parents.

2.3 What is parent work?

We will see that even the attempt to define and name parent work is difficult and implies a variety of meanings. First, it's important to acknowledge parent work as 'what makes child psychotherapy different from adult psychotherapy' (Gvion & Bar, 2014, p.58). There seems to be a general agreement that parent work's primary purpose is to support the child overall, and specifically when they are in therapy. Green suggests that the 'broad aim of work with parents … is to engage them in an unfolding process in which their child could gradually be understood and responded to in his or her own right' (2000, p.29). Slade reiterates that '… there is certainly no single way of approaching this work that will be universally helpful to children and families … we often find our way as we go' (2008, pp.207-208).

Interestingly, in all these descriptions, there is little thinking about parents in their own right, let alone about the work with them deserving a special space. In that sense, Sutton and Hughes, who coined the term 'psychotherapy of parenthood', are an exception. They indeed have been

trying to ‘capture its essential and significant nature’ (2005, p.185). When talking about parent work, it’s hard not to talk about the variation in the practical aspects of ‘doing’ parent work. My own thesis very much began there, when I became curious about clinicians’ different practices. My thinking has since developed and led me to look at what *underlies* the varieties, which I will talk about next. It’s important to acknowledge, however, as this overview has shown, that when we think of parent work practice, we are indeed engaging with a ‘challenging, complex and important’ area (Sutton & Hughes, 2005, p.185) that has a contradictory nature where ‘the parental presence as therapy agents, namely as a medium and support for the therapeutic process, is one of the paradoxical parameters of working with children’ (Gvion & Bar, 2014, p.70).

The main area of conflict, as I have identified, is with the kind of relationship therapists have with parents and the way in which they position themselves in relation to parents. This core conflict, I believe, manifests itself in two main areas. First, therapists’ attitudes and way of managing the boundaries and the setting for the work, and what can often translate into manifold practical considerations, such as whether the same or separate therapist should work with parents, the frequency parents should be seen, the consistency of setting, and how much to share with parents between sessions (e.g. Altman, 2004; Frick, 2000; Ruszczynski, 1993; Sutton & Hughes, 2005; Gvion & Bar, 2014). Whitefield and Midgley ask whether the setting needs to be in ‘the same room, the same time’ (2015, p.277), and Siskind wonders ‘at what age should we consider the child too old for us to continue to maintain regular contact with his parents? What is the child’s right to confidentiality and what is the parents’ right to know what is going on in their child’s treatment?’ (1997, pp.4-6).

Second is the therapeutic way of working with parents and, therefore, the choice of technique. For example, the reliance on transference and countertransference processes, the acknowledgement of unconscious processes, and the offering of interpretations along these lines. Underneath these variations in technique and practicalities, I believe, lie much deeper variations in views, perceptions and experiences of parents and the work with them. I will concentrate next on therapists’ views of parents as they arise in the literature.

2.4 Conflictual views of parents:

a. From blame to empathy:

The views towards parents and the place they take in their child's development seem to have developed over the years. In the past, the psychoanalytic and child psychotherapy literature seemed to take a more blaming attitude towards parents. Interestingly, though, it was easier to access papers where clinicians were writing *against* a historical parent blaming attitude. Leo Kanner, for example, an American psychiatrist who had noticed and written about autism in children, was seen as looking for reasons in the parents and therefore blaming. In his early writings he asks, 'whether or to what extent the parents' personality contributed to the condition of the children?' (1944, p.217). Klauber too, recognises Kanner's views as ones that can be perceived as blaming, due to his focus on aetiology (1989, p.87). Many years later, James Harris comes to Kanner's defence, writing that 'Kanner, unlike Bettelheim, did not blame parents for causing autism …', and that 'he rejected psychological care rearing approaches that blamed mothers long before publishing his paper on autism' (2019, p.6). Harris also provides historical context, taking into account the time in which Kanner was writing, which can help explain his views:

> *'Although Kanner's conclusion that infantile autism was an innate disorder eventually set the stage for modern genetic studies, at the time his paper was published, the focus in psychiatry, especially in psychoanalysis, was on the role of psychosocial factors as causative in the aetiology of psychiatric disorders' (2018, p.4).*

Without being able to fully know the underlying beliefs, we can see that the preoccupation with guilt, who attributes blame to who, and the need to defend against this, are present.

According to Klauber, 'Tischler (1971, 1979)', for example, '… propounded a much more subtle and complex model, which found it impossible simply to blame mothers or parents' (Klauber, 1989, p.87). In his writings, he tries to help clinicians develop awareness of not only the impact of working with immense child trauma and disturbance but also what they as themselves bring to their relationship with children and parents. 'The great divergence of views on the aetiology of childhood psychosis … seem to me to be partly due to the emotional attitudes [of clinicians]'. Later he adds that 'careful attention to the bias and preconceptions one brings into this work, and the various types of countertransference, which emerge during it, is an essential condition for sound treatment and research' (1979, pp.29-30).

Lydia Folkart, in her paper about working with mothers at The Cassel, a psychiatric hospital, noticed 'a distorted view [among staff] of the child as an extension of the mother and a receptacle for her problems' (1964, p.46). She felt these views led to an 'over-emphasis of the mother's role in the psychic development of her child', which fed into the 'already heightened guilt feelings of the mothers about the damaging effects … that their own illness had on the child' (Folkart, 1964, p.46).

As we will see, CAPTs are preoccupied with parental guilt in their work with parents. Barth has noticed that

> *'To a greater or lesser extent, most analysts seem to agree that psychodynamics evolve from an intricate interplay between actual experience and the meaning such experience has for the individual … Yet the language of psychoanalysis often appears to imply a belief that someone … is at fault in the development of the individual's dynamics' (1989, p.186).*

Trudy Klauber asks directly: '… How far do we unconsciously blame parents for their children? Are parents bound to feel some measure of guilt when something is *wrong* with their children?' (1998, p.86). While it may not be easy to admit to such views, therapists' reflective practice allows them to be observed and noticed.

Perhaps it is not then surprising there was a need to counter these negative views with more benign ones felt to be fairer to parents. The experience of working with parents of children with more severe difficulties could have originally led to these negative views, yet later on, could also have prompted a shift in the thinking, putting therapists in touch with how parents feel. Houzel, in her paper about working with parents of autistic children, reveals her awareness of old views about aetiology and how 'ineffective but also sometimes harmful' they were (2000, p.116). The parents of those children often exhibit a great anxiety and were seen as the 'source of that anxiety' (2000, p.117). Houzel encourages parents not to blame themselves, rather to 'speculate on the meaning of their child's symptoms and to support them in their search for meaning' (2000, p.120).

Klauber, who also worked with the trauma of parents of 'severely disturbed children' (1989, p.85), touches on the difficulty therapists can have in differentiating *their own emotional*

difficulties in the work with a disturbed child from the parents' anxieties and emotional struggles. In a situation where therapists feel a strong identification with the suffering child, their own emotional difficulties (separate to the child and parent) may be masked.

We can see how therapists' views of parents are interlinked with the experience of working with parents, and how this can get more complicated in a profession where CAPTs' feelings and experiences are important both as a tool to understand the other's emotional world but also in their own right as an expression of therapists' own difficulties and struggles in managing this work. Those feelings may partly represent the 'real responses' to having countertransference responses. The ability to differentiate between the two seems to be an ongoing challenge for the therapist. Bernstein and Glenn have written too about this, saying that 'countertransference then is but one type of emotional reaction to patients. There are other types of counter-reactions as well, and all require discussion' (1988, p.225). They enlisted six different categories of the analyst's possible emotional reactions: 'Countertransference; Transference to patients or their parents; Relating to patients or parents based on character traits; Identification; Narcissistic attachments to the patient; and Responses to the patient or parents as real people' (1988, p.225).

I would like to state further that it might be therapists' raw experiences and intense, uncomfortable feelings that made them first flee from this subject. Touching these raw feelings and experiences is uncomfortable not only because it can put therapists in an unfavourable light, but also because it can expose therapists' vulnerable position and strip them of what might feel like their protective professional identity. For the purpose of this research, however, I would like to make space for CAPTs' 'real' feelings and struggles and to pay attention to the ways in which they can get easily overlooked and not receive proper acknowledgment.

Moving on, we can see much evidence in their writings of therapists being aware of parents' difficult feelings in the therapeutic work. Folkart notes 'how frightened they [mothers] were of what I might discover about their children' and how easily they were prone 'to blame themselves for anything that might have gone wrong with their children' (1964, p.47). Jarvis became aware of 'the painful and extreme emotional burden that … parents are experiencing' (2005, p.213). Gvion and Bar write not only about parents' feelings in relation to their child's difficulties, but also about their child being in therapy. Backed by previous studies, they describe complex feelings of 'relief, hope, gratefulness, guilt, anxiety,

apprehension, jealousy and aversion' (2014, p.63). They also write about the feeling of rejection when parents are asked to stay both literally and symbolically 'behind a "closed child's room"' (meaning the child therapy room's door) (2014, p.64).

It seems that even though we can track some positive development over time on therapists' view of parents, it is harder to pinpoint the subtle ways in which these 'guilt-oriented' views may be lingering. It could be in the use of language, in the assumptions of both therapists and parents, and in parents' inclination to blame themselves and 'find a reason' for their children's difficulties 'somewhere'. How do we know guilt and blame haven't been pushed somewhere else, into some of what we recognise these days as dysfunctional services or failing policies? How do we know we haven't projected them into our own profession? It is therefore possible that both parents and therapists (and children) are influenced by wider forces. These questions would thus benefit from further exploration.

b. From burdensome to value and importance

John Bolland voices rather critically, though reflectively too, that therapists seem to hope parents 'will not *interfere* with the analytic process' (1974, p.12 – my italics). Diana Siskind acknowledges a sense of burden in therapists who work with parents, theorising that therapists 'do not feel *free* to interpret these often hostile communications (verbal and nonverbal) of the parents of our child patients …' (1997, p.14 – my italics). Siskind implies there are some restricting aspects within parent work practice that impact therapists' sense of freedom in the work and, I believe, their sense of enjoyment too. I will develop this point later. The restricting aspects of the work are possibly interlinked with restricting views of parents and the relationship with them, important only for the sake of supporting their child's therapy rather than for getting to know them better in their own right.

Novick and Novick summarise, somewhat pessimistically, the vicissitudes and 'tantalising' changes in the views of parents: 'Parents were first ignored, then, in the halcyon days of psychoanalysis, taken for granted, and now, in the struggle with the array of apparently simpler solutions, parents are seen as the main interference with the start, maintenance, or appropriate ending of analysis' (2000, p.59). Like before, we can identify different kinds of voices. Bolland, for example, supports the idea of taking a more positive and respectful attitude towards parents and says that '… the value of the contacts with the parents lies in getting to

know what kind of people they are, not to diminish them by using them as information-givers about their child and his activities outside the analysis …' (1974, p.12).

A shift in views about parents can also be seen in parallel to the developing theory and research about the relationship between child and parent. Novick and Novick write about the change in Erna Furman's (1995) views of parents, and how she moved from focusing on parents 'as the prime source of interference with therapy' to focusing on the interactional and reciprocal quality of 'the parent-child relationship' (2000, pp.60-61). According to them, she had claimed even further that '… when we disregard the parent, we leave out crucial parts of the child's self, sometimes the best parts, and when we treat the parent and disregard the child, we commit the same mistake' (cited in Novick & Novick, 2000, p.61).

What seems to be additionally 'interfering' and complicated is the underlying conflict about the position of omnipotence and power. On one hand, CAPTs who see parents as 'the major contributor to the child's difficulties' are also worried about 'becom[ing] the more benign and more effective caretaker to the child …' (Jacobs, 2006, p.228) and therefore occupying a position of power in relation to the parents. Martha Harris spoke too about being 'wary of attempting to take responsibility for the management of the child's life outside the treatment room' (1968, p.63). Dilly Daws writes that 'we design our professional trainings to help curb such omnipotent feelings within ourselves …' (1986, p.104).

On the other hand, 'resolving' this dynamic by 'minimising' therapists' contribution and attributing more importance to parents can end up in its own problematic polarising conflict, where parents are being pushed into a powerful position with too much emphasis on their influence on their children (whether 'good' or 'bad'). This can result in parents feeling under pressure, too powerful, guilty and responsible for their children (which is the position we tried to move away from in the first place). It can also result in therapists seeing parents as too powerful and themselves as powerless in relation to them and in general. This can lead to a vicious circle where parents can be seen by therapists as 'dangerous' 'if one does not find a way to get along with them', or when they 'undermine the therapist's work', or 'take their child out of treatment' (Siskind, 1997, p.4). From here it's only a short step back to forming blaming attitudes towards parents or seeing them as intrusive or a 'burden'. Not getting caught up in this conflict of being 'too powerful' vs. being 'powerless' is difficult, as the literature on parents indicates.

In contemporary practice, based on research, there seems to be a commonly held view among CAPTs that parents are immensely important to their child's ability to change and benefit from therapy (e.g. Kennedy, 2003; Trowel et al., 2003; Wachs & Jacobs, 2006) and, moreover, that parents need their own space. In the retrospective study they conducted, Fonagy and Target found that:

> *'With an intensive and complex treatment over some years… it is by no means clear that the analytic work has been the crucial ingredient… although some confirmation did emerge, in multivariate analyses of treatment outcome, that additional aspects of the Centre's work (parent guidance, psychotherapeutic treatment of parents…) did have an impact on the extent of change in the child's functioning' (1996, p.63).*

Sutton and Hughes declared that it's even rather 'unethical (at times), apart from being ineffective, to provide psychotherapy for a child without ensuring that the parents (or alternative carers) also receive therapeutic help' (2005, p.185).

However, what seems to be left unclear is whether CAPTs feel parent work is *needed* or *wanted*. We have reached the point of collectively accepting that parent work is *important*, but that doesn't tell us what CAPTs actually feel about it – whether they feel the pressure and need to do it or whether they actually feel they want to engage with parents. What has really happened to the 'old' views of seeing parents as 'intrusive' or 'guilty'? Have we gained a better understanding of those 'uncomfortable' feelings? Have we really processed them or just located them elsewhere and avoided them altogether? Being aware of the difference between 'needing' and 'wanting' may turn out to be important. I will return to this issue in the Discussion chapter.

c. From dependence to independence in the relationship

How CAPTs see parents and their relationship with them – in other words, what parents are for CAPTs – has important consequences for the technique used in parent work. Diana Siskind tackles this issue by asking, 'When the parent of a child in treatment is seen by his or her child's therapist, is that parent to be viewed as a patient or as something other than a patient? … What do we call the relationship between the child's parents and the child's therapist? … How simple our life would be if the boundaries of patienthood were so clearly demarcated…' (1997, pp.9-13). Klauber articulated the implications of these dilemmas and the core conflict in parent work

when she said '… How can we make use of the transference and, most particularly, the countertransference when we are working with parents but not usually 'doing psychotherapy'?' (1998, p.86).

There seems to be a spectrum of views about what parents are for CAPTs, what CAPTs call the work they do with parents, and how CAPTs work with parents. On one end is the more common view that sees parents as *'parents but not patients'* (e.g. Sutton & Hughes, 2005). Here CAPTs tend to rely on a mixture of conscious and unconscious aspects in the relationship and although they might observe transference and countertransference processes[1], they would not favour addressing them directly with parents. The main aim is to support and strengthen the parents in their parental role, and the child – whether in therapy or not – is very much the focus. 'Usually the therapist works with the parents in an array of educative efforts and facilitative interventions, only rarely with interpretative interventions. [Those] might well be used, however, if parents become disillusioned or discouraged with the therapy and begin to express their dissatisfaction in ways that interfere with the treatment' (Kernberg & Chazan, 1991, p.86).

At the other end of the spectrum is the view that sees 'parents as patients' (e.g. Rustin, 1998), where CAPTs rely more on unconscious parts and aspects of the relationship with parents and make more direct use of transference and countertransference processes. The underlying reasons for the different approaches are varied and not always clear in the literature. They seem to be influenced by the type of engagement with parents such as assessment, consultation, and ongoing work; by the therapist's experience and training; and by clinical judgment – how seriously parents are able to take their 'children's welfare' (Rustin, 1998, p.249).

Other aspects that I believe combine elements of the above are how much CAPTs feel able to 'allow' parents to be *dependent* on them in the therapeutic encounter and how comfortable therapists are with the *intensity* of the relationship with parents. Another, seldom talked about aspect, is how comfortable therapists feel with their own dependency on parents, the pressure to engage with them and their own inherent vulnerable, helpless and powerless position in

[1] By 'transference', I will be talking about those aspects that represent 'an unconscious aspect of the relationship and is one of multiple unconscious processes such as polarization, splitting, projections, anxieties and enactment that prevail in therapy and which therapists need to be aware of' (Horne, 2000).

relation to the work and parents' cooperation (e.g Folkart, 1964). This can especially be the case when an experience of rivalries, tensions and power dynamics prevail in the relationship with parents (Bolland, 1974).

Lastly, I wonder about the deep-rooted pain, conflict and ambivalent feelings intrinsic to the 'parenting' experience in all its forms; of being parented, of parenting, and working with parents. It might be that every time we work with parents, we inevitably touch a powerful, primary area to do with our relationship with parents, real or symbolic, and with rudimentary experiences of pain, growth and the ongoing conflict between moving away and staying close.

Going back to the work with parents itself, we can see that choosing, or being pushed into how one wants to work with parents, is not a 'simple' dilemma, as Rustin captures: 'There are two areas of concern [when working with parents]: one is when there is a refusal on the part of parents to take their children's welfare seriously; the second is where therapy with the parent may endanger their capacity to sustain adult functioning' (1998, p.249).

Within the 'parents not patients' view there seem to be variations too. One type of engagement with parents can be seen as more *collaborative*, and based on 'therapeutic alliance' (e.g. Zetzel, 1956) or 'working alliance' (e.g. Greenson, 1965), or a 'partnership' model (Horne, 2000), where parents and therapists work towards a shared aim of understanding the child. Furthermore, therapists who have worked with foster and adoptive parents have sometimes seen them as 'colleagues' and the relationship with them as a working rather than a therapeutic relationship (based on personal clinical experience and from interviews). Martha Harris talked about refraining from interpreting unconscious material with parents (Harris & Carr, 1966) but, as in previous examples, she added a word of caution when she said she sometimes gave 'advice' to parents (Harris, 1968).

Trevatt (2005) explains the model in the Parent Service he has been working in, which among other services, offers short-term consultation work with parents. He says that 'as therapists offering consultation to parents, we are trying to help the parent to 'parent' more effectively…' (p. 223). This approach towards parents as well as therapists tries to 'reinforce' that they are not the 'experts' and attempts to empower parents in their parental role, so they feel they can 'do it for themselves' rather than encouraging dependence on the professionals. 'We may be

approached as experts but we prefer to see parents as the nearest things to 'experts' on their own family…' (p.225).

Whitefield and Midgley also found that when talking about their parent work, CAPTs varied in how they saw parents and themselves, and consequently their use of the transference: 'whilst all participants took note of the transference, some participants appeared to make more direct use of it than others' (2015, p.285). They also found that one underlying reason for variation in the use of the transference was therapists' views and feelings about parents' dependency within the relationship. 'Interpreting the transference was viewed as potentially drawing the parent into a more dependant relationship, which was seen as risky' (p.284) and, indeed, one of the participants in their research had said that 'I'm not seeing them as patients as much as parents really' (p. 278). Another said that 'I don't think of myself as a therapist in that situation … I see myself more in a supportive role' (p. 278).

What seems to characterise those therapists who hold the 'parents not patients' view, is not only what seems to be a struggle to position themselves comfortably in relation to parents, but the use of language and tone, which contains a sense of weariness. The opposite view, in favour of seeing parents as 'patients', see the use of 'infantile transference within the therapy [as] supportive of improved parental functioning' (Rustin, 1998, p.248). Siskin doesn't only allow parents' dependence but also sees 'dependence' as the natural, obvious position of parents in the work. She thinks it's rather 'safer to view the child's parents as patients than to view them as anything else' due to what she recognises as 'the power of the unconscious' (1997, p.15).

Like before, rather than positioning the areas of conflict in a polarised way, it's important to acknowledge, in Sutton and Hughes's words, 'that one cannot underestimate the complexity of the task of managing, to the fullest benefit, the issues that arise from both child and parental sources' (2005, p.181), and that 'establishing the therapeutic contract with parents involves an ongoing negotiation with both the conscious and the unconscious' (2005, p.175). They also allude to the fact that parents have a side in this conflict too, and due to the experiential nature of the work, they need themselves to have a chance to experience some work, before deciding on which level they want to engage.

My own observation is that parent work creates a particular conflict for therapists who were trained in a psychoanalytic tradition, as their main tool of working is through attention to

unconscious processes as well as the transference and countertransference processes within the relationship. To have to use these core elements of the approach in a tentative way or attempting to avoid using them seems quite a difficult task, conflictual in its essence. This is then related to a worry about the boundaries of the work and the sense that if this is not defined clearly there could be a situation of stepping out of the boundaries to something else, such as adult psychotherapy or couple psychotherapy rather than 'parent work'. We get a sense of an underlying experience of worry and burden rather than a sense of 'calm' and 'freedom' to choose what works for whom. Either way, we seem to be left with quite a pertinent question, if parents are *not* patients, then *what are they?* Can we find a way to define that? Importantly, do we need to?

2.5 We are two, going on three, four, five ...

In order to remain open to these questions, we also need to be aware of an inclination – illustrated in how I organised and structured the topics in the chapter – towards a simplistic 'one vs. another' view. It's important to bear in mind that the struggle to hold complexity, in parallel with the struggle to hold both child and parent in mind and to position oneself in relation to them, is another conflict and 'complication that is intrinsic to the process of treating a child' (Siskind, 1997, p.14). This has been acknowledged in the literature by Bick (1962), Green (2000) and Siskind, the latter of whom said 'There are always too many people in the consulting room, too many currents to track and juggle' (1997, p.14). Beverly Tydeman has written about the '… constant effort' therapists need to make '… to balance the parents' and the children's needs' (2011, p.7).

Going back to the roots of the field, Winnicott famously stated that 'there is no such thing as an infant, only mother and infant together' (1975, p.99). Bailey elaborated on this, saying 'we should add that there is no such thing as a toddler, a child, or an adolescent, as their parents are always present in our work, even if we are mostly working with the child' (2006, p.155). We can see how difficult, and probably even artificial, it is to draw a clear line between parent and child. In the realm of relationships – including the relationships involved in parent work – as well as in the human mind and experience, things are not so clearly demarcated.

In summary, in this chapter I have been tracing some of the complexities and conflicts of parent work in the literature, where therapists struggle with managing a range of feelings and tensions inherent in their views of parents. I have also described therapists' struggle to define what this

work is about, who parents are for them and how to position themselves in relation to parents. Some of the underlying driving forces of these conflicts and tensions seem to be linked to the intensity of the experience of working with parents; with how comfortable therapists feel about parents' dependence on them; and with how comfortable therapists feel towards managing the vicissitudes in their own position to parents as sometimes vulnerable and powerless, and sometimes potentially quite powerful. I have also suggested that it's important that as a profession we reflect on how we choose to 'parent' our own anxieties, pains and ambivalence.

Whatever the underlying issues may be, we can see that working with children and parents seems to evoke something quite powerful. The response to this seems to vary from complete avoidance – as we see in the general neglect of this area – to poignant, tense discussions, which often seem to show opposite sides of the spectrum, as I have tried to illustrate through the structure of the chapter. I have also noticed – in the content and language used – preoccupation with concerns, pressures, weariness, worries about potential danger in relation to power, boundaries, and the technique of working with parents.

Yet, there still seem to be many unexplored areas about how therapists really feel, how open we are to know and talk *freely* about those feelings, how much we are able to tolerate and stay with the complexities, tensions and ambivalence in the work. When therapists experience uncomfortable feelings about parent work, how do they understand them, how do they process and manage them? How comfortable we are with the uncertainties and the flexibility this work seems to require, how many of our decisions and choices in the work are influenced by pressures, how open we are to reflect on the structure of our trainings and profession and its impact on the work, and how much do we aim and wish to enjoy this work and our own creative role in it?

My aim in this research project is to begin to attend to these gaps and the subtleties of CAPT's feelings, thoughts and experiences towards parents and parent work. I endeavour to create a space for therapists' experiences to be shared and talked about, to allow complexities and tensions to unfold and prevail, and to be available for further exploration. Before moving on to hear about CAPTs' experience of parent work in their own words (in the Findings chapters), I will explain the way in which this research was designed and conducted, and the methodology used to analyse my participants' accounts. I will discuss how it enabled me to gather and understand their experiences in a narrative form.

Chapter 3

Method

Language makes you feel you have an inside.
(Cupitt, 1990: 159)

Having reviewed parent work in the literature, I will now explain how I designed this study to address my research questions. I will begin by discussing the questions I was initially interested in exploring: What are parents for us as CAPTs? What are we trying to avoid by not giving them enough space in theory, training and practice? What is it that we might be feeling uncomfortable about? How open are we to explore tensions, conflicts and ambivalence in our work and profession? What kind of stories will I be hearing about parents and parent work when CAPTs talk about their parent work practice? What sort of experiences will these stories depict? What sort of professional identity will unfold through the stories that therapists will share? What is the nature and meaning of CAPTs' professional identity and in what way is it tied up with the experiences of working with parents?

I chose a qualitative research framework to address these questions, because qualitative research is '… as much about social practices as about experience' (Silverman, 2016, p.3) and is aimed at exploring the meaning of the individual experience, rather than its properties (e.g. Smith, 2003, p.1). My research, conducted within a social context as part of the Psychosocial Studies Department at Birkbeck, aims to reveal CAPTs' experiences of parent work as defined in the stories they tell. However, the assumption within qualitative research is that neither language nor speech enable direct access to the human experience. 'To speak of the world or mind at all requires language. Such words as matter and mental process are not mirrors of the world, but constituents of language systems' (Gergen, 2001, pp.805-806).

Prior to choosing the specific methodology for analysing interview accounts, I conducted a general content analysis (e.g. Braun and Clarke, 2006). I read through all the interviews, trying to pick up common themes again based on the interviews' overt content. The main themes were:

- The relationship between children and parents. For example, the origins of problems within families, who influences who, how parents support their children's therapy and how children understand parents coming to ask for help.

- The work of the child psychotherapist. For example, looking at things differently, looking instead of reacting, providing a space to think and reflect, offering something unique, helping the child through the parent and containing negative feelings.
- CAT's approach towards their work with parents. For instance, they work jointly/collaboratively with parents, are supportive of parents, try to be respectful and non-judgmental, listen, give the sense parents know more, that it's the parents' choice to engage with therapy, and that therapists need to work flexibly, they need to identify who the parent is, they need to work with the parents in order to help the child.
- Perspectives towards parents. For example, parents can be seen as sometimes envious of therapists, therapists sometimes see parents as difficult to work with, and parents may be feeling despair, guilt, criticism, worry, anger, frustration and humiliation.
- The approach to transference. For instance, therapists need to use transference in a light way, being careful when using it – parents are not patients.
- The focus of the work; some say the focus is the parents, others the child, and others the relationship between child and parent.
- Differences between working with birth parents and foster and adoptive parents.
- Variety in ways of working: same or different therapist to the parents; working with other professionals; the difference between private and non-private work.

These themes, although interesting and instructive, are very broad, and I felt they didn't reveal anything about the *why* – why therapists are preoccupied with these themes and not with others, and what sort of feelings, motivations and wishes might be underlying them. The themes also didn't say much about the *how*. I found myself naturally inclined to listen during interviews, to how accounts were given, what sort of language was used, what sort of affect accompanied their speech, what sort of impressions I was left with during and after interviews. I thus needed to find a methodology that would enable me to probe into more subtle levels of communication, which could reveal the 'why' and the 'how'. I also felt that focusing on smaller interview segments would be better suited to a deep level of exploration. I will next discuss how I chose a methodology and describe it in detail.

3.1 Methodology

Different methodologies rely on different epistemological and theoretical orientations and, as such, differ in the way they see language as a sense-making tool.

Interpretative phenomenological analysis (IPA), for example, has 'two primary aims: to look in detail at how someone makes sense of life experience, and to give a detailed interpretation of the account to understand the experience' (Tuffour, 2017, p.1). For my study, I was interested in personal stories as a way of creating meaning and forming identities, as well as the way the stories were being told to me. I was fascinated by the use of *speech*, not just the language, as an active position from which therapists could communicate something important about their experiences.

Riessman, whose theoretical views played an important role in helping me choose a methodology, says people are active participants who use language to make sense of their experiences and, also, to 'communicate meaning, that is, make particular points to an audience' (2008, p.11). In this way, language is seen as a constructive, active, meaning-making tool. It is because of this aspect of speech and language I was interested in a different approach.

Discourse analysis (DA), of the kind inspired by Foucauldian theory (Potter & Wetherell, 1987; Willig, 2001), is concerned with texts and is based on the assumption of '… language as productive and performative' (Willig, 2003, p.162) and people's talk as '*action oriented*' (Willig, 2003, p.163), which means that 'what people say tells us something about what they are *doing* with their words (disclaiming, excusing, justifying, persuading, pleading, etc.)' (Willig, 2003, p.162). Discourse is seen to be used by people not necessarily for the purpose of conveying personal meaning, but to address some ideological, political or social viewpoint (Smith, Flowers & Larkin, 2009). As such, people attempt to acquire power of one meaning over another (Edwards & Potter, 1992). Even though I did believe my participants' narratives would be based on wider social discourses around parents, parenthood, therapy, therapists and children, for the purpose of this research, I was interested in the way they exerted meaning to parent work through their personal experiences. I therefore didn't choose this methodology either.

Narrative Analysis (NA), on the other hand, offers a way of looking at individual accounts as *personal stories* about therapists' work with parents, and seemed best suited to answering my research questions. My questions were aimed at exploring the very 'real' feelings and personal experiences in relation to parent work. 'It is precisely because of their subjectivity – their rootedness in time, place, and personal experience, and their perspective-ridden character – that we value them' (Personal Narratives Group, 1989, pp.263-264).

It thus made sense to me that by telling me stories about their work with parents, CAPTs were also negotiating their position in relation to parents and children. They were focussing on *who they were* in relation to parents, as well as what space they occupy as therapists in the community of CAPTs and as responsible adults in wider society. I was hoping to learn something about how people who try to make an impact on the lives of children and parents actually see *themselves*. Also, I was interested in how their agreement to take part in this research is related to an intentional process to construct an identity that can be explored and communicated to others. There are different approaches to NA (e.g. Labov & Waletzky, 1967) and within psychology (e.g. Mishler, 1986; Polkinghorne, 1988) and education (e.g. Witherell & Noddings, 1991). To analyse the narratives, I took Gee's sociolinguistic approach.

As discussed, Riessman describes narratives as 'strategic, functional, and purposeful' (2008, p.8) and talks about their use for 'convinc[ing] a listener who was not there that something important happened' (1993, p.20). I felt Gee's sociolinguistic approach to narratives (e.g. 1986, 1991) was particularly good at revealing *how* participants were doing it.

My first task was to find an appropriate small narrative segment for fuller analysis. My search was guided by the general description of narratives within the literature – small segments that seem to tell a story, that have a beginning and an end and where something interesting is going on – either in the intensity of speech or in signs of tensions or conflicts the interviewee seems to grapple with. Specifically, in my interviews, I found the immediate response to the first question often quite evocative and interesting. It was only after I identified and picked up a narrative segment that I could begin to implement Gee's (1991) method to analyse it.

Gee's method has two levels: a macro-structural and a micro-linguistic level. I always started with the micro-level, which was about listening to the auditory characteristics of speech (meaning listening to the audio interview over and over again); and micro-linguistic looks, particularly at the pitch glide – 'a movement in the pitch of the voice that (in English) falls, rises, rises-and-falls, or falls-and-rises in relation to the normal (base) pitch level of the sentence' (Bolinger, 1986; Crystal, 1979; Ladd, 1980, cited in Gee, 1991, p.21). Gee explains that the 'pitch glide signals the focus of the sentence, the information that the speaker wants the hearer to take as new or asserted information' (p.21). Brazil, Coulthard and Johns explain that 'whatever the focus of the sentence, this does not change the literal meaning of the sentence … but it does alter how the sentence fits with the context of interaction between

speaker and hearer…' (1980, p.10). Any sentence with one pitch glide is called an *idea unit* (p.21), and '... each pitch glide signals a different focus and, thereby, a different idea unit' (Gee, 1991, p.22). The 'idea units' are the basis for the next level of analysis – the 'macro- structural' level. However, before moving on to explain the next level, I will detail the way in which I applied Gee's micro-analysis, as I have adapted it slightly.

After listening to the chosen segments over and over again, I marked *pitch glide* (stressed words, signified with capital letters) and a sense of *stop* (but not a pause), which gave the word before or after a definite feel, similar to the quality of stressed words. This was signified like this – (|); *spaced words*, words the interviewee seemed to prolong but not necessarily stress, signified with a hyphen between each letter (e.g. 'w-o-r-d'); *pauses* were signified with the number of seconds I could count during silence (e.g. 3 SEC.); *breathes* between words or sentences were signified as (BREATH). Other noticeable characteristics, such as lowering the voice/voice becomes louder, speech becomes faster/slower or tone of speech gets softer/more forceful were written in descriptive words in brackets next to the relevant sentences. Words and sentences in bold stand for me, the interviewer, and non-bold words stand for the interviewee. A clear and visual account of this form of analysis can be seen in extracts that will be presented in the next chapter.

When the narrative was fully presented on the micro level, I could move on to the macro level. In this stage, 'idea units are grouped into lines', which are numbered chronologically. 'Each line is about one central idea, or topic' (p.22), and a group of lines form a larger unit called *stanzas* (Gee, 1986, 1988; Hymes, 1981; Scollon & Scollon, 1981, cited in Gee, 1991, p.23). 'Stanzas' are, according to Gee, '… the basic building blocks of extended pieces of discursive language (such as narratives….)' (p.23). A group of stanzas '… fall into related pairs, which [Gee calls] *strophes*' (p.23). The idea units, lines, stanzas and strophes together represent 'the structure of narrative' (p.27) and 'each level', according to Gee, 'makes its own contribution to meaning' (Gee, 1991, p.27).

Analysing a narrative at the micro level was indeed a tedious task that required much effort, concentration and tenacity. However, once this was done, it often felt as though a whole new level of rich information and meaning was revealed – this was both satisfying and striking. Then arranging the narrative into a macro-structural level often felt much more straightforward,

and sentences would ‘fall’ more easily into place. Finding titles for each stanza and strophe wasn’t always that easy though, as it required simplicity yet accuracy.

After the narrative was ready in its new structure, I could begin to analyse and interpret the meaning of its structure and prosaic characteristics. I often first analysed it at a micro level and then at the macro level, at that point keeping each level of analysis separate as each provided a different angle into the narrative’s meaning. Only at the last stage did I integrate both analyses into one. This is the account that can be found in the three Finding chapters.

3.2 Method

a. Sample and recruiting criteria

The recommended sample in NA varies from between 7 and 20 participants (e.g. Squire, 2013, p.54; Goodson and Sikes, 2017, pp.75-76). It is possible to go into quite a deep analysis using NA, so I felt the focus should be on the quality and depth of the analysis rather than on the number of accounts. For my research, I decided to interview senior CAPTs with many years of experience and who currently have a private practice. It was important for me to speak to psychotherapists who have experienced parent work from different angles. For example, in both the private and public sectors, and who have had a chance to work alongside professionals from different disciplines and an opportunity to develop their own style of working with parents.

Following a pilot interview, I went through the ACP register and identified about 45 names and e-mail addresses of CAPTs I had heard about over the years. I then asked the ACP administration team to email the potential participants on my behalf, describing the research topic and asking if they wished to volunteer to be interviewed.[2] An information sheet was attached to the e-mail and then given to each interviewee at the interview.[3] In parallel, I approached in person senior psychotherapists I have known either as colleagues or lecturers to ask if they would be interested in being interviewed. In total, 10 CAPTs (in addition to the one pilot interviewee) agreed to take part.

It is worth noting that my sample wasn’t very diverse. All were White British and had trained locally (although some had different professions prior to their CAP training). The majority were female, were involved in teaching as well as practice, and bar one, the sample was limited

[2] Please see Appendix 1 (E-mail requesting volunteers)
[3] Please see Appendix 2 (Information sheet for interviewees)

to a single geographic area. In terms of experience within the profession, I recruited at one level of seniority, and their personal interest in participating. They all had experience working in the NHS, and some had experience working in other settings, such as hospitals and the voluntary sector.

I had been interested in recruiting a more diverse group. For example, I wanted to interview newly qualified therapists as well as experienced ones and I had hoped to approach therapists from different cultural backgrounds. However, the sample I ended up with were those willing to cooperate and give their time, but that were also easy to approach and access. Those who it took longer to arrange interviews or to travel to see unfortunately had to be put on hold as I was running out of time. My recruitment methodology was thus dictated somewhat by this constricted timeframe and, as such, by the readiness with which people agreed and arranged to be interviewed. I also encountered data saturation – I got to a point where I felt the topics seemed to repeat and I could stop interviewing. Although this could have been down to the lack of diversity in the sample, I believe it indicates some consistent themes that repeatedly arise in parent work. I will reflect on the sample further in the Reflexivity section. The interviews themselves took place in the participants' private practice. They lasted between 50-90 minutes and, initially, were recorded on a tape recorder (with cassette) as well as on an electronic device, although after the first few interviews, I used an electronic device only (an iPod or a mobile phone), as the tape recorder's quality was unsatisfactory. The interviewee chose the time and place of the interview. The information sheet and consent form were handed in during each interview and a signed copy of the consent form was left with participants and I kept a second signed copy.[4]

All 11 interviews (including the pilot) were transcribed. One I had to withdraw due to very poor sound quality. A further two were not used – one was too long and the other was cut short because of technical problems with the recording device. I was left with seven comprehensible interviews, from which I chose an average of 3-6 narrative segments for a full analysis. Those segments were chosen either due to their emotionally intense quality (such as a passionate or assertive tone), where I sensed something *interesting* was going on in the talk, or due to their narrative form, where I could identify a story with a beginning, middle and an end. I realised

[4] Please see Appendix 3 (Consent form for interviewees).

too, that I often found participants' immediate, spontaneous responses to the first (and most open-ended) question very telling.

b. Interview schedule

The interview was conducted as an open-ended interview and was initially comprised of four main questions, presented to participants in chronological order.[5] I started each interview with an introduction, briefly telling them about the stage I was at in my CAP training, and about the doctorate research programme. I went on to talk about how my interest in parent work emerged out of my own personal experiences at the clinic I was trained in. The first question I always asked was: 'What is the place of parents in Child Psychotherapy? (and) How do you make sense of Parent Work in your daily practice?' Over time, I felt that this first question, while broad, allowed for a rich response that delved directly into my topic, producing intense, interesting accounts.

Moreover, I began to feel that the immediacy and rawness of participants' natural response to this question was particularly important, striking and telling in itself. With time, as my own thoughts about the subject developed and became more formulated, I felt that both the content of the first question and the responses it triggered were in fact more relevant to the research topic. I also knew that the rich and free discussion that it evoked was more important than insisting on referring to other more specific points. Therefore, with time, the other questions were dropped or just mentioned briefly.

c. Ethics

As discussed, I decided to focus on CAPTs who work in private practice (only or alongside another setting). The alternative would have been conducting research within the NHS, where ethical approvals are harder to get, and the process can take a long time. I still needed to get ethical approval for this research, and this was done through the university.[6] During the ethical approval process, I considered how my interview questions and the topic itself had the potential to raise discomfort, as it was aimed at exploring uncomfortable feelings and often unspoken views; however, the conversation was very unlikely to have a harmful or distressful impact on

[5] Please see Appendix 4 (Interview Schedule)
[6] Please see Appendix 5 (Ethic form)

senior psychotherapists. These were CAPTs experienced in managing their emotional responses and were often well supported by colleagues and other therapists.

To adhere to the ethical values for this research, psychotherapists could talk about their experiences of working with parents in general, but if they wanted to give any clinical examples, they would have to be from their private practice only. I also asked them to omit any identifiable details of patients (such as names and places) and I omitted any specific clinical examples from my chosen narrative segments.

To keep interviewees' confidentiality, each one had a number code that was later used for the transcripts and analysis, so they were not attached to any specific name. Any identifiable details within transcripts were omitted. All transcripts and original recordings of interviews were (and are) stored on encrypted computers and electronic devices (with passwords). Documents with more sensitive details in them have been encrypted. Original signed consent forms and other hard-copy documents have been kept in locked cabinets. Interviewees' names and genders were changed, and the names of interviewees presented later in the Finding chapter are pseudonyms.

3.3 Reflexivity

Lucy Yardley (2000) has been making an attempt to outline what would be the 'characteristics of good (qualitative) research', some being 'transparency and coherence' and within it, 'reflexivity' (p.219). She explains the characteristics she chooses that fit with qualitative research, which holds that '… knowledge cannot be objective, but is always shaped by the purposes, perspective and activities of those who create it' and who also believe that it's impossible to 'exclude the element of subjectivity in the interpretation of the data' (p.218).
I would like to reflect on my own position as a researcher – my background and how it may have impacted the way I conducted this research and looked at my interviewees' accounts. I will begin by reflecting on my position in relation to my topic and my participants, and I will move on to reflect on the research, its method, methodology and design.

My position as a researcher

I feel I have been occupying a dual position of 'insider' and 'outsider' in relation to my research and my participants. As an *insider*, I share my status as a middle-class white woman with the majority of my participants (although some may be from more affluent backgrounds). Like me,

most have achieved advanced academic degrees. We have also shared our training in child psychotherapy, our registration with the ACP and our psychoanalytic perspective.

As an *outsider*, my country of origin is different to most (if not all) of my participants. English is not my first language and my heritage isn't British. As such, I have felt very strongly that I am a foreigner in this context. It affected the way I framed and articulated my questions, at times I was perhaps more direct, and at other times 'clumsier'. Also, some cultural assumptions weren't familiar to me, like the experiences of schooling. Another aspect of my 'outsider' position was my role. At the time, I was a CAPT trainee interviewing qualified senior CAPTs about their work. I was aware of this uneven positioning and how it impacted the way I conducted interviews. I tried to stay modest and was wary of sounding too critical or too formal and too friendly, or even too anxious. I also didn't want my interviewees to feel they had to occupy a place of either 'teaching' me, 'protecting' me or being 'tested' by me. It was thus initially hard to establish a comfortable, relaxed position.

However, this improved with time and might have led to my gradual move into conducting the interviews as a more open discussion, where it didn't feel like I was the one who simply 'questioned' or challenged them. Burck has said in the context of both family therapy and qualitative research that '[they can] inform each other fruitfully about how the tensions in working across power differentials may be managed' (2005, p.243). Being female meant I shared the same gender with most of my participants. In a predominantly female profession, it's hard to pinpoint how gender issues affected the way the interview was conducted. I personally didn't feel much difference in the dynamic and atmosphere when interviewing male therapists compared to female ones, though my participants may have experienced a difference.

Going back to how I felt as an 'insider' is particularly important for the subject of this research: parents. I believe that as I shared a white middle-class upbringing, a common training, and a common knowledge of psychoanalytic ideas with my interviewees, we may have assumed that we shared a wide set of values about parenting and child rearing that we may have taken for granted. I will mention just a few of those potential shared ideas: the idea that the first five years of a child's life, specifically the first year, determine the child's development and pattern of relationships and attachments that they expect and shape; the idea that a child is dependent on their parents for a long period of time and that they need to be dependent and therefore need caregivers to be available on both a physical and emotional levels for quite a while. CAPTs

may also share an understanding of the impact of trauma, and inter-generational trauma and stress, how it lasts and is not easy to 'undo'.

Given how diverse 'parents' are as a group, it is highly likely, therefore, that the 'subjects' we were discussing in the interview – parents – do not necessarily share those values and knowledge but employ a wide range of understandings of child development and the role of parents. It is thus also likely that we were putting expectations on our 'subjects' that we were unaware of and the parents were therefore not given the chance to evoke in us the experience that they 'get it right'. This is confirmed by Salmon's view that: 'All narratives are, in a fundamental sense, co-constructed. The audience, whether physically present or not, exerts a crucial influence on what can and cannot be said, how things should be expressed, what can be taken for granted, what needs explaining, and so on' (Salmon & Reissman 2013, p.199).

This issue quite likely represents a much bigger gap between the expectations, knowledge and understandings that we bring to the therapeutic encounter and that, right from the start, can set up an uneven dynamic in the level of expertise and power. It's worth noting that it might be precisely this uneven dynamic which underlies some of therapists' views and experiences of parent work.

Another source of difference between us, as therapists, and the 'subject' of our research could be the attitudes to therapeutic work. Despite the many struggles, complexities and tensions therapists experience and have to manage in their work (and which I have been trying to depict in this research), I believe therapists overall take pride in their work. They know they are in a helping profession, involved in a 'kind act'. They try to 'give' (their attention, containment, presence, etc.) and their professional position can be a competent one (even though therapists may not experience themselves like that all the time). Parents, however, are coming to be helped, and they already might be coming from a position of feeling incompetent, they may not feel proud of 'their work' at being a parent, and may not feel valued, appreciated and acknowledged. This, once again, might set up an uneven dynamic that could impact therapists' views and experiences of their work with parents.

As therapists, we are often part of a support system that is ingrained in our training and work ethics (e.g. having regular peer supervision, going to conferences for continual professional development, etc.). We might take this for granted and not realise it feels very different when

one doesn't have this kind of support system and access to thoughtful people. There may be many other aspects that we, as therapists, may share and base our expectations and assumptions on unknowingly (even the belief in therapy itself). That may be one of the main weaknesses of this study and any research that examines only therapists' views. Research about parents that doesn't include parents is inherently partial. It might seem even more problematic not to represent parents in any way as the problem of them being 'left out' of our thinking has been the reason for this research and a large part of the problem in the first place. I don't think this invalidates this research, but future research should address this important issue.

Another important aspect alongside what my participants shared and didn't share, was my relationship with them. Yardley writes that:

> *'... for researchers who believe that our experience of the world is profoundly influenced by our assumptions, intentions and actions, it is equally important to openly reflect on how such factors may have affected the product of the research investigation'. She goes on to say that 'this is a kind of disclosure, sometimes known as 'reflexivity'' (2000, p.222).*

I found it important, once the thesis was written, to contact my participants again to update them on my progress (especially as this research project spread over a long period of time). I wanted to give them an opportunity to learn what I made of their accounts and what new understandings and conclusions I drew from them. I wanted to encourage them to give feedback and share their thoughts, while being clear that their feedback would not be incorporated into the work at this stage. However, it would be important for keeping the discussion going, as my research itself recommends sharing, connecting, thinking and exploring the issues further.

Lastly, since it has been a long period of research, my professional and personal positions changed. I started this research and conducted the interviews when I was still a trainee and not a mother; however, when I reached the stage of analysing the material and writing I was a qualified CAPT as well as a mother of two children. These changes have certainly affected the way in which I took the research further as well as in my thinking and analysis.

My research

Theoretical context:

Theoretically, this research relies on a very specific paradigm of psychoanalytic work within child psychotherapy in the UK. Yet, even within this paradigm, I had to choose a narrower framework than that of classical psychotherapy work, excluding Under 5, Family Therapy and Couples Therapy, for example, as well as other areas of work with parents. There thus might be alternative ways of working and supporting parents, as well as additional theoretical resources that weren't included in this research, and to extend knowledge, it is important to link with other theoretical approaches and understandings.

Sample:

I have already discussed the lack of diversity on many levels in my sample: geographically, culturally, ethnically, and in terms of gender and seniority. The particular sample I have chosen might support certain views and experiences over others. Further research that seeks out a more diverse input is necessary.

Language:

I have tried to observe my own natural way of writing throughout the dissertation, looking at my use of language, particularly of pronouns. I was surprised to notice that I tend to alternate a lot between the pronouns 'we', 'them', 'us' and 'they' when talking about therapists. Accordingly, I have sometimes named my own participants in this way, at other times altering this with 'therapists', 'CAPTs', 'interviewees'. It was interesting to me as it has also been a notable finding in my interviewees' accounts. Underlying it, I wonder if there might have been an emotional conflict. When I was observing 'positive' aspects about therapists and the work, or when I had felt some sort of identification towards aspects of the work, I perhaps felt I was 'one of them', had a sense of belonging to the community of therapists, or that we are 'in the same boat'. In those instances, I tended to use the pronoun 'us'. Alternatively, when I was describing more challenging, 'difficult' aspects, I perhaps wanted to keep myself remote and changed my language accordingly to 'they'. The frequent change in my own language could also reflect my own complicated position as somebody who occupies multiple roles, positions and identifications, such as therapist, researcher and parent. I think it reflects the complexity of holding – at every single moment – different positions and each time a different role gets pushed to the fore it affects the language I used. It was also interesting to observe a parallel

process in which, as mentioned, my own participants seemed to go through a similar process when talking about parents.

Before moving forward, it's important to reiterate that 'meaning is fluid and contextual … all we have is talk and texts that represent reality partly, selectively and imperfectly' (Riessman, 1993, p.15). In this sense, my research is no different.

In the following three chapters I present the findings of the research after I analysed the interviews using Gee's method of Narrative Analysis.

Chapter 4
Finding I
Pressure / Threat
(Fight, Flight, Freeze I)

***'...** not that I omnipotently believe I can make an ENORMOUS amount of difference'*

(Int. 5, 2.1, line 155)

The first narrative theme is about the internal and external sense of pressure, difficulty and threat CAPTs seem to be experiencing in their work with parents. I identified a spectrum of difficulties that all had in common the therapist's experience of having *no choice* about working with parents, and having *no control* over the pressures, threats and difficulties in the work. At one extreme were difficulties that seemed to be experienced as imposing a threat of annihilation on the whole therapeutic encounter; these pressures seemed to be in parallel to an experience of having 'no choice' about working with parents. At the other end of the spectrum were more 'ordinary' difficulties, part of the nature of parent work, but which still pose pressure and make the therapist's work difficult.

I have identified three key narratives within this first narrative theme:

1. A sense of *obligation* (therapists *have* to do the work as no one else will or no one else will be able to do it in the same way), manifested also in a sense of responsibility (the work is immensely important and not doing it would have a big impact on the child); a sense of *burden* and *heavy load* (there is always more to be done, to be aware of); and a sense of '*seriousness'* (serious decisions have to be made and they therefore need to be the 'right' ones).
2. *Internal difficulties, problems and challenges* intrinsic to this type of work and *external difficulties*, in the shape of unsupportive services; scarce resources; services with a different working ethos and parents who are difficult to work with.
3. A *sense of danger*, which manifested in stories about how therapists need to be *careful* doing their job and be aware of all sorts of 'dangers' (such as parents' dependence on therapists and parents terminating engagement with the therapist or their child's therapy).

I will be illustrating these aspects of 'threats' and 'pressures' as they seem to be conveyed in

the CAPTs' talk by using narrative extracts from different interviews and through detailed NA. The first extract is taken from an interview with Nancy (pseudonym). It presents her response to my first question: 'What's the place of parents in child psychotherapy and how do you make sense of parent work?'

4.1 Nancy (Int. 3, extract 1.2):

Strophe 1: Therapist thinks it's essential to see the work with the child in the context of the whole family

Stanza 1: It's essential to see the work with the child in the context of the whole family

97. (5:43) **How do you make SENSE (|) (first part of the sentence voice is louder) of parent work in y-o-u-r daily practice … um …**
98. **and maybe what's the place of PARENTS in child psychotherapy (3 SEC. PAUSE), so broad question (quieter voice) (Laugh).**
99. (5:57) For me it's essential (|) absolutely essential (2 SEC. PAUSE) (BREATH)
100. that (|) you see the work with the child in the CONTEXT of the w-h-o-l-e (|) family **Hmm**

Stanza 2: (therefore) You need to do everything you can to engage the parents

101. so that I think y-o-u r-e-a-l-l-y (4 SEC. PAUSE) NEED to do everything you CAN to engage the parents (soft ending to the sentence)

Stanza 3: The reasons for (the importance of) engaging the parents – Without the parents being prepared to think and work on issues in the family, the child can travel so far

102. because they are ... I think very much all the time, I mean Winnicottian terms, say the facilitating environment (BREATH) for the child,
103. So WITHOUT the parents REALLY (BREATH) (3 SEC. pause)
104. hmm being prepared to think about (|)
105. and work on issues that going on in the family
106. I mean the child can travel (2 SEC. PAUSE) so far **Hmm**

Stanza 4: (Reservation) Sometimes you can't engage the parents sufficiently

107. (BREATH) and of course (louder voice) sometimes you really can't engage the parents sufficiently

Strophe 2: Not being able to engage the parents sufficiently is a very difficult issue

Stanza 1: It's a very difficult issue (when you can't engage the parents sufficiently)

108. and I think this is a (|)VERY, VERY difficult issue,

Stanza 2: (The therapist explains the reason for that) – It's hard to know what to do if a child can use the therapy more but the parents aren't able to engage.

109. if a child you KNOW could use the therapy more
110. but the parents are really (BREATH) hmm NOT able to engage,
111. it's very hard to know what to do, (BREATH) so … (3 SEC. PAUSE)

Stanza 3: It's therefore essential to see the parents together with the child at the start of therapy

112. I think it's absolutely essential (|) **Hmm**
113. to s-e-e the PARENTS (|) maybe together with the child at the START of the therapy

Stanza 4: It's essential to keep a good working relationship with the parents

114. and (taking a breath) to REALLY keep (BREATH) a good working relationship with them **Hmm**

Strophe 3: The therapist needs to prepare parents for the difficulties to come at the start of therapy

115. and (new force) to ALERT them to the fact that there will be difficulties
116. and those are the times you have to work MORE closely together **Hmm**,
117. (BREATH) you know I will be saying it at the START (stress) that when things get tough you know
118. not for the parents to just think ah, this child psychotherapy stuff doesn't WORK (BREATH)
119. but to realise that's the time you have got to get closer
120. and really try to work these (breath) DISAGREEMENTS,
121. these CONflicts,
122. these PROBLEMS that are going on at home,
123. to work, trying to work them out together (soft ending of the sentence) **Hmm**.

Strophe 4: (Coda), Parents are central

124. (7:25) S-O ... I see them as CENTRAL **Hmm**

Lines 99-100 present Nancy's immediate response to my question: 'For me it's essential (|) absolutely essential (2 SEC. PAUSE) (BREATH) that (|) you see the work with the child in the CONTEXT of the w-h-o-l-e (|) family'. Her response is made in an absolute, assertive, conclusive tone. Immediately we are taken into what feels like an intense, powerful domain. At the same time, it feels like a restricted area, which excludes any space for consideration

and/or hesitation. The repetition of the word ‘essential’ conveys the impact of ‘no escape’ *or ‘no choice’* about working with parents. This illustrates the theme about ‘a sense of obligation’.

The next sentence in line 101 is quite dramatic. The speech conveys a sense of necessity and urgency, as if working with parents is not a matter of choice, but obligation. More than that, there is a *sense of a threat*, as if not being able to engage parents could bring on *very undesirable (yet vague at this point) circumstances*. Whatever the unwanted consequences, they seem to create a sense of pressure and obligation to engage parents. As the narrative progresses, we hear again how difficult it is not to be able to engage parents: ‘I think this is a (|)VERY, VERY difficult issue’ (line 108) (when parents are not able to engage). A sense of danger comes up again when the word ‘Alert’ appears (in line 115). This time it’s about alerting parents to ‘the fact that there will be difficulties’ (in the child’s therapy, along the way).

The general atmosphere is one of potential difficulty and danger, as parents need to be ‘alert’. It may also be a message for therapists to be ‘alert’ to the unknown potential ‘difficulties’ (and risks?). We don’t know what the difficulties might be, but they contain a sense of danger (because of the preceding word ‘alert’). The apprehension about difficulties continues in the shape of ‘Disagreements’, ‘Conflicts’ and ‘Problems’ (these words are emphasised in lines 120-122). We therefore see the manifestation of the ‘sense of danger’ theme as interlinked with the internal ‘difficulties’ theme (intrinsic to the parent work).

Looking at what was said before and in between the talk about difficulties, we can see the therapist talks twice about ‘times you have to work MORE closely together’ (line 116) and later, ‘that’s the time you have got to get closer’ (line 119) and worry ‘for the parents [not] to just think ah, this child psychotherapy stuff doesn’t WORK’ (line 118). Putting this in the context of an atmosphere of danger and apprehension about difficulties, it is possible that the threat revealed here and, indeed, felt as dangerous, is the complete annihilation of the therapeutic encounter, the break of the ‘togetherness’ of parent-therapist and the fear that the parents will leave the therapy or terminate the child’s therapy, because they don’t think it works. We can see the tension between the need, as it appears at the beginning to keep the ‘CONTEXT of the w-h-o-l-e family’ (line 100) and in the end to see ‘them (parents) as CENTRAL’ (line 124) and the threat of disintegration, split and separateness of the whole (as appears in the shape of different types of difficulties). The narrative thus begins and ends with the same message. Its circular nature encapsulates the listener and keeps him / her in the

mindset that it's essential to work with parents. The strictness of this message conveys the feeling that seeing parents is not a matter of choice. It illustrates the 'heavy load' and 'obligation' themes.

4.2 Rick (Int. 10, segment 1.1):

This narrative starts with the therapist talking about his own early experience of parent work, where seeing parents on a weekly basis was the norm, whereas nowadays 'fortnightly would be thought in MOST clinics to be quite GENEROUS'. Here we see the theme of Pressure emerging:

Strophe 2: The needs of the parent are (at least) equal to the needs of the child

Stanza 1: The needs of the parent are at least equal to the needs of the child

314. (breath) However I think, hmm, SOMETIMES t-h-e (2 sec.),
315. ah … ah … if you think about the ASSESSMENT CAREFULLY,
316. the NEE-DS of the parent or parents, hmm,
317. are at LEAST equal to the needs of the child,

Stanza 2: The question of what to give priority is a serious issue

318. and the question of what to give priority to is a Serious issue.

Stanza 3: Therapist thinks sometimes the priority should be a treatment for the parent, not the child

319. Sometimes I think the RIGHT outcome would be parent treatment
320. not child treatment.
321. **Right.**
322. And actually to give that as a priority,

Stanza 4 (Reservation): CAMHS services don't feel commissioned to provide work for parents unless it supports the child

323. and I think that's become (breath) VERY difficult in CAMHS services
324. because MANY CAMHS services DON'T feel
325. that they are … coMMISIONED to provide work for parents,
326. EXCEPT in so far as it's supporting something for a child. **ye**

Stanza 5: Therapist thinks this is completely wrong and doesn't make sense in terms of taking the child's interests seriously

327. Which I think is really WRONG (|),
328. completely wrong (|) conceptually
329. and it doesn't make sense in terms of

330. taking the child's interests seriously,

Stanza 6 (reservation): Therapist understands however that people think that there are major constraints there

331. but (|) I'm well aware that people feel
332. there are major constraints there.

Strophe 3: Child psychotherapy without parent work is contraindicated

Stanza 1: Therapist would start with an assessment to check which anxieties belong to child, which to parent, parents or carers

333. (breath) So I suppose I would (|) ah ... ah ...
334. if I'm thinking about it MYSELF I would say
335. well you start with really … an assessment
336. about where are the anxieties in this situation,
337. WHICH belong to the child,
338. which belong to the parent or parents (2 sec.) or carers,

Stanza 2: The question of working with adopted or foster carers is also very important

339. because obviously, you know,
340. we get so many looked after children in child psychotherapy practice now
341. that the QUESTION of work with adopted or foster, foster carers is also VERY important (2 sec.).
342. And I've done a lot of that myself in the past (2 sec.)

Stanza 3: Therapist's absolute assumption is that child psychotherapy without some parent work is contraindicated

343. Hmm … (softer voice) (3 sec.) tze … I think my own, hmm … (5 sec.) ABSOLUTE assumption is that
344. child psychotherapy with, withOUT SOME parent work is STRONGLY contraindicated.
345. **Okay.**
346. hmm, it MIGHT be quite infrequent,
347. and I suppose I'm just thinking about a case that I'm involved in,

As we move along in the narrative, the dramatic language increases. A sense of a 'heavy' feeling and burden comes across, of a therapist who needs to deal with something serious and difficult, which he needs to get 'right'. The therapist is talking about the importance of doing an assessment and correctly prioritising the children's and parents' needs. The sequence of the

word CAREFULLY (line 315) (the half-stressed), Serious (lines 318, 330) and then the debate between RIGHT vs. WRONG (lines 319; 327) creates a serious atmosphere. It's an attempt to let us know something is going on that the therapist doesn't agree with yet is supposed to work with. The stressed word CAREFULLY (in line 315) implies that something might go wrong if one is *not* careful.

The therapist goes on to say (in line 318) that 'the question of what to give priority is a Serious issue'. We hear that thinking about the NEE-DS of parents and children is a serious issue, as they are at LEAST equal, and therefore probably present 'at least' equal / even pressure on the therapist, who needs to find a way to prioritise them (lines 316-317). The talk then moves into a debate about what's right ('Sometimes I think the RIGHT outcome would be parent treatment, not child treatment' Lines 319-320) and what's Wrong ('… which I think is really WRONG (|), completely wrong (|) conceptually' in Lines 327-328). Both Right and Wrong are stressed, enabling the therapist to convey an intense process around judging, deciphering right from wrong, and deciding what should come first and what should come second (children's vs. parents' needs). This is an example of the 'heavy load' theme, with a serious attitude and sense of responsibility. Linked to this seems to be a sense of danger around those serious decisions that need to be made.

In between the extremities (right vs. wrong), we get to hear about a real external threat, where there are services that take sides ('Many CAMHS services Don't feel they are coMMISIONED to provide work for parents', lines 325-326), leaving the therapist burdened with doing the work himself. After a short, calmer episode (lines 331-332), the narrative gathers intensity when the therapist returns to a more personal tone (in line 334), saying: 'if I'm thinking about it MYSELF I would say …'. This shift clarifies that although the words 'major constraints' (in line 332) are not stressed, their location in the middle of an intense segment and, consequently, the appearance of the stressed word Myself, reveals that it's the therapist left to carry the awareness of the parents' and children's needs, of what's wrong, and to deal with the existing constraints on his own. This illustrates the *external difficulties* theme and how it imposes threat on the therapist's work.

The narrative ends with a sequence of sentences highlighting what I see as *the 'heavy duty' the CAPT has to manage quite alone*. In line 341, he says: '... the QUESTION of work with adopted or foster, foster carers is also VERY important'. 'Question' is emphasised, which we hear is

Very important. This gives the listener a sense of a big dilemma that carries heavy weight and which the CAPT, we learn just after, had to deal with on his own: ‘And I've done a lot of that myself in the past’ (line 342). The fact that ‘Question’ appears towards the end of the narrative gives a sense that the dilemmas and questions the therapist needs to attend to are endless. There will always be something ‘else’, some other ‘pressing’ issue to consider. In this way, the therapist is trying to let us know about the load of work and about a sense of endless pressure. As the narrative progresses, the tone of speech becomes more definitive and more personal, saying that to do anything with a child without the parents is completely unhelpful. ‘I think my own ABSOLUTE assumption is that child psychotherapy with, withOUT SOME parent work is STRONGLY contraindicated’.

As in Nancy’s narrative, which had a definitive, confident tone, there is a sense here that this kind of tone reflects the strong, absolute position the therapist needs to adopt to overcome the many pressures, threats and dilemmas described.

4.3 John (Int. 5, segment 2.1):

Strophe 1: The therapist is often the person who has known the child the longest

Stanza 1: There are lots of changes in people involved with the child

121. Inevitably this is a case where
122. there have been LOTS of changes of social workers, local authority social workers

Stanza 2: Nobody really knows the case

123. so Nobody really KNOWS the case NOW (big breath)

Stanza 3: Therapist has been involved the longest

124. You know nobody has been involved N-O-W as long as I H-A-V-E (stronger voice, sounds a bit cynical/ annoyed)
125. Um … (more quietly, more softly) (3 sec.) (Sigh) **hmm**

Stanza 4: Therapist has known the child the longest

126. (24:25) which is something that I quite often find (talking quietly)
127. That I end up being the person (still talking quietly) (quick, big breath)
128. who has KNOWN the child the longest in these sort of situations **hmm** (3 sec.)
129. **Really?** Yeah (|) ... (3 sec.)

Stanza 5: Some children get moved around a lot

130. Sometimes you know children who are (voice stronger but not strong) (3 sec.)
131. Who have been in

132. Who get MOVED from placement to placement (suddenly much stronger voice)
133. or residential care into foster care … (saying very quietly, voice barely heard, as if it's a by-the-way comment) ah … (3 sec.)

Stanza 6 (repetition): Therapist is the person who has known the child the longest

134. I ended up being the person who has known them the longest,
135. Including the social workers (talking very quietly in the last two sentences) (4 sec.) (24:42) **Yes**
136. S-O (3 SEC.)

Strophe 2: Therapist is invited to network meetings but prefers not to go

Stanza 1: Therapist is invited to network meetings but doesn't go on the whole

137. **(24:45) so you are probably invited quite a lot to network meetings I imagine if you …**
138. I am (new tone, tired) but I don't G-O on the w-h-o-l-e … (talking slowly, sentence fades out towards the end) (Sigh)
139. **you don't?**
140. n-o ... I don't

Stanza 2: Therapist explains why he doesn't go to network meetings – he wants to keep it separate

141. Um … (5 sec.) I try and keep separate (quick breath)
142. Um … (3 sec.) I mean (stronger voice), A..ACtually (voice stronger, with new force), interestingly (4 sec.)

Strophe 3: Therapist is in fact in the process of revising his opinion about attending network meetings (reservation)

Stanza 1: Therapist is revising his opinion about attending network meetings

143. I'm, I am sort of reVising my oPINION a bit about that (quiet Breath)
144. Um ... about attending network meetings and ... hmm ... LAC reviews (Breath)
145. Just because (|) you know (2 sec.)

Stanza 2: The reason the therapist is revising his opinion is the irrational decisions that are being made about the children's future

146. WHAT (|) I'm finding
147. Along with everybody else at the moment is that (saying quickly)
148. because of funding cuts (talking here more quietly again)
149. SUCH irrational decisions are being made SO quickly
150. About the future of looked after children **Hmm** (Breath)

151. That hmm

Stanza 3: Therapist therefore thinks it's dangerous not to attend those meetings

152. I'm beginning to think that it's dangerous
153. NOT to be at these sort of meetings

Stanza 4: Therapist doesn't think he can make an enormous difference (Reservation)

154. (25:35) not that I omnipotently (said with a laugh – until the end of sentence) believe
155. I can make ENORMOUS amount of difference (Breath)

Stanza 5: (Therapist explains again the reason for revising his decision not to attend network meetings) – children's care plans have completely changed suddenly and with no warning at network (LAC) meetings

156. But I have just seen so many cases
157. In the last Couple of months where SUDDENLY (|)
158. The care plans COMPLETELY changed
159. Turned over at a LAC review (saying the last few words very quietly) (Breath), you know (saying quickly and quietly)
160. with NO warning at all …

Stanza 6: The therapist's conclusion is that it's important to be present at network meetings

161. and I think it probably is increasingly important (quieter voice again)
162. to be present at that sort of meetings … (quietly, voice nearly disappears towards the end of the last word) **hmm**

Stanza 7: Therapist repeats the reason for his decision to attend network meetings- (decisions) come out of the blue with no planning and thought

163. because they come out of the BLUE **hmm ... (quietly)**
164. (26.00) NO planning, no thought, no thinking **hmm … yeah ...** hmm ...

Stanza 8: keeping it separate (e.g. not attending network meetings) sounds rigid to the therapist (reservation)

165. **But overall you found that it's important to KEEP this ah ... separation or**
166. I HAVE done but I ALSO think (new stronger voice and tone)
167. I mean, that makes it sound very sort of hmm ... (breath) classical … and hmm ... rigid
168. and I DON'T think ... (saying quickly)
169. What (|) I suppose … MY (|)
170. (26:23) just thinking about LAC

The first theme illustrated in this extract is a sense of obligation and having no choice. Strophe 1 depicts the change in people involved in the children's lives as well as change in the children's own lives. Against this background of change, the therapist has been the stable person, the one who has been there and known the child the longest. This is said in many different ways. Its purpose is to make us, the readers and listeners, understand the therapist stands out in his special position, both in the children's lives and among the professionals involved in their lives. It also shows us the therapist's special qualities, his strength, commitment and eagerness to stick with his cases. It seems important this point isn't overlooked (this time). However, there seems to be an imbedded conflict in this strophe. On one hand, being the only person involved enables the therapist to occupy an important position. On the other hand, the therapist tries to show us that he really had no choice about this position – rather than *choosing* to occupy this position, he was *pushed* into it (my emphasis).

The next strophe (Strophe 2) talks about the therapist being invited to network meetings that he prefers not to attend. On one hand, the first part – 'therapist being invited to network meetings' – seems to continue to show the therapist's importance. The second part is somewhat surprising in that the therapist chooses to reject the invitations. It gives a sense of him occupying a position of power where he can afford to accept or reject them. At first glance, we can see it as a reaction expressing the therapist's frustration at being the only person involved, the only person who cares and does all the hard work. However, we know there is also a sense of underlying ambivalence, as it is the word GO that is stressed, and the sentence finishes with a (sad? accepting? exhausted?) sigh (line 138). We can thus think of this as reflecting the therapist's attempt to regain control over a frustrating situation out of his control.

It also gives a sense of roles and positions being reversed. Strophe 1 shows, in a latent way, the child being rejected / refused by many professionals (in the way they come and go), except by the therapist, who puts himself in the position of the one who sticks with the child. In Strophe 2, however, it's the therapist who 'rejects' by turning down the invitation to participate in review meetings. It can be thought of as rejecting the professionals involved (who abandoned him with the child with no support) or it may reflect an identification with the child whose reaction to 'being rejected' is to 'reject' himself now. It seems the above illustrates both the 'external difficulties' theme and the resulted 'sense of danger' theme, as the external situation feels dangerous in the lack of thoughtfulness and serious approach towards the child.

Linked with those two themes is the 'sense of obligation' theme, where the therapist feels he has 'no choice' but to get involved. The therapist's attempt to continue explaining his decision and the fact he shows more overt reservation and ambivalence about it in the beginning of Strophe 3, 'I am sort of reVising my oPINION a bit about that Am ... about attending network meetings and ... hm ... LAC reviews' (lines 143-144), exemplifies the dynamic nature of a narrative, which the therapist constructs *while* he is talking and listening to his own speech. The therapist may have become aware of the way in which the child, like him, has no control over the therapist's decisions (he may have become aware of the danger of taking advantage of his powerful position and of repeating the cycle of rejection). The fact he chose to emphasise the words 'Opinion' and 'Revisiting' conveys a process where the therapist tries to regain control not only of the content of his decisions, but also of the way he constructs his speech. Compared to Strophe 2, which was quite short, as if to represent the simplicity in keeping things 'separate' (line 141), Strophe 3 is much longer.

Strophe 3 seems to present – through the many stanzas, repetitions and strong, angry language within the stanzas – the therapist struggling to negotiate his position. On one hand, he presents his participation in network meetings as a 'must', something he cannot afford to refuse, as it is in *fact 'dangerous'* (line 152); the alternative would be to allow 'irrational decisions to be taken' (line 149). On the other hand, he diminishes his position to where he can't believe he can make an 'ENORMOUS amount of difference' (line 155). The ambivalence is still well embedded, as it is the word ENORMOUS which is stressed and, in the line before, the adverb 'omnipotently' is followed by a laugh.

The tone and stressed words in the remaining part of the narrative convey a sense of shock and danger: 'care plan COMPLETELY changed' 'SUDDENLY', and there was 'NO warning at all…'. In addition, 'They (decisions in network meetings) come out of the BLUE', and, once again, with 'NO planning', thought or thinking behind them. We can thus well understand why decisions the therapist makes are carrying such a heavy weight and sense of responsibility.

The therapist, however, continues to show he is very much constructing his narrative *while* talking and listening to himself, and is telling us about the worry of 'sound[ing] very sort of classical and rigid' (line 167). Indeed, the narrative's structure over its three strophes conveys a sense of turbulence, where the therapist's position moves between one of power and certainty to one of withdrawal and despair. Perhaps the underlying sense of lack of control, lack of

freedom to choose, and being lonely and unseen are the catalysing conditions for such turbulence.

In summary, we hear from therapists who seem to be acutely aware of serious issues that contain an element of danger and threat. It might be the danger of the therapeutic encounter with parents breaking down; the lack of available external resources for parents; the services' inability to meet and prioritise the needs of children and parents appropriately; or it could be too many changes being imposed on a child who has already suffered trauma in his life. The CAPTs seem to respond to this sense of danger by constructing a strong, firm voice to make sure we understand how critical the situation is. At the same time, they seem to feel a great sense of responsibility and obligation. As such, they often feel pushed into a situation where they feel they don't have much choice about reacting in a certain way or even getting angry and occupying the strong position they occupied in the first place. Some ambivalence was expressed about being pushed into a 'no choice' position.

Chapter 5

Finding II

A Wobbly Space

'... it's NONsense to see the child outSIDE that context'.

(Int. 3, segment 4.2)

The second narrative theme is what I have called a 'Wobbly Space'. By space, I mean the therapeutic space between the therapist and the people they work with. I could see that therapists talk not only about the actual experience of working with parents, but about how they perceive and experience the work in their mind. I found that even when therapists were talking directly about their work with a child or with a parent, the person in focus is actually quite fluid. It seemed as if therapists were drawing a narrative about a therapeutic space with changeable boundaries where who is 'in' and / or 'out' can change from moment to moment.

Their speech has revealed three main aspects of this narrative theme:

1. The constant change in nouns in some narratives (e.g. from 'child' to 'parent' to 'grandparents' and so on) suggests the focus of the work changes constantly.
2. The use of language and stressed words that describe boundaries and what might belong 'in' or 'outside' the boundaries (e.g. 'outside', 'no', 'apart', 'except', 'either … or', 'context', 'which', 'between', 'balance', 'within', 'whole', 'out of the blue', 'closely', 'together', etc'). This kind of language suggested therapists were somewhat preoccupied with issues of position, location and space.
3. A change in pronouns or from nouns to pronouns indicating a move between a closer and distant relationship within the therapeutic space (e.g. from 'parents' to 'they', from talking about 'a parent' to moving to talk about 'the parent', a move from a personal talk – using the pronouns 'me' and 'I', to a more general / distant talk – 'whose job it is', or using the pronouns 'we', 'you' – 'you get a description of …' or 'it'- 'it's trying to help parents …').

I have chosen to present the following extract again; not only does it illustrate the theme well, we can see how the three main narrative themes that I present in the finding chapters (of pressure / threat, wobbly space and identity in action) constantly overlap.

5.1 Nancy (Interview 3, segment 1.2):

Strophe 1: Therapist thinks it's essential to see the work with the child in the context of the whole family

Stanza 1: It's essential to see the work with the child in the context of the whole family

125. **(5:43) How do you make SENSE (|) (first part of the sentence voice is louder) of parent work in y-o-u-r daily practice … um …**
126. **and maybe what's the place of PARENTS in child psychotherapy (3 SEC. PAUSE), so broad question (quieter voice) (Laugh).**
127. (5:57) For me it's essential (|) absolutely essential (2 SEC. PAUSE) (BREATH)
128. that (|) you see the work with the child in the CONTEXT of the w-h-o-l-e (|) family **Hmm**

Stanza 2: (therefore) You need to do everything you can to engage the parents

129. so that I think y-o-u r-e-a-l-l-y (4 SEC. PAUSE) NEED to do everything you CAN to engage the parents (soft ending to the sentence)

Stanza 3: The reasons for (the importance of) engaging the parents –

Without the parents being prepared to think and work on issues in the family, the child can travel so far

130. because they are ... I think very much all the time I mean Winnicotian terms, say the facilitating environment (BREATH) for the child,
131. so WITHOUT the parents REALLY (BREATH) (3 SEC. pause)
132. hmm being prepared to think about (|)
133. and work on issues that going on in the family
134. I mean the child can travel (2 SEC. PAUSE) so far **Hmm**

Stanza 4: (Reservation) Sometimes you can't engage the parents sufficiently

135. (BREATH) and of course (louder voice) sometimes you really can't engage the parents sufficiently

Strophe 2: Not being able to engage the parents sufficiently is a very difficult issue

Stanza 1: It's a very difficult issue (when you can't engage the parents sufficiently)

136. and I think this is a (|)VERY, VERY difficult issue,

Stanza 2: (The therapist explains the reason for that) – It's hard to know what to do if a child can use the therapy more but the parents aren't able to engage.

137. if a child you KNOW could use the therapy more
138. but the parents are really (BREATH) hmm NOT able to engage,
139. it's very hard to know what to do, (BREATH) so … (3 SEC. PAUSE)

Stanza 3: It's therefore essential to see the parents together with the child at the start of therapy

140. I think it's absolutely essential (|) **Hmm**
141. to s-e-e the PARENTS (|) maybe together with the child at the START of the therapy

Stanza 4: It's essential to keep a good working relationship with the parents

142. and (taking a breath) to REALLY keep (BREATH) a good working relationship with them **Hmm**

Strophe 3: The therapist needs to prepare parents for the difficulties to come at the start of therapy

143. and (new force) to ALERT them to the fact that there will be difficulties
144. and those are the times you have to work MORE closely together **Hmm**,
145. (BREATH) you know I will be saying it at the START that when things get tough you know
146. not for the parents to just think ah, this child psychotherapy stuff doesn't WORK (BREATH)
147. but to realise that's the time you have got to get closer
148. and really try to work these (breath) DISAGREEMENTS,
149. these CONflicts,
150. these PROBLEMS that are going on at home,
151. to work, trying to work them out together (soft ending of the sentence) **Hmm**.

Strophe 4: (Coda), Parents are central

152. (7:25) S-O ... I see them as CENTRAL **Hmm**

The therapist has quite a dramatic response to my first question about what sense she makes of parent work in child psychotherapy. The overall sense is of a dramatic narrative from a strong, assertive therapist. Trying to look at the way in which the narrative develops, we can see it begins with a personal pronoun (all italics in the next quotes are my addition) – 'For *me* it's essential' (line 127). It then moves quickly to using the pronoun 'You' which gives a less personalised tone – '(it's essential that) *you* see the work with the child in the context of the whole family' (line 128) and then back to a sentence that contains both a personalised position and a distant one – '*I* think *you* really need to do everything *you* can to engage *the parents*' (line 129). Line 130 also contains a personalised tone when the interviewee says, 'I think', 'I mean'. In short, when looking at the use of pronouns just in the first sentences (lines 127-130), we see a frequent move between pronouns and nouns: 'me- you- the child- family- I- you- you-

the parents- they- I- I- the child'. The narrative ends with a personalised tone again, '*I* see them as Central' (line 152). The therapist seems to be trying to negotiate the context for her work – who the patient really is. She also seems to be trying to negotiate the level she wants to engage with parents on a personal level, as the phrase 'for me' shows, or on a more professional / distant level, as the use of the word 'they' shows. There is also a move to theoretical terms in line 130 (Winnicott and 'the facilitating environment'– a notion he coined).

It's also interesting to see the move between Child to Parents when we look at the structure of the narrative at the beginning (through the strophes' and stanzas' titles). In Strophe 1, Stanza 1, the focus is the child – 'it's essential to see the work with the child in the context of the whole family', whereas in Stanza 2 (in the same strophe), the focus is on the parents – 'you need to do everything you can to engage the parents'. We see a dynamic here where to explain something about the child, the focus moves to the parents and the other way around. Only Stanza 3 (in Strophe 1), brings the two together – 'without the parents being prepared to think and work on issues in the family, the child can travel so far'. In this stanza, we hear why it's so important to engage the parents.

When the therapist says in lines 128-129 '(it's essential that) you see the work with the child in the CONTEXT of the w-h-o-l-e (|) family, so that I think y-o-u r-e-a-l-l-y (4 SEC. PAUSE) NEED to do everything you CAN to engage the parents', she conveys a sense it's not something that she needs to do ('to see the work with the child in the context of the whole family and to do everything you can to engage parents'), but it's something we ALL need to do. In that sense, the focus moves from the therapist interviewee herself to a collective entity of either the community of CAPTs or adults in general or even society, who are ultimately responsible for children. I spoke in Finding Chapter 1 about a responsibility narrative. Here, the narrative of responsibility also seems related to the narrative about position and space. It seems that one of the unspoken questions is: *'Who is in the centre of responsibility?', 'Who is responsible for parents and children?'*

We can also identify the wobbly space of the whole narrative. The narrative starts with an inclusive statement '(for me it's essential … you see the work with the child in) the CONTEXT of the w-h-o-l-e family' (lines 127-128). However, when we move on and look for words that describe the therapeutic relationship, we can identify the following list: 'engage- WITHOUT (the word 'without', combines the concept of 'with' and 'out' at the same time, meaning-

closeness/ unity and separateness/ distance at the same time)- can't engage- (VERY, VERY) difficult issue- NOT (able to engage)- it's very hard (to know)- together- (good) working relationship- with- ALERT- difficulties- (MORE) closely together- tough- not- doesn't (WORK)- get closer- DISAGREEMENTS- CONflicts (interesting split stress, as 'CON'- means 'with')- PROBLEMS- (work them out) together- CENTRAL'.

I attempted to find out if the narrative continues to be inclusive, as it was at the beginning. However, the above list shows a constant move between separateness and closeness. An experience of separateness, distance and sense of threat on the unity of the therapeutic relationship was captured through words that describe difficulties and words that appear in a negative form. An experience of closeness and unity in the therapeutic relationship was captured in words that describe cooperation. Altogether, this list of words shows the therapist's preoccupation with issues of space, boundaries, closeness and separation. And so, what starts as an attempt to construct a narrative of inclusiveness is revealed as quite a difficult thing to maintain. Instead, it quickly breaks down into a constant shift between closeness and distance in the relationship between therapist and parents. The position of parents, children and the therapist change all the time too.

However, the word 'CENTRAL' at the very end of the narrative reveals an attempt to bring the narrative to a conclusive point, rather than staying with its dynamic character. It ends with an attempt to find a clear position for parents in the centre. This is curious and might indicate the dynamic of change or ambivalence is indeed associated with a sense of fragility in the therapist's mind and is therefore being avoided in the end. It also shows that the initial attempt to construct a narrative about wholeness, where all are equally included (child and parent), is quite difficult to maintain alongside a whole narrative. It seems the attempt to talk about an 'inclusive context' leads almost unavoidably and ironically to a breakdown of that context.

We can also track the way the 'breakage' or the threat of 'breakage' is constructed within the narrative, as well as the oscillations within the therapeutic space. The use of the stressed word WITHOUT (in line 155) possibly reveals the worry about *absence* (the 'out' aspect). The therapist may be trying to tell us that if something or someone is missing, the context (of the whole family) will get lost too. The stressed words 'NEED' and 'CAN' ('y-o-u r-e-a-l-l-y NEED to do everything you CAN to engage the parents', in line 129) highlight quite dramatically the efforts the therapist needs to make to keep parents in context. It gives a sense

that, underlying the view that the context of the child work needs to be inclusive, is a worry or experience of that context being fragile. The way the talk is structured here thus gives a sense that it's actually very hard to hold onto the bigger context of the family, and yet necessary to do so. Then, what starts as a reservation or an obstacle to seeing the work with the child in the context of the whole family in Strophe 1, Stanza 4: 'sometimes you can't engage the parents sufficiently', turns into a theme in itself in Strophe 2: 'not being able to engage the parents sufficiently, is a very difficult issue'.

The way the therapist structures her talk in Strophe 2 makes it gradually clear that the context she is talking about is the therapist's struggle to keep the parents in context (not the context of the family in itself). Strophe 2 shows that difficulties can be a cause for separation (where therapy with a child may not happen or may breakdown), whereas Strophe 3 shows that difficulties can be a cause for union: 'the therapist needs to prepare parents for the difficulties to come at the start of therapy' (meaning that engaging and preparing the parents can make therapy with the child possible or prevent the therapy from breaking down).

Looking at these three strophes together shows the fragility of the context of the whole family – it can easily break down into a place of difficulty and doubt that can either split or unite. The split vs. union the therapist is talking about seems to be between parents and therapists. The therapist could be trying to tell us that to keep the context of the whole family, one needs to keep another context, the context of the therapeutic relationship between therapists and parents.

The conclusive statement with which the narrative ends, 'S-O I see them (the parents) as CENTRAL' (line 152), shows the interviewee has been struggling with the issue of 'centrality', who is positioned in the centre of the work. The assertive tone and the stress on the word 'central' indicates a tension about what to keep at the centre – the aspect of wholeness or separateness. The assertive tone and use of 'So' shows that the therapist wants to come to a definite conclusion about who is in the centre. However, the use of the pronouns 'I', 'them' and then 'central', with only the word 'Central' being stressed gives a sense that the tension has not yet been resolved. Perhaps it's still not clear who needs to be in the centre of the work. And if, as discussed, it's possible at all to state who is in the centre, the focus and centrality of members change all the time in the work and in the therapist's mind.

5.2 Miriam (Interview 11, segment 3.1):

Strophe 1: How therapist is working with her parent-patient (How she is trying to help her). Based on an example:

Stanza 1: Therapist is trying actively to hold onto the healthy parts (of the parent-patient)

384. **so in a way when she slips back into those states,**
385. **as you said where she's not really in a thinking place and, hmm**
386. **I, I imagine your ROLE probably CHanges a bit WITH that**
387. **because you can't really help her refLect on her CHILDHOOD, those moments.** Hmm, hmm,
388. **So what do you think you are doing then for her,**
389. **or what's your role then becomes for her at those times?**
390. I think at those times I'm, I'm AC-TIVE-LY, hmm,
391. TRYING to hold onto the more HEALTHY aspects of her,

Stanza 2: Therapist is holding on to the healthy parts to fight against something internal that is making the patient unable to feel good about herself

392. and in order to sort of fight against this
393. very Persecutory **hmm** (2 sec.) internal object really, that,
394. that makes her unable to, to ... feel good (said quickly) about herself and unable.

Stanza 3 (that could be a new strophe!): Therapist is talking about a balance she is looking for in the work (between recognising the needs and actions the patient can take)

395. (big breath) And IT'S, it's that sort of BALANCE betw-een, hmm – (2 sec.),
396. Recognising what perhaps NEEDS to be done,
397. or that she CAN take certain actions, hmm,

Stanza 4: Therapist is trying not to interpret too directly

398. but actually (stronger voice) TRYING through … (3 sec.), I mean to (said quickly),
399. to inTerpret it too directly with HE-R ... in terms of

Strophe 2: Therapist is recognising an interesting area to think about in the work with parents

Stanza 1: How much therapists can draw the transference to themselves is an interesting area

400. I mean (said quickly and with a new tone) this is an interesting area I think with parents (big breath),
401. is actually HOW much DO you draw the transference onto yourself (ending the sentence more quietly)

Stanza 2: Therapists are not giving parents personal analysis / psychotherapy

402. (breath) beCAUSE you're NOT giving a parent a personal analysis
403. or personal psychotherapy (quick breath),
404. and in FACT in THAT particular case
405. SHE is having her own individual counselling,
406. I don't know if (|) that's psychoanalytic or NOT (|)
407. but THAT'S where she needs to take **hmm** quite a lot of her ISSUES.

Stanza 3: This area is a dilemma for psychotherapists

408. And if I (lengthened word) ... I mean I think this probably is quite a dilemma actually for psychotherapists (quick breath),
409. if I (stressed word) am actually picking up her transference to M-E,
410. and EVEN now in terms of working towards an ending,

Stanza 4: Therapist is wary about picking up patient's transference to her (by talking about patient's loss towards the ending of therapy)

411. I'm WARY (big stress) of talking about he-r loss of M-E TOO much, **yeah**

Stanza 5 (reservation): Therapist however feels she needs pick up some of the transference (by talking about the patient's sense of loss and how it stirs up her losses as a child and her feeling of being abandoned by the therapist)

412. Because, although, I mean I think we DO have to do some of that
413. because I need to acknowledge that she's feeling abandoned by ME, **yeah**
414. and how much it stirs up her losses as a child
415. and her difficulty in really focusing on that.

Stanza 6 (reservation): Therapist however has been wary of drawing the patient into a more dependant relationship (by picking up the transference to her)

416. HMM, but I've been wary GENERALLY of ... DRAWING the re ...,
417. DRAWING her more into a dependent relationship. (24:43)
418. I think that's what I mean.
419. Because I think if you're …

Strophe 3: Therapist is talking about a balance between looking at the patient as an 'adult' and looking at the patient as a 'parent'

Stanza 1: There (needs to be) a balance between 'this is an adult', 'this is a parent'

420. it's that balance between THIS is an adult,
421. THIS is a parent,

Stanza 2: You want the parent to parent the child, not to be dependent on you

422. and you're wanting the parent to PARENT the child,

423. you're not wanting them to be dependent on YOU

Stanza 3: By making parents dependant on therapist, you make them more infantile rather than respecting them

424. so that you're actually making them more INFANTILE in some ways,

425. RATHER than respecting

Stanza 4: (the kind of thing therapist would have liked to tell her patients) 'look what you are doing and able to do for your child'

426. LOOK as a parent look what you're doing,

427. you're actually being able to do THIS for your child

428. and THAT for your child,

Stanza 5: In this way therapist is enabling the adult bit in the patient feel valued

429. to sort of enAble the adult bit of them **hmm** to feel valued,

Stanza 6 (repetition): There are always healthy parts (in the parent- patient)

430. and, um, you know, there's always HEALTHY aspects.

(moving to talk about something she has read)

In this narrative's structure we can see the interviewee is trying to work out all sorts of tensions: between past and present, between her own experience and traditional psychoanalytic ideas, and between different ways to construct parents in her mind, e.g., as 'adults' vs. as 'parents'. The child is not mentioned directly, only to describe the core of the parent's function. It seems the interviewee is trying to work out a balance between her own way of practicing and her patient's needs.

When we look at all three strophes, we can see the first focuses on the therapist's personal experience (and personal way of working), and the second is a mix of the therapist's personal experience and a more general view 'shared' by all. The last strophe seeks to find some 'balance'. The 'balance' the interviewee seems to be looking for is not only between the different aspects of the parent but also between the different aspects of the therapist's work – the personal aspect and the more shared theoretical, conceptual one. However, we can see how the therapist is also trying to find some balance within her own personal dilemma when working with parents. In this case, whether to pick up on the transference or not. If she does, it could make the parent feel more infantile, less respected and less able to parent their own child.

If she doesn't, she may end up ignoring or not giving enough space to other parts of the parent that are important to understand too.

In Strophe 2 we can see a 'dance' between distancing and coming closer to parents. There is a sense of a real drama, with the therapist internally debating how to go about her relationship with the parent. This is reflected by the sense of worry that comes across in the talk as well as the reservations and ambivalence reflected through the use of stressed negative words, such as 'Not' (what she *doesn't* want to do) and words which imply some distance, such as 'fact', 'that', 'because', 'even', 'issues'.

The stressed word WARY (line 411) is positioned at the centre of this drama around which the therapist is trying to position herself. Although she is stressing what she is *not* giving to the patient, she is stressing the word 'Her' (the parent- patient) as well as pronouns related to herself, such as 'me' (stressed 3 times). The word 'Drawing' is stressed twice, capturing the tension between the pull to 'draw' the transference towards the therapist and the wariness and ambivalence about doing so. In a way, we can again see here how the attempt to find the 'right' distance / closeness to parents through the talk creates intense, dramatic talk. We can see how the therapist is generally feeling she is the focus of it, the one able to generate good feelings (when she described before the good things she does for her patient in segment 1.1) and bad feelings. If the therapist feels she is so powerful in generating both good and bad feelings in her patient, this might be one reason why there is a need to pull away from the intensity, to distant herself. The attempt of the interviewee to look at this dilemma as a general one, shared by all psychotherapists, reflects the attempt to feel more supported by the community of CAPTs.

Strophe 2, and its emotional intensity, is placed in the middle of the narrative, as if the drama needed to be encapsulated securely between the first and the third strophes. The first focuses on the therapist's identity by talking about what she is for the parent and how she works with her. The third strophe focuses on where the therapist wants to locate the parent in relation to her.

In Strophe 3, where the sentences are short and focused, with less hesitation and fewer breaks between words and sentences, the way the talk is organised gives a sense of a therapist trying to make order, to put things back in place and adhere to 'facts' to pull away from the emotional

drama in the last strophe. She is now not only trying to separate out what her role entails and how close she needs to be to the patient (which was the centre of the dilemma in the last strophe), she is trying to separate out parts of her patient. It is as if she has given up on trying to put things in order between them; now she moves to try and make order of the patient's 'status': 'THIS is an adult'; 'THIS is a parent'; The stress is again on more distant / factual words such as 'This', but reinforces the intention to make order. The focus has moved to what the parent can do for the child, rather than what the therapist can do for the parent.

In summary, these two narrative segments depict a certain preoccupation and struggle with space and position – who and what is outside, who and what is inside, where the focus should be, and how and where to position oneself as a therapist. We get a sense that relationships and engaging with another contain strong feelings of ambivalence about both closeness and distance and the therapist is rather lonely in this struggle. There are also glimpses of the previous theme of danger and weariness being expressed in this dynamic as well as the space in itself – its potential wobbliness and fragility as a source of worry. Like before, the therapist seems to feel ambivalence and worry about the position they occupy when it feels too central, too responsible or too powerful. This can then be a catalyst for the dynamic of moving closer vs. more distant. The therapists seem to manage these struggles by attempting to occupy a solid, strong position, while at the same time seeking some sense of belonging to a wider community.

Chapter 6
Finding III
Identity in Action
(Fight, Flight, Freeze III)

'I find myself doing quite a lot of emPOWERING of parents'

(Int. 11, 1.1., line 161)

In this chapter, I will be presenting the third and last narrative theme – the way CAPTs seem to grapple with their identity as therapists. I assume that even though one's identity may have some stability, the situation and 'work' of the interview – talking, listening, thinking (both with the interviewer and to themselves) – triggers some kind of internal work on aspects of therapists' professional identity. I had expected then, not only to hear about stable aspects of their identity, but also to witness some process of *construction* of aspects of identity through the way they talk, what I would call 'identity process'.

Similar to the previous theme, I have found a 'spectrum' of identity where, on one end, we hear a more hesitant, doubtful aspect and on the other end, a more assertive, confident, strong aspect of the identity. However, I have called this theme 'Identity in Action', as my analysis of therapists' narratives has shown that the strong part of their identity, associated with both action and / or development, is more dominant than the 'hesitant' aspect.

The narrative extracts that I have chosen highlight what I have identified as five narratives of Identity in Action:

1. Strong identity comes across through *definite, assertive categorical language* (such as 'So, absolutely, definitely, I am sure' etc.).
2. Active identity is displayed through the use of verbs that have a *'doing' quality* to them (such as 'do', 'try' etc.), rather than ones that have a 'being' quality (such as 'sit', 'reflect', 'think' etc.).
3. Active identify is associated with activities that, specifically, entail a *sense of effort and obligation* (such as 'you have to' etc.).
4. Active identity is associated with a driving force towards *change and development*, either within oneself or in others. For example, a description of change in practice over

time or a wish to change views, practice etc., and an identity that develops into a more inclusive one as the narrative progresses.

5. I have looked at therapists' *experience* of their 'active' identity and found that sometimes they seem to experience frustration or being 'stuck' in relation to their active attempts.

6.1 Miriam (Interview 11, segment 1.1):

Strophe 1: Therapist feels she has changed and does more empowering of parents

Stanza 1: Therapist feels she has changed a bit

154. I mean it's, it's (new tone), hmm, I suppose I've CHANGED a bit.

Stanza 2: When therapist was first working with parents, she was developing the relationship with parents and bringing the transference out (with parents)

155. I think when I was first working **yeah** with parents (quiet breath),
156. I would be M-O-R-E trying to sort of (cutting the sentence)
157. I suppose I was sort of thinking about it in terms of what (|) is the transference
158. and developing (breath), kind of bringing that transference out **yeah**
159. and developing the relationship with the parent.

Stanza 3: Now, therapist finds herself doing quite a lot of empowering, affirming and valuing parents (in what way therapist changed)

160. (BIG BREATH) (new tone) I think NOW MORE, and I think it's influenced a bit by under-5's, **yeah** (3 sec.)
161. I find myself doing quite a lot of emPOWERING of parents **hmm**
162. And, and aFFirming them and VALUING them (slight laugh) (breath), you know, um,

Stanza 4: The change is because therapist feels parents can feel so demoralised (by feeling a failure as a parent)

163. because I think maybe particularly with mmm ... (|) with younger children **yeah**
164. Parents, and I suppose (said quickly) I mean MOTHERS **yeah** mainly,
165. can feel so deMoralised, you know, by (|)
166. feeling a failure as, as a parent, and, and, hmm,

Strophe 2 (reservation): Empowering parents depends on how reflective they are

Stanza 1: If parents are not reflective, then it's more important to work on the relationship between parent and therapist

167. I suppose it's diffi … (new tone), it depends on, it depends on (said quickly) actually

168. HOW reflective the parent is (voice gets quicker towards the end of sentence / fading out)
169. If they're NOT able to be reflective (new, more energetic voice),
170. and in a sense it's more important I think
171. to work on the relationship between (breath) you and the PARENT (slight stress) **yeah**

Stanza 2: This enables parents to reflect on their own experiences

172. and, and enable them to sort of reflect
173. on their own experiences through that (breath),

Stanza 3: If parents are reflective, then affirming them is more important

174. If they ARE quite reflective,
175. I think then (|) sometimes the sort of Affirmation of them as parents is more important,

Stanza 4: Because you can trust they will keep thinking about the child

176. 'cause you can trust they will keep thinking **yeah** a bit about the child (voice gets quieter).
177. **Yeah, yeah,**
178. Is that the kind of thing you (|) were thinking about? (10:04 min.)
179. **Yeah, yeah, yeah, yeah, it's all yeah.**
180. Yeah.

In the first strophe, the therapist constructs a story about a change in her identity and way of working. The word 'CHANGED' is stressed in the first sentence of the narrative (line 154); she is letting us know about a change process that has *already* occurred and, in that sense, telling us about a process and identity that is complete. The identity she describes is one that contains positive, active aspects, which enable the therapist to 'aFFirm', 'VALUE' and 'emPOWER' parents (those active aspects of her identity are being stressed).

Even though she is telling us about a process she went through in the past, talking about it now seems to bring it to life again. The emphasis on the words 'NOW MORE' (in line 160) supports the sense that her identity is, indeed, being constructed again while she is talking, thinking and listening to her own talk. The word 'More' is also stressed before, as part of the story about her past identity: 'I would be M-O-R-E trying to …' (line 156). The stressed word MORE, then, seems to represent two aspects of the identity. One belongs to the past and may indicate a part of her identity involved with a sense of effort and hard work – she was trying to do *more*. The second aspect of MORE is linked to her present identity and to the narrative as presented in the

interview. The narrative build-up towards these words in lines 160-162, which represent the core of her current identity, suggests the intention is to lead us to attach more attention to her current identity (rather than past): 'I find myself doing quite a lot of emPOWERING of parents …' (line 161), and she adds: 'aFFirming them and VALUING them' (parents, line 162). The stressed words show an active, positive role the therapist has constructed for herself, geared towards promoting positive change in the parents she is working with.

Stanza 4 in Strophe 1 seems to be quieter and calmer compared to the previous stanzas. It's as if most of the construction work of the narrative has already been done. The therapist stresses fully only the word MOTHERS (line 164). It's rare in interviews for words to be emphasised that describe the actual members of the therapeutic encounter. Therefore, I think it's important the word MOTHERS is being stressed in this context, as it may indicate the therapist's attempt to let us know her identity is not only tied to the active aspect of change and action she is employing, but with *whom* she is working. The fact she experienced mothers as feeling 'demoralised' (line 165) may have been the driving force for her attempt to construct a strong, active, positive identity. This kind of identity is perhaps experienced as needed for the mothers, but in a parallel process, is perhaps also needed for the therapist. Talking about empowering, valuing and affirming parents could contribute to a professional identity that is also experienced as empowered, valued and affirmed. This is supported by what happens to the identity process in the second half of the narrative.

Strophe 2 shows some hesitation and reservation compared to the more confident view and way of working the therapist expressed in the first strophe. The intensity of speech seems to lessen. The general tone puts less emphasis on words, and the way the narrative finishes with a question to me (the interviewer), is as if it's expressing some uncertainty and doubt. The stressed words 'How' and then 'Not', support the nature of this strophe, showing us that things are dependent on the How ('how reflective the parent is' – line 168) and on thinking about what the therapist is Not (line 169). In this part, even though a more 'doubtful', 'checking' aspect of the identity comes up, the process in which the therapist is engaged and that enables her to reveal this aspect of her identity is very active indeed. It's only by the therapist carefully listening and being alert to the words she has chosen that she can modify her speech accordingly.

The use of the slightly stressed word ‘Parents’ this time, and not ‘mothers’, suggests the therapist may be a bit more remote from her topic, which perhaps she felt necessary to do to take a more observant stance towards her own speech and way of constructing her identity within it. It’s as if she was actively constructing her professional identity in the first part of the narrative and in the second, she is observing and changing it accordingly. The partial stress on the word ‘Affirmation’ in this part, though, may be presenting a reference to the part of her identity that was so important for her and that she wanted to let us know about in the first part. The way she constructs an identity seems more dependent on the parents she is working with, suggesting that once the identity seems less firm and confident, there is space to include the parents’ contribution to it. We can witness then, two aspects of the therapist’s identity. One is more doubtful, reserved. The other is the expansion and development of the identity, not only in the way in which it can include the parents, but also in the way the therapist can move flexibly between her ‘old’ and ‘new’ identities and adapt them accordingly. It’s more dynamic, rather than complete and exclusive.

6.2 Felicity (Interview 8, segment 2.1):

Strophe 1: Being a parent changed and helped therapist’s identification with the parent

Stanza 1: Being a parent helped therapist’s identification with the parent

202. I (stressed and louder voice) think being a PARENT
203. helped my identification with the parent.
204. Ever, you know, I used to immediately ask ... [unclear], you know (laugh, **laugh**).

Stanza 2: Therapist’s identification changed from becoming a parent

205. HMM … SO … I think my identification changed
206. from becoming a parent.

Stanza 3: Becoming a parent meant therapist could not see things from the child’s perspective anymore

207. I could no longer JUST (|) SEE it from the child’s perspective. (4 sec.) (breath)
208. I suppose (4 sec.) there’s also (4 sec.) hmm … (3 sec.)

Strophe 2: Therapist’s orientation changed over the years and she learned you can’t work with the child unless you have an alliance with the parents

Stanza 1: Therapist’s orientation changed over the years

209. another issue that CHANGED my orientation

Stanza 2: Therapist learned she can’t work with the child unless she has alliance with the parents

210. is that I learned over the years that
211. you can't work with a child
212. unless you've got an alliance with the parents. **hmm**

Stanza 3: Either the child therapist or somebody else should work with the parents

213. And Either YO-U or somebody has to,

Stanza 4: Therapist does private work and has to make good relationship with parents

214. and I do quite a lot of private work now
215. and I HAVE to make a good relationship with the parents. (breath)

Stanza 5: Therapist is usually working alone so have to work with both child and parent

216. And usually I'm working alone, **hm** S-O I (stressed) have to do both.
217. **Right.**

Stanza 6: Therapist found that if she doesn't hold the parent, she won't hold the child

218. And if I don't hold the parent
219. I won't hold the child.

('So you have to be able to assess the parents quite well'
'We have special skills nobody else has, so we mustn't dilute them').

The language here is a language of Change: 'my identification changed'; 'could no longer just'; 'changed my orientation'; 'I learned over the years'. In her talk, the therapist is trying to say something about her personal journey in the profession over the years, a journey of learning and change and growth, as the talk seems to be around the transition to adulthood, not only in a developmental, physical way, through becoming a parent, but also in the state of mind, a state of mind that has shifted from one that can only include the child to one that can include the parent too. The therapist is trying to use her talk to say something about the things you have to let go of, e.g. focusing on the child only, and the things that inevitably change, e.g. the identification with the parent that is an inevitable change that comes with growing, time passing, gaining experience and learning. The phrase 'I could no longer' implies a change that had happened already and wasn't under the therapist's control, but that is also associated with an emotional state of sadness and pain over things that inevitably had to change.

Perhaps the therapist is trying to say that although the development and growth in her personal and professional life were helpful, necessary and unavoidable, there was pain involved. It wasn't an easy process to let go of a singular identification with the child, as if something of the child's special and exclusive place in the therapy, and in the therapist's mind, got lost, and

this is painful for the therapist. She is possibly talking about a 'less wanted' aspect of change, one that brought the therapist feelings of frustration, anger, pain and sadness. This could explain the change in the quality of the language and content between Strophe 1 and the beginning of Strophe 2, from a personal form, which relies on the use of the pronoun 'I' (e.g. 'I think', 'I suppose'), to a language that is more distant and that moves away from the difficult aspects of change.

In terms of the content, the therapist moves to talk about a change in her 'orientation'. The tone of speech sounds less hesitant and more rigid, containing a lot of conditioning ('if … then' relationship): 'you can't work with a child unless you've got an alliance with the parents' (lines 211-212); 'if I don't hold the parent I won't hold the child' (lines 218-219); 'Either YO-U or somebody has to' (have an alliance with the parents) (line 213); 'I HAVE to make a good relationship with the parents' (line 215)'; ('and usually I'm working alone,) S-O I have to do both' (line 216). This change in the structure of the sentences seems to reflect an experience of being pressured and obliged to work with parents (Stanza 2 in Strophe 2). We can see a change in the way the therapist constructs parents too. Whereas before, the change to identifying with parents was presented in a positive and natural manner 'being a PARENT helped my identification with parents' (lines 202-203). Here the work with parents is presented as something the therapist had to do, not necessarily wanted to do, or developed into doing in a more natural (and relaxed?) way.

On one hand, there is expansion in the narrative on a personal and professional level from one-sided thinking (identifying only with the child and seeing things only from the child's perspective) to two-sided thinking – keeping the child and parent in mind at the same time. It is a move from being a therapist-(adult)-non-parent to being a therapist-(adult)-parent. On the other hand, we can see a one-sided form of work creeping in again when the therapist says towards the end of the narrative that 'usually I'm working alone' (line 216). Perhaps the movement from one-sidedness to two-sidedness back to one-sidedness reveals something about the constant challenge in the CAPT's work to keep two in mind (especially when she is often a singular therapist).

Another aspect of 'interchangeability' of positions can be seen in the narrative structure. In Strophe 1, 'Being a parent' comes first and identification with parents comes second (Stanza 1), but in Stanza 2, the opposite happens and identification with parents comes first ('my

identification changed') and becoming a parent comes second ('from becoming a parent'). A similar thing happens in Strophe 2, where the child comes first and the parent second: 'you can't work with a child unless you've got an alliance with the parents' (in Stanza 2). And then it changes to the parent coming first and the child second: 'if I don't hold the parent I won't hold the child' (Stanza 6). All this revolves around the stressed word CHANGED (line 209) in the middle of the narrative. Once again, it seems as if the therapist is letting us know something important about how part of the professional identity of being a CAPT is the ability to change positions and relationships in mind and the therapist's core experience is of an active process of constant change.

However, what sounds like an experience of pressure in the second half of the narrative and some possible 'loneliness' in the work could be highlighting the difficulty in needing to change constantly. I also wonder if what we are hearing is that working alone, somehow, puts more pressure not only on the work (as the therapist then feels under more pressure to see parents), but also on the ability to incorporate two (or three if we include the therapist) in mind and to change accordingly. Perhaps the move back to a more singular position towards the end of the narrative (when the therapist is letting us know she is usually 'working alone') is an expression of an underlying frustration at the difficulty of being left on her own to do quite a complicated piece of work, which requires the ability to work with children and parents at the same time, holding both in mind and changing one's thinking when needed. When the therapist says in the end, 'off' narrative, that 'We have special skills nobody else has, so we mustn't dilute them', perhaps she is telling us that when working alone and under some pressure, the way to manage is by empowering one's own identity. But, this still does not solve the problem of 'loneliness' in the work. It's hard to know if there is any hope that the state of 'loneliness' might change, as the therapist ends in quite a definitive way, not implying more possible future change.

In summary, we hear about therapists' professional identity that is tied to processes of change and development, whether that is the development and change they went through in their professional and personal lives or the change and development they try to bring to the lives of the people with whom they work. Overall, this process seems to be characterised by a dynamic, positive feeling. There is a sense of a therapist who is making effort and trying to adhere to an active position in order to foster change in the patients. The way therapists construct their identity through the narrative is active too. They listen, and sometimes express doubts and reservations, and change the narrative accordingly. However, we also get a sense that change

and development are not easy processes. They can be painful and inevitably mean letting go of something else, often good and familiar; they also mean being flexible and open to something new. Not all changes feel welcome. Development in identity also means giving up on exclusive identity of being just a child's therapist, for example, towards a more inclusive identity. Like we have seen in the previous theme, it's not easy to occupy an inclusive space within the work and within one's identity.

Chapter 7

Discussion

Fight, Flight, Freeze, (For)give

Based on the three main narrative themes, we have seen that CAPTs are quite prone to feeling their work is done under some degree of threat and danger, within an ever changing 'wobbly' setting, one which requires of them to 'hold on' to an active, assertive position and professional identity. Therapists seem to experience a range of worries and concerns – a worry about the therapy breaking down and parents disengaging and pulling their child out, or concern about a difficult relationship dynamic with parents that can feel threatening or rivalrous. Other worries are around the ambiguity embedded in the work and a concern about crossing boundaries and exercising practice that is not 'psychoanalytic' enough or that puts patients in the wrong position or in a different type of engagement, instead of 'parent work'. There are also external sources of danger around the scarce resources available to treat parents, or services that don't prioritise their needs or which are experienced by therapists as not considerate enough of children's and parents' needs.

We have seen that CAPTs seem to manage these pressures and sense of threat, as well as the 'wobbly' setting in which they work, by constructing ambivalent relationships with parents and adhering to a strong, assertive and active professional identity, one that strives for development and change. It seems then, that each of the narrative themes can be seen as reflecting the nature of the *experience* of working with parents; for example, carrying a sense of heavy responsibility, obligation, having 'no-choice', potential danger, as well as uncertainty and ambiguity, where one's position is constantly changing, and requiring a strong, active position. It can also be seen as reflecting a way of *managing* the range of complexities within the work, such as taking more responsibility, keeping distance / getting close to parents, and by making more effort and trying harder to support parents to change.

The literature and political context support these findings. We have seen there *are* scarce resources; there does appear to be a growing 'mental health crisis' amongst children and adolescents in the UK; there *are* issues with the way the training and the discipline is structured, as will be described later; and there *are* gaps where CAPTs do not feel well supported.

Moreover, in reality, there are difficulties intrinsic to therapeutic work, child therapy work and, more specifically, to parent work. Parents can disengage and child therapies can break down or terminate prematurely as a consequence. The practice often involves intense, powerful, difficult feelings and the relationships between therapist and patient and parent are the bedrock of these feelings. Lastly, the structure of the profession, the discipline as a whole and the training feed into some of the already existing complexities within the parent work practice.

What was new and interesting to find out, however, was the way in which therapists manage their struggles, anxieties and experiences of pressure, and the way in which this in itself 'costs' them an additional kind of stress and leads to the kind of difficulties and threats therapists were feeling in the first place. In this constellation, they seem to lose the space they need to reflect on their real feelings and experiences, to separate out needs from 'wants', to have time to figure out and make sense of what they like and what they don't, what feels comfortable and what's not. The stretched framework then seems to manifest into a 'stretched' space, where an element of freedom, creativity, joy and flexibility seems impossible and even dangerous.

Another idea, pushing the thinking even further, would be to look at the three themes as revealing something that goes beyond the experience of just working with parents, about the rather 'existential' nature of the anxieties and struggles child psychotherapists experience. The three themes can then be seen as resonating powerfully in many other areas of work and parent work can be seen as a helpful avenue to access and reveal them. There might also be something unique about working with parents, which somehow embeds a condensed version of those wider themes, somehow 'stretches the therapists' experience to its limits'.

I will now move on to focus in more detail on some of the smaller narratives within each of the three big narrative themes I have found and look at how they are interlinked.

7.1 Sense of Danger

In my own findings, I have discovered that a sense of danger had various manifestations and could be captured in all three themes. For example, within Wobbly Space we observed a sense of threat of annihilation, termination or breakage of the therapeutic encounter; a worry about the relationship with parents being too distant vs. too close; and a sense of danger in relation to the boundaries and stepping into a different framework that would not be seen as parent work. The Identity in Action theme is the only place where a sense of danger didn't come up

directly; yet, as I will show later, it is perhaps partly about how to manage and position oneself in the face of the different kinds of pressures, threats and dangers therapists experience in parent work. Rustin seems to have captured the tension between the two main types of 'dangers'; the danger *within* therapy itself on the one hand, and the danger of '*no*' therapy work on the other. 'Two areas of concern: one is when there is a refusal on the part of parents to take their children's welfare seriously; the second is where therapy with the parent may endanger their capacity to sustain adult functioning' (1998, p.249). Earlier, I suggested possible underlying reasons for that, but here I want to focus on one that seems to link my findings and the literature: the position of power.

7.2 Sense of Power ('powerfulness' vs 'powerlessness')

It is not surprising that therapists – in a profession whose role is to care for and treat people's emotional difficulties and, sometimes severe, mental health problems – feel a great sense of responsibility and take their work very seriously. However, the literature seems to have revealed that a *sense of power* also contributes to a sense of pressure and responsibility. One aspect of power can be related to the therapeutic work itself and is based on the core psychoanalytic belief in the unconscious.

Based on my reading and my training (e.g. Klein, 1961) it seems psychoanalytically-trained CAPTs are aware of the power of the unconscious (as well as the super-ego) as an (unseen) driving force that affects how they – as well as patients, parents and services – behave, act and think. It might be then that a belief in the power of the unconscious (especially when it's seen as containing 'unpleasant' feelings, drives and states) together with a projection process onto parents, therapists and therapy itself, makes all three experienced as powerful and, consequently, potentially dangerous. A report of the 9th Psychoanalytical Congress remarked that '… the super-ego's power of moral inhibition is weakened by its excessive severity and by the punishment-system, while the centrifugal pressure of the two [the other one is the unconscious] narrowly restricted instincts gains in strength … the mere disguising of the meaning does not suffice to put the censorship out of action' (Alexander, 1926, p.123). To further support this view of danger from the unconscious, Ernest Jones talked about 'the power of the unconscious', saying that:

> *Every minute we are being moved by forces stirring in the depths of our being of which we know absolutely nothing … Normally the energy of the unconscious, [through*

> *sublimation] flows with relative freedom … it is the great feeding-source of our personality… Abnormally – and by this I mean usually – what happens is that some of the unconscious energy fails to find this satisfactory outlet and is thus forced into indirect channels where it agitates the personality …* (1934, p.72).

This sense of 'danger' can be traced right back to the start of child therapy too. S. Freud said: 'You have had small children in analysis? ... Is it not most risky for the children?' (1926, p.214). Later he goes on to say '… it may be hoped that things will turn out no worse for the other 'victims' of early analysis' (1926, p.215). Other evidence of concern and suspicion towards child therapy can be seen in the response to the tragic death of Hermine Hug-Hellmuth, a pioneering child therapist and head of the Viennese Child Guidance Centre who was murdered by her nephew in Berlin in 1924. 'Hermine Hug-Hellmuth … is murdered by her 18-year-old nephew Rudolph. She brought him up and analysed him as a child, and her murder fuels anxieties about the dangers of child psychoanalysis' (Timeline, Melanie Klein Trust website).

In the Introduction I discussed the external stresses CAPTs deal with and how they feel obliged to respond to what they recognise as a crisis in children's mental health in the UK. We have also seen in the political debate that CAPTs feel they need to fight to be seen; they experience their position and maintenance of their profession as vulnerable. Thus, CAPTs seem to experience their position (also in a cultural-political context) as varying between being too 'powerful' (in the early days) and as under threat of being too 'powerless' (currently).

A second aspect of power relates to the therapist's position. The following extracts from the literature shows this power narrative and its links to a sense of danger and responsibility. In Daws' case, for example, the mother of a child she was seeing (the child had fallen asleep during a session) asked her after the child's session: 'Did you hypnotise [her]?' (1986, p.104). This question seems to show a parent's underlying worry that her child's therapist, and perhaps therapy itself, is indeed powerful enough to do something to her – in this case alter her mind state. The therapist is also showing she is not surprised by the parents' worry and assumption; she regards the mother's question as legitimate.

There is a clear connection between this kind of worry and the one my interviewee, Felicity, described when she suggested that 'people are fairly scared of us aren't they?' (Felicity, Int. 8, 4.1, lines 1760-1765). Jacobs describes how it's common for child therapists to see parents 'as

the major contributors to the child's difficulties' and the result of this is that 'the therapist too often becomes the more benign and more effective caretaker to the child' (2006, p.228). Similarly, Harris said that 'experience … has made me wary of attempting to take responsibility for the management of the child's life outside the treatment room' (1968, p.63). This is notable not only because again there seems to be an underlying sense of danger in a therapist occupying a position of 'power', but because therapists themselves seem to be aware and worried enough that they attempt to monitor, regulate and alert themselves to the potential danger. As much as this shows an important self-reflective practice of the profession, it also becomes a potential source of worry. Therapists, by 'warning' each other, seem to occupy a somewhat persecutory position towards themselves, rather than an understanding, empathetic, protective and supportive one.

On one level, therapists experience all sorts of understandable and somewhat inevitable anxieties, worries and tensions within their work. However, the way they as a profession choose to regard those difficult aspects by 'warning' against them creates a further source of worry and may deepen the already existing anxiety. It is thus important that we as a profession and a discipline are aware of the way we choose to deal with and manage our own anxieties. We might need to think how we want to 'parent' ourselves and what kind of 'parents' we want to be to ourselves.

The third aspect of 'power' can be related to a therapist's occupying a 'powerless' position and, accordingly, the parent is experienced as occupying a 'powerful' position. In the Literature Review, I examined a historical blaming attitude towards parents that seemed to be based on the assumption that parents are powerful in their influence on their children. Tisiantis et al. describe some positive developments in child psychotherapy towards including parents more: 'This shift has to do with the child's inner feeling that his or her parents are also responsible for the mental changes that occur in him or her and *not just the therapist'* (2000, p.60 – my italics). However, such thinking can also be the source of viewing parents as 'too powerful'. Consequently, parents are the ones to 'blame' when something goes wrong, which can lead to therapists' feelings of apprehension and even danger towards parents, as we have seen. In theory it seems there must be ways to avoid getting 'caught up' in a powerful vs. powerless dynamic, but we can see how complicated this is in the face of external threats (to both the profession and to children's mental health services) when CAPTs might feel the only way to make themselves and their value seen is by showing the 'powerfulness' of their work.

In the Introduction I discussed the current sociopolitical context for CAPTs' work, which we can indeed think of as presenting a 'sense of danger' outside. I also mentioned the main campaigns with which the ACP is involved. 'Treat Them Right' was founded in January 2018 to flag up the threat that ACP-registered child psychotherapists within CAMHS and the specialist services they offer are under. The threat is 'due to the ongoing uncertainty over the funding of training, the squeeze on resources for CAMHS, and the changes to the way CAMHS are commissioned and designed' (ACP Newsletter, January / February, 2018).'Silent Catastrophe: Responding to the danger signs of children and young people's mental health services in trouble' was set up in June 2018 (ACP Report, 2018) to respond to the lack of available services and good quality services to meet children and young people's mental health needs. The language (here and in the fuller report) seems to confirm the narrative of my themes, e.g. 'serious challenge', 'concern', 'danger signs', 'essential', 'crucial'.

We can therefore see the link between narratives of power within the profession and outside (maybe what seems to be culturally attributed to therapy and therapists), and between an experience of danger, worry and threat within the profession. This might become even more complicated when we think of child psychotherapy as existing under an 'ongoing' pressure to 'prove' it is a safe practice as well as that it 'works' and is very much 'needed'. The development of the field towards audits, an academic component and status (my own doctorate research is, of course, evidence of that) also shows a push towards 'formalising' – grounding and acknowledging the efficacy, value and necessity of this discipline. We can therefore see what an uneasy set of forces and experiences child therapists have to manage. I do hope that by recognising the pressures and highlighting the way we manage them could help solidify child psychotherapy's position both internally, in psychoanalysis, and externally, so we are able to help and respond to those who can benefit from our work.

7.3 Closeness vs. Distance

I will now discuss my findings about therapists' preoccupation with the issue of closeness vs. distance in the therapeutic relationship with parents and how this manifested through a frequent move between the two sides of the issue. I have discussed examples from the literature that have dedicated lengthy debates to how CAPTs should see parents (e.g. as patients or 'not-patients') and how to manage the relationship with them. For example, debates about the technique of working with parents – how much to interpret, how much to address unconscious processes and how much to address and use the transference and countertransference processes.

Rustin writes that ‘we were very carefully trained in working within the psychoanalytic model of observation of transference and countertransference phenomena, and the interpretation of unconscious material, with insight as a primary goal of the work, but this kind of approach was by no means always appropriate or acceptable to parents’ (1998, p.234).

In light of the previous narrative theme, and considering an underlying reason for this current narrative, I wonder if therapists’ seeming uncertainty and ambivalence to how they want to position themselves in relation to parents could be a form of *defence* against an underlying sense of danger (in this case, the risk of ‘crossing’ the boundaries’), and / or against the lack of support and guidance from training schools, supervision, internal discussions and theory. It could also be a defence against the mixed messages coming from both the theory and the training schools. Even though in the psychoanalytic tradition we are trained to observe and understand unconscious processes and to use transference and countertransference processes as tools to make sense of and work with patients, when it comes to parents we are somehow expected to ‘strip ourselves of’ this knowledge and these tools. This seems contradictory to what we were taught. The ambivalence towards parents may therefore be a defence against the difficulties described as well as a way to compromise and manage an area left ambiguous and controversial.

7.4 ‘Double bind’ boundaries

Another aspect that stood out from my research findings in relation to Wobbly Space was boundaries. Once again, it seems the literature can provide reasons for why the preoccupation with boundaries came up so frequently.

The issue of professional boundaries is embedded in the CAP profession. Boundaries are needed to provide a safe, structured space that allows deeper ‘unstructured’ internal work to take place and to provide both holding and containment to the ‘drama’ and vicissitudes of the patient’s emotional world and work. It is also there to protect both therapist and patient. There is much evidence for this in the literature. For example, Winnicott (1972), wrote that ‘… the setting and the therapeutic contract maintain the existence of the actual and the symbolic and creativity and play can only exist within it’ (cited in Gvion & Bar, 2014, p.70). Furthermore, Gvion and Bar write that: ‘The setting makes it possible to define the differences between work with the child and the parents … [it] actually enables the existence of the triangular space … ‘(2014, p.70).

However, when it comes to parent work, the setting's boundaries seem to create a *double bind situation*, where the fear about 'crossing' the line (e.g. by 'allowing' parents to become dependent on therapists) makes the boundaries of the therapeutic setting (as therapists experience them) an 'area of danger' rather than a protective 'comfort zone'. Another aspect that could explain why boundaries have become a *double bind* difficulty, particularly in parent work, is the very nature and structure of the child psychotherapy discipline in the UK. CAPTs can only work with children. To be able to work with parents as 'adult-patients', they need further training in 'adult psychotherapy' or 'psychoanalysis' or 'couple work' (or all of these).

Of course, parent work is unique. Simultaneously there can be work with parents specifically to support the child (in or out of therapy), yet parents are also adults in their own right. It seems rather difficult to try and 'separate out' the part of them that is 'just' a 'parent to a particular child' and the part of them that is an 'adult'. The structure and divisions between the different trainings, qualifications and psychotherapy disciplines that were created to provide clear, safe, protective boundaries for both therapists and patients with parent work can create an area about which the therapist might be wary. This is confirmed in Rustin's words, who said that we have not yet '… solved the problem of how to train for the component of adult work within any child psychotherapist's practice' (1998, p.235) and she adds that 'Perhaps our anxieties on this score are one source of the tendency for child psychotherapists to go on to train as adult therapists or analysts …' (1998, p.235). This is also confirmed in Whitfield and Midgley, who found that therapists seemed to vary in how 'confident' or 'competent' (2015, p.278) they feel, and those CAPTs who had trained as adult psychotherapists as well, said it was helping them 'in their work with parents' childhood experiences' (2015, p.278), and those who didn't said they were 'more self-conscious about the rules' (2015, p.278).

We can say the boundaries are always present in therapeutic work, whether it is parent work or not, but I would like to take this further. I am not suggesting anything unethical or harmful about the way CAPTs work. Rather, in light of the emerging themes of 'heavy weight', 'pressure', 'sense of obligation', 'no choice', danger and threat, I would like to allow a space to think about the subtle ways therapists *experience* boundaries and the subtle ways these boundaries might be experienced as a *hindrance* impacting (and possibly limiting) therapists' sense of freedom, choice, joy, creativity, ease and confidence in their work with parents.

However, I think the problem is more complicated. Apart from the issue of boundaries presenting difficulty, there is the issue of the work with parents not having sufficient space in training schools – the primary reason for doing this research. Sutton and Hughes suggest that 'the training of all disciplines might be enhanced by additional training in the psychotherapy of parenthood, including practitioners with training in child or adult psychotherapy' (2005, p.186). On one hand, specialist training in the 'psychotherapy of parenthood' could indeed provide and create space for thinking about parents and the work with them. On the other hand, creating further, separate training, might once again create a situation with 'more boundaries' that those who haven't done this specialist training might be worried to cross.

7.5 Changes and oscillations within the Wobbly Space

Two other key aspects of the Wobbly Space are the constant move and change in the use of nouns and pronouns (e.g. from 'child' to 'parent' to 'grandparents' and from 'parents' to 'they' to 'a parent' and from 'we' to 'I' to 'us' and 'you). This suggests the focus of the work changes constantly as well as how one positions oneself in relation to parents.

There is a place to elaborate on the very *special* space within the parent work: 'Child psychotherapy does not occur in a vacuum. The formulation, design, and implementation of intervention strategies must take a number of intersecting contexts into consideration; these include the contexts of development, the family, and the child's culture' (Shirk & Russell, 1996, p.340). Winnicott's famous statement that 'there is no such thing as an infant, only mother and infant together' (1975, p.99) suggests that even before starting therapy the child is already part of an existing relationship(s). The Wobbly Space theme seems to reveal not only the 'many' participants CAPTs need to deal with (both in person and internally), but the multiple layers CAPTs need to be aware of, hold in mind and move between. As Menzo, Placcioespase and Zilke (2005) said: 'An overall understanding of the child therefore depends to a great extent on the therapist's ability to listen and identify the variety of layers present in the child's emotional environment' (cited in Gvion & Bar, 2014, p.67).

It seems that we often work within a space that is somewhat 'wobbly'. Another way of thinking about this space is what has been widely described in the psychoanalytic literature as

> *'[the] "triangular space" - i.e., a space bounded by the three persons of the Oedipal situation [mother, father and child] and all their potential relationships. It includes,*

> *therefore, the possibility of being a participant in a relationship and observed by a third person as well as being an observer of a relationship between two people' (Britton, 1989, p.86).*

Gvion and Bar add that 'from this standpoint, the child is allowed to look at him or herself interacting with others and can adopt additional points of view' (2014, p.61). We can see then how the experience of 'mental freedom' (Gvion & Bar, 2014, p.61) and 'space' are interrelated and how important it is to create a space within the therapeutic work to encompass its complex, multi-layered nature, to include the many 'participants' as well as to enable the therapist to move freely and flexibly between them (whether in reality or just in his mind).

Similarly, therapists might feel they need a space to encompass the multiple roles they occupy, especially as they develop and 'grow' in their professional and personal journey. They might start as CAPT trainees, but with time might become not only qualified CAPTs, but also supervisors, researchers, seminar leaders, teaching staff, heads of programmes or courses, adult/couple therapists and so on. On a personal level, they might be or become parents themselves. Neither the literature nor my own therapists' accounts seems to have dealt with this issue directly. It seems very complicated not only to hold and keep boundaries, but also to exercise enough mental freedom to 'move' freely between different 'roles' (e.g. Beall, 1972; Yishay & Oren, 2006; Gvion & Bar, 2014).

In the context of this dissertation, we can see how necessary it is to create an 'external space' (in the form of specialist supervision, courses and internal discussions, as recommended by Whitefield & Midgley, 2015) to contain and facilitate the development of an 'internal space' (the therapeutic work with children and parents and the development of the therapist and the therapist's identity).

An Active, Strong Therapist

Of the three themes, on the surface I have found the following aspect of Identity in Action the most unexpected. The fact that therapists seem to use quite an 'active' language with verbs that have a 'doing' quality rather than a 'being' quality is not the way we would stereotypically think of therapists. We often think of them as 'sitting with', 'staying with', 'thinking', 'reflecting', 'containing'. The other surprising aspect of this theme is the way therapists seem to occupy a somewhat assertive position when they talk about their work with parents. This

comes across through the use of a strong, definite tone of voice and categorical language. This finding seems counterintuitive as, again, stereotypically, we might have an image of therapists as 'soft', 'patient', 'gentle'.

A Passion for Change and Development

Throughout the interviews, I felt there was a great sense of passion mixed with care and concern towards parents' pain, suffering and vulnerabilities. The literature, as shown, is full of sympathetic, compassionate and sensitive accounts of parents as well as children, even if it's less obvious at first glance. However, that does not take away from the fact that work with children and parents requires a tremendous amount of effort and goodwill.

The overall preoccupation with the subject in different ways seems to have an underlying intention to effect change and development in those with whom CAPTs work. To bring about change and a push towards development, it looks as though one indeed needs to hold on to a great *active* force. Furthermore, considering the CAPT field's relative newness, its rather shaky start and the current sociopolitical background, it is unsurprising CAPTs feel they need to occupy a strong, confident position that can enable them to, when needed, 'fight' and act. It also makes sense they might need to hold on to active attempts to survive and make themselves known to those who might need them, as well as to make an impact on a smaller scale (day-to-day therapeutic work) and on a larger scale (public policies, structure and management of mental health services).

In light of the two other narrative themes found in this research – Pressure / Threat and Wobbly Space – therapists once again seem to have to maintain inner strength and determination to withstand the internal and external pressures, potential dangers and threats to functioning in often uncertain, ambiguous conditions.

It would be interesting to explore whether the 'active narrative' is something that resonates in other areas of therapeutic work within the psychoanalytic tradition. There is, for example, Symington's 'belief that no healing of a permanent nature can come from anything less than an inner creative act' (2018, p.xvii) and Solomonson suggests an active approach in his paper 'Therapeutic action in psychoanalytic therapy with toddlers and parents' (2015, p.112). Lastly, as positive feelings were somewhat less common in my interviewees' accounts, I also wonder whether the intense, strong and powerful feelings that seem to have been revealed so clearly

under the Identity in Action theme are also a substitute, or a more 'legitimate' outlet for expressing strong, positive feelings such as joy and fulfilment in regards to parent work. This also needs future exploration.

The Identity in Action theme then is important not only in revealing what I feel is CAPTs' 'feisty' side, but also a compassionate, empathetic and giving side. At the same time, it is an ongoing task to discern how much of the strength or 'feistiness' therapists seem to employ is needed to foster change and development and how much of it could be a *defensive stance* against the type of difficulties described throughout the thesis. Even if therapists' strong identity contains a 'defensive' element, it doesn't mean this 'defence' should be eliminated. Rather, I think it can provide yet another way of understanding ourselves as a profession and the way in which we manage our anxieties. This narrative theme also offers an alternative way to go about the 'power' conflict. Rather than feeling 'powerful' vs. 'powerless', therapists might cultivate their professions' inbuilt identity of 'inner strength'.

This brings me to this chapter's title: Fight, Flight, Freeze, (For)give. It attempts to unite the three narrative themes. In the face of pressures and threat (Pressure theme) that therapists struggle to position themselves against (Wobbly Space theme), they show their underlying passion, attempts and efforts to do, give and make a difference (Identity in Action). Byng-Hall writes from a family therapy perspective that 'arguably the two vital steps in all forms of therapy are forgiveness for neglect or for attacks made on oneself, and reparation made for injustice done to others' (1986, p.5). Through this dissertation, I wish to acknowledge the difficulty in being a CAPT and in working with parents, as well as sympathise and show compassion for their and the parents' difficulties, vulnerabilities and limitations. I wish to offer CAPTs a space to feel free to carry on thinking, exploring and connecting between the profession in general and, in particular, the debate about parents and the work with them.

7.6 Summary

In this chapter, I have discussed in more depth aspects of my three main narrative themes, explored a link between them as well as with the ones that seemed to arise in the literature and, even more so, in the current language used to describe external pressures and threats. We saw the way *threat* and *danger*, and a sense of responsibility and obligation, came together with the therapists' need to 'make an effort', act and to emphasise the profession's importance and value. By this, they were revealing the professional identity they use to manage both the

internal and external challenges within their work with parents, as well as the way in which this becomes a source of stress and worry in itself. I contemplated whether the three themes could be seen as referring to rather more global 'existential' themes, embedded in the work and experience of the child psychotherapist and, in that sense, parent work being an invaluable vehicle to access those themes.

I discussed the problem of double-bind boundaries where the boundaries protect but, at the same time, can be experienced as a source of worry and threat. I also considered the double-bind difficulty with responsibility, where a sense of responsibility is often tied up with 'power'. The more responsible a therapist feels, the more powerful they may feel, which on one hand, can lead to a sense of worry and danger (therapists don't want to feel 'too powerful') and, on the other hand, a sense of obligation, where therapists feel they end up in a position they haven't really chosen. The tension and pressure around having 'no-choice' compromises the ability to open up a space to explore tensions, ambivalence and difficult feelings, which seems to have been largely why this topic was avoided in the first place.

I looked at the conflict of therapists being trained to use psychoanalytic thinking and techniques, but at the same time being 'required' to use those elements differently in parent work. I looked at the therapist's difficult position within a 'wobbly space' and the possible defensive elements in the wobbly space against pressures and threats, which impact the ambivalence and shifts within the relationship with parents (e.g. being close vs. distant, dependant vs. independent, etc.). I further explored the unique space of child therapy, which reflects the vicissitudes and dynamic nature of relationships in CAPTs' mind and in the work. I wondered if establishing an external safe space (in terms of teaching, writing and supervision) would give therapists enough internal space to express freely what they really feel (as opposed to what their countertransference responses tell them they feel); what they really want (as opposed to what they feel they need and ought to do); and what choices (regarding their parent work) they 'really' want to make.

The structure of the training and the profession feeds into these kinds of difficulties, pressures and avoidance and may leave the therapists to manage on their own. Today, resonating with the narratives about 'pressures', 'danger', 'power' and the oscillation between these extremes, we hear that CAPTs seem to be much more concerned about the lack of psychotherapy

available to vulnerable children and those who most need it, as opposed to child therapy's early days when a main concern was about it being 'too powerful'.

The last theme, Identity in Action, looked at how therapists manage parent work's dynamic nature, pressures and ambiguities. I wondered again about a defensive element that therapists might feel they need to hold on to in order to manage the many pressures in the work in the absence of adequate support and guidance. Identity in Action also seemed to reflect therapists' significant passion to help and make a difference, their commitment to 'work hard' towards this goal (sometimes against the odds). The reality of threats and dangers I have described proved therapists do need their 'feisty' qualities to maintain the profession and the service they can offer to vulnerable children and families. I also wondered whether intense accounts represented a 'legitimate' outlet for positive feelings about the parent work practice such as fulfilment and joy.

Chapter 8
Conclusion

This doctorate dissertation has been designed to explore the area of parent work in the context of CAPTs' work with parents and the place of parents within this practice. This qualitative, empirical project has been spread over a period of 10 years (with 2 long breaks in the middle). It originated from my own personal experience as a CAPT trainee when I became curious about the gap in parent work in both literature and practice and wanted to explore it further. I have thus designed this research to enable me to hear about CAPTs' experiences of their work with parents and, through their talk, to reveal the particular stories and narratives about the work, the profession and the professional identity they have constructed.

In the light of the external pressures and threats to the profession today and the worrying sociopolitical circumstances that put children's and young people's mental health in serious danger, it seems almost a luxury to write a dissertation about parents. Yet, as I have tried to show, we have a duty to ensure that now, more than ever, parents aren't being overlooked, forgotten and neglected in the midst of the crisis. Moreover, at a time when we are looking to strengthen and integrate our own profession, practice and sense of community, this study should help in further bolstering our organisation and profession internally. It also doesn't seem right to look at the fight for children's mental health in isolation from their parents. The parents are important as well, not only because they make this fight more visible but also because as parents, they too want the best for their children.

The historical context of child and parent work wasn't easy to capture and, at times, proved ambiguous and contradictory. I have looked at the views of parents across history and noted that they vary from critical and blaming to empathic; from seeing parents as 'burdensome' to important and valuable for the child in general and the therapy specifically; and to seeing them as 'patients' or 'not-patients'. The last view proved to be linked to variations in the way of working with parents and with technical choices such as the use of transference and countertransference processes within the relationship.

The literature revealed that the main worry seemed to be about the relationship with parents. Particularly, it was about the dependency within the relationship, framework and boundary of

the work setting and the intensity of the relationship and sense of responsibility and power. Therapists were worried about occupying a 'too powerful' position in relation to parents but, equally, about occupying a 'powerless' position. This often led to therapists seeing parents as 'too powerful' and had the potential to lead us back to the view of parents from which we as a profession have tried to move on.

The position therapists tend to take with parents seems to relate to the type of engagement, clinical judgment, experience, and training, and what I have assumed as personal preference and tendencies. By this I mean how comfortable and confident therapists feel with any of the above aspects in their parent work. It seems to me that the subject of parenting, in the shape of 'working with parents', 'being a parent' and 'parenting others', is particularly intense and evokes powerful feelings. Therapists' awareness and self-reflection might in fact be a 'double-edged sword', where *alerting* and warning themselves of unfavourable or unhelpful views can evoke an experience of pressure, 'threat' and restrictions in regards to parent work.

These experiences can be seen sometimes in the rather polarised views towards parents and in the way we ended up not hearing much about therapists' 'real' feelings and wishes (as opposed to what *needs* to happen) and their struggles with parent work, as if there was no space or legitimation for it. This experience was further confirmed when analysis of therapists' accounts also revealed a sense of pressure and obligation, as if therapists had 'no choice' about their work with parents. The structure of the profession, training and discipline (where there are clear divisions and no place for an 'adult' component nor recognition of parent work as a specialist area) seems to have fed into a worry about 'crossing' boundaries, and therefore a sense of restricted freedom, creativity and joy in this practice.

The literature revealed also issues around the nature of the profession; the vulnerable position therapists face in terms of possible breakage and premature termination; the sense of having no control over the events; the sense of 'power' attributed to the process of therapy; and the way in which the experience of pain, conflict and ambivalence are probably inevitably part of the experience of parenting in all its shapes. This is strongly related to our professional identity in the work and the way we 'parent' our own tensions and uncomfortable experiences ourselves in this profession. The literature, as well as the findings in this research, revealed potential underlying reasons for the complexities and, consequently, avoidance of this topic in the first place.

My research questions were thus multifaceted. I attempted to address: what parents are for us and what else we are trying to avoid; what we feel uncomfortable about; what we would want if we had the choice; how comfortable we are when it comes to having to exercise a more flexible, creative practice; how much we strive to enjoy our work; how comfortable we are in thinking about the ways in which the structure of our training, profession and discipline might affect the way we conduct and experience parent work. Not all of the questions were answered. However, the purpose wasn't to answer them all, but rather to open up a space to look and acknowledge the experiences, to begin to make sense of them, and to see how they affect our identity.

After discussing my questions, I described my sample, explained the reasons for it and why I chose Narrative Analysis (NA) as the preferable methodology. I also spoke about the research's weaknesses, what could have been done differently, and about my own position as a researcher. I considered how my position could have influenced the way I conducted this research as well as the way I approached and analysed the material.

I presented the main narrative themes that emerged from deep analysis on segments from interviewees' accounts. The first was Pressure / Threat: an experience of pressure, a heavy, serious attitude towards parent work practice; a sense of responsibility and having 'no choice' about working with parents; and finally, what became one of the main aspects of pressure / threat that I focused on – a sense of danger within the work. The second theme was Wobbly Space, where parents were moving in and out of focus, and therapists seemed to move between feeling close and then distant to parents; and a preoccupation with the setting's boundaries. The third theme was Identity in Action, where therapists seemed to occupy a solid, certain professional identity in relation to parents based on active efforts and attempts to work towards change and development within themselves and others. I have shown the way in which these three themes are interlinked. I found that the theory and practice came together as well as the external reality CAPTs work against.

This research has increased my own awareness and understanding of various dilemmas, conflicts and complexities embedded in the parent work practice. It has enabled me to elucidate aspects in CAPTs' experiences that were either missed or taken for granted and to better understand what has been underlying this area's relative neglect in the literature, teaching and supervision. This research has also opened up an unexpected new possibility to look at the main

anxieties and struggles that characterise the child psychotherapist's work with parents as indications of wider 'existential' themes that underlie many other areas of work. Looking at these themes through this angle, we can understand something deeper about 'what it's like being a child psychotherapist' in general, and can also understand parent work as a fertile ground for allowing these insights to reveal themselves.

I see the value of this research as allowing parents and the work with them to occupy an important space in our profession, as well as opening up a space to talk freely about experiences, thoughts and feelings related to parent work. In so doing, this research joins some other recent, important research.

In the context of the worrying sociopolitical climate, it could, as I have noted, be seen as a luxury to wish to promote not only the thinking about parents but also a fulfilling practice. Ultimately, however, I hope that the more discussions we have amongst ourselves, the more we feel connected, supported, and therefore empowered – as the profession indeed strives for – to face external struggles and dangers, as well as feeling safe and free enough to explore and stay with our own internal dilemmas, conflicts and tensions. It's important that both we, parents and children, benefit from our work, thinking and discussions.

8.1 Further research and where we go from here:

Hear more about therapists' experiences:

Given the dearth of research into parent work, it is important, alongside the recent literature, for example, Whitefield and Midgley (2015) and Holmes (2018), to further research CAPTs' experiences of working with parents. It would be important to encourage CAPTs to talk about and share their experiences and to extend the study to larger groups of CAPTs, which this research didn't cover. It would be good, for instance, to include newly qualified therapists; those from other geopolitical locations; as well as to hear about CAPTs' experiences with diverse populations, such as those who work with parents from minority ethnic groups, parents of children with special needs, in hospital settings and more. This would help to bring richer and 'thicker' material to explore and make sense of across a broader range of therapists and experiences.

Search for alternative and additional narratives that affect us:

My research showed the importance of the narratives CAPTs hold in relation to their work with parents, and I have begun to make sense of what might be underlying those narratives. It is, however, important to search for other narratives about parents, parenthood, mothers, therapy, and childhood to identify wider social narratives that might impact the perceptions and experiences CAPTs have of parents, children and the work. It would also be valuable to see whether the narrative themes found in this research (primarily in a psychoanalytic discipline) resonate with other disciplines, such as sociology, psychology and anthropology. It would be interesting to do this by looking outside psychoanalytic literature and / or by interviewing larger groups, outside the CAPT community. 'The social role of stories – how they are connected to the flow of power in the wider world – is an important facet of narrative theory' (Riessman, 2008, p.8).

I wonder too whether, for example, the 'responsibility' narrative might be connected to a wider narrative about '*Who is responsible for children in our society?'* as well as to therapists' sense of belonging and being part of a bigger group. I wonder how much 'responsibility' over children people wish to own, share or pass around. We can see evidence that this subject has preoccupied others both within and outside the psychoanalytic literature. For example, Bolland said that 'because of our cultural attitudes to children, which include the idea that they need direction and guidance by adults, it may be extremely difficult for the analyst to stand aside, especially as the parents themselves will assume that the analyst, as another adult, will feel the same kind of responsibility as they do' (1974, p.13). Houzel has also stated that 'if anyone is to be held responsible for creating the risk of infantile autism, then we all should be – parents, collaterals, professionals, we all have a duty to offer the support of our mindfulness to mothers …' (2000, p.133).

Outside the psychoanalytic literature, within a sociological-cultural discipline, we can hear Furedi (2002, 2008a), who had coined the term 'parental determinism', which means 'a form of deterministic thinking that construes the everyday activities of parents as directly and casually associated with 'failing' or harming children, and so the wider society' (cited in Lee, Bristow, Faircloth & Macvarish, 2014, p.3). Furedi has been trying to challenge this perception, which highlights 'the main development in parenting culture…' (p.3). He further said that '… once children are seen as the responsibility of a mother and father rather than of a larger

community the modern view of parenting acquires salience' (cited in Lee, Bristow, Faircloth & Macvarish, 2014, p.7).

The voice of the parents

Lastly, given the intense and powerful experiences that have come up in response to working with parents, I wonder what it's like being a parent, working with a child therapist. It would be very important to hear the parents' voice – what they have to say and how they talk about their experiences of meeting and working with a CAPT. As little as we hear the CAPTs' voice, in fact, we don't hear the parent's voice at all. If we indeed strive to understand our work and profession better, we must then listen to and understand what the people we work with have to say – what they feel and think, and what their experiences are like.

Bibliography

Association of Child Psychotherapy (ACP) (2018). *"'Silent Catastrophe' – Responding to the danger signs of children and young people's mental health services in trouble".* A Report from the Association of Child Psychotherapists on a Survey and Case Studies about NHS Child and Adolescent Mental Health Services. London: ACP.

ACP (2018). *What is Treat Them Right all about?* ACP Newsletter, January/February 2018 [email].

ACP (2018). *Young people's mental health is a 'worsening crisis'. Action is needed*, ACP Newsletter, August 2018 [email].

ACP (2019). *About the ACP*. [online]. Available at: https://childpsychotherapy.org.uk/about-acp.

Ainsowrth, M.D.S., Blehar, M.C., Walters, E. and Wall, S. (2015). Patterns of Attachment: A Psychological Study of the Strange Situation, classic edn. New York: Psychology Press.

Alexander, F. (Dr.) (1925). Neurosis and the Whole Personality (Berlin). In: Report of the Ninth Psycho-Analytical Congress (1926). *Bulletin of the International Psycho-Analytic Association,* 7, pp. 119-143.

Altman, N. (2000). Reconsidering Parent Involvement in Child Psychotherapy in the Light of Recent Developments in Attachment Theory. *Journal of Infant Child Adolescent Psychotherapy*, 1(1), pp. 53-59.

Bailey, T. (2006). There is no such thing as an adolescent. In: M. Lanyado and A. Horne (eds.). *A Question of Technique*. London: Routledge, pp. 155- 171.

Baldwin, E. (2014). Recognizing Guilt and Shame: Therapeutic Ruptures with Parents of Children in Psychotherapy. *Psychoanalytic Social Work*, 21(1-2), pp. 2-18.

Barth, D.F. (1989). Blaming the Parent. *The Annual of Psychoanalysis*, 17, pp. 185-201.

Beall, L. (1972). The corrupt contract: problems in conjoint therapy with parents and children. *American Journal of Orthopsychiatry*, 42(1), pp. 77-81.

Benedek, T. (1959). Parenthood as a developmental phase. *Journal of the American Psychoanalytic Association*, 7, pp. 389-417.

Berlin, N. (2008). Tripartite therapy with older children: mutuality in the relationship of a parent–child attachment. *Journal of Child Psychotherapy*, 34(3), pp. 335-363.

Bernstein, I. and Glenn, J. (1988). The Child and Adolescent Analyst's Emotional Reactions to his Patients and their Parents. *International Journal of Psychoanalysis*, 15, pp. 225-241.

Bick, E. (1962). Symposium on child analysis: child analysis today. *The International Journal of Psychoanalysis*, 43, pp. 328- 329.

Bolland, J. (1974). Us and Them? - The Child, The Analyst and the Parents. *Journal of Child Psychotherapy*, 3(4), pp. 5-14.

Bolinger, D. (1986). *Intonation and its parts: Melody in spoken English.* Stanford, CA: Stanford University Press.

Braunl, V. and Clarke, V. (2006). Using Thematic Analysis in Psychology. *Qualitative Research in Psychology*, 3, pp. 77-101.

Brazelton, T.B., Koslowski, B. and Main, M. (1974). The early mother- infant interactions' and 'The origins of reciprocity: the early mother- infant relationship. In: M. Lewis and L.A. Rosenblum (eds.), *The Effect of the Infant on its Caregivers*. London: Wiley Interscience.

Brazil, D. C., Coulthard, R.M. and Johns, C. M. (1980). *Discourse intonation and language teaching*. London: Longman.

Britton, R. (1989). Chapter 2: The Missing Link: Parental Sexuality in the Oedipus Complex. In: R. Britton, R., M. Feldman, E. O'Shaughnessy and J. Steiner, (eds.). *The Oedipus Complex Today: Clinical Implications*. London: Karnac Books, pp. 83-101.

Burck, C. (2005). Comparing Qualitative Research Methodologies for Systemic Research: The Use of Grounded Theory, Discourse Analysis and Narrative Analysis. *Journal of Family Therapy*, 27, pp. 237-262.

Byng Hall, J. (1986). Family scripts: a concept which can bridge child psychotherapy and family therapy thinking. *Journal of Child Psychotherapy,* 12(1), pp. 3-13.

Cohn, J.F. and Tronick, E.Z. (1988). Mother–infant face-to-face interaction: influence is Bidirectional and unrelated to periodic cycles in either partner's behaviours. *Developmental Psychology*, 24(3), pp. 386-392.

Crystal, D. (1979). *Prosodic systems and intonation in English.* Cambridge: Cambridge University Press.

Cupitt, D. (1990). *Creation Out Of Nothing*. London: S. C. M. Press.

Daws, D. (1986). Consent in Child Psychotherapy: The Conflicts for Child Patients, Parents and Professionals. *Journal of Child Psychotherapy.*, 12(1), pp. 103-111.

Daws, D. (1999). Parent—Infant Psychotherapy: Remembering the Oedipus Complex. *Psychoanalytic Inquiry*, 19, pp. 267-278.

Edwards, J. and Maltby, J. (1998). Holding the Child in Mind: Work with Parents and Families in a Consultation Service. *Journal of Child Psychotherapy*, 24(1), pp. 109-133.

Edwards, D. and Potter, J. (1992). *Discursive Psychology*. London: Sage.

Emanuel, L. (2006). A slow unfolding – at double speed: reflections on ways of working with parents and their young children within the Tavistock clinic's under-fives service. *Journal of Child Psychotherapy*, 32(1), pp. 66-84.

Emanuel, L. and Bradley, E. (eds.). (2008). *"What Can The Matter Be?" Therapeutic Interventions with Parents, Infants and Young Children.* London: Karnac Books.

Folkart, L. (1964). The Role of a Child Psychotherapist in an In-Patient Setting. *Journal of Child Psychotherapy*, 1(2), pp. 44-54.

Fonagy, P. and Target, M. (1996). Predictors of Outcome In Child Psychoanalysis: A Retrospective Study Of 763 Cases At The Anna Freud Centre. *Journal of the American Psychoanalytic Association*, 44, pp. 27-77.

Frick, M.E. (2000). Parental Therapy – in theory and practice. In: J. Tsiantis, S. Boalt Boethious, B. Hallerfors, A. Horne and L. Tischler (Eds.). *Work with Parents: Psychoanalytic Psychotherapy with Children and Adolescent*. London: Karnac Books, pp. 65-92.

Freud, S. (1909). Analysis of a Phobia in a Five-Year-Old Boy. *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume X (1909): Two Case Histories ('Little Hans' and the 'Rat Man')*, pp. 1-150.

Freud, S. (1926). The Question of Lay Analysis. *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume XX (1925-1926): An Autobiographical Study, Inhibitions, Symptoms and Anxiety, The Question of Lay Analysis and Other Works*, pp. 177-258.

Furman, E. (1982). Mothers have to be there to be Left. *Psychoanalytic Study of the Child*, 37, pp. 15-28.

Gee, J. P. (1986). Units in the production of narrative discourse. *Discourse Processes*, 9, pp. 391-422.

Gee, J. P. (1991). A Linguistic Approach to Narrative. *Journal of Narrative and Life History/ Narrative Inquiry*, 1, pp. 15-39.

Geissmann, C. and Geissmann, P. (1998). *A History of Child Psychoanalysis*. London and New York: Routledge. Published in association with the Institute of Psychoanalysis, with the assistance of Melanie Klein Trust, Anna Freud Centre and the French Ministry of Culture.

Gergen, K.J (2001). Psychological science in a postmodern context. *American Psychological Association*, Vol. 56 (10), pp**.** 803-813.

Goodson, I. and Sikes, P. (2017). Techniques For Doing Life History. In: I. Goodson (ed.). *The Routledge International Handbook on Narrative and Life History.* Oxon: Routledge, pp. 72-88.

Green, V. (2000). Therapeutic space for re-creating the child in the mind of the parents. In: J. Tsiantis, S. Boalt Boethious, B. Hallerfors, A. Horne, and L. Tischler (eds.). *Work with Parents: Psychoanalytic Psychotherapy with Children and Adolescent.* London: Karnac, pp. 25- 46.

Greenson, R.R. (1965). The Working Alliance and the Transference Neurosis. *Psychoanalytic Quarterly,* 34, pp. 155-181.

Gvion, Y. and Bar, N. (2014). Sliding doors: some reflections on the parent–child–therapist triangle in parent work–child psychotherapy. *Journal of Child Psychotherapy,* 40(1), pp. 58-72.

Harris, J. (2018). Leo Kanner and autism: a 75-year perspective. *International Review of Psychiatry*, 30 (1), p. 3–17.

Harris, M. and Carr, H. (1966). Therapeutic Consultations. *Journal of Child Psychotherapy,* 1(4), pp. 13-19.

Harris, M. (1968). The Child Psychotherapist and the Patient's Family. *Journal of Child Psychotherapy*, 2(2), pp. 50-63.

Holmes, J. (2018). Aims in parent work: a brief qualitative survey. *Journal of Child Psychotherapy*, 44 (2), pp. 263-274.

Horne, A. (2000). Keeping the child in mind: thoughts on work with parents of children in therapy. In: J. Tsiantis, S. Boalt Boethious, B. Hallerfors, A. Horne, and L. Tischler, eds., *Work with Parents: Psychoanalytic Psychotherapy with Children and Adolescent.* London: Karnac, pp. 47-64.

Horne, A. and Lanyado, M. (eds.) (2009). *Through Assessment to Consultation: Independent Psychoanalytic Approaches with Children and Adolescents.* London and New York: Routledge.

Houzel, D. (2000). Working with children of autistic children. In: J. Tsiantis, S. Boalt Boethious, B. Hallerfors, A. Horne, and L. Tischler (eds.). *Work with Parents: Psychoanalytic Psychotherapy with Children and Adolescent.* London: Karnac, pp. 115-134.

Hopkins, J. (1992). Infant-parent psychotherapy. *Journal of Child Psychotherapy,* 18(1), pp. 5-17.

Jacobs, L. (2006). Parent-Cantered Work: A Relational Shift in Child Treatment. *Journal of Infant Child Adolescent Psychotherapy*, 5(2), pp. 226-239.

Jarvis, C. (2005). Parenting problems: research and clinical perspectives on parenting adolescents: *Journal of Child Psychotherapy*, 31(2), pp. 209-220.

Jones, E. (1934). How the Mind Works. *International Journal of Psychoanalysis,* pp. 71-73.

Kanner, L. (1944). Early infantile autism. *Journal of Paediatrics*, 25, pp. 211-217.

Kennedy, E. (2003). *Child and Adolescent Psychotherapy. A systemic review of psychoanalytic approaches.* London: North Central London Strategic Health Authority.

Kernberg, P. F. and Chazan, S. E., with the collaboration of A. Frankel., J.R. Hariton., R.S. Kruger., P. Saunders and H. Scholl (1991). *Children with conduct disorders: A psychotherapy manual.* New York: Basic Books.

Klauber, T. (1998). The Significance of Trauma in Work with the Parents of Severely

Disturbed Children, and its Implications for Work with Parents in General. *Journal of Child Psychotherapy*, 24(1), pp. 85-107.

Klein, M. (1961). *Narrative of a Child Analysis.* London: Hogarth Press.

Kohrman, R., Fineberg, H. H., Gelman, R. L. and Weiss, S. (1971). Technique of child analysis: Problems of countertransference. *The International Journal of Psychoanalysis*, 52(4), pp. 487-497.

Labov, W. and Waletzky, J. (1967). Narrative analysis: Oral versions of personal Experiences. In: J. Helm (ed.). *Essays on the verbal and visual arts.* Seattle: America Ethnological Society / University of Washington Press, pp. 12-44.

Ladd, R.D. (1980). *Intonational meaning.* Bloomington: Indiana University Press.

Lanyado, M. and Horne, A. (eds.) (2009). *The Handbook of Child and Adolescent Psychotherapist: Psychoanalytic approaches*, 2nd edn. London and New York: Routledge.

Lee, E. (2014). Introduction. In: E. Lee, J. Bristow, C. Faircloth, and J. Macvarish. *Parenting Culture Studies*. London: Palgrave Macmillan, pp. 1-22.

Melanie Klein Trust. *1921-1925- Berlin: child analysis begins*. [Online]. Available at: https://melanie-klein-trust.org.uk/timeline/1921-1925/).

Meltzoff, M. K. and Moore, M. K. (1992). Early imitation within a functional framework: The importance of personal identity, movement and development. *Infant Behaviour and Development*, 15, pp. 479-505.

Midgley, N. (2012). Peter Heller's *A Child Analysis with Anna Freud*: The Significance of the Case for the History of Child Psychoanalysis. *Journal of the American Psychoanalytic Association*, 60(1):45-69.

Midgley, N., O'Keeffe, S., French, L. and Kennedy, E. (2017). Psychodynamic psychotherapy for children and adolescents: An updated narrative review of the evidence base. *Journal of Child Psychotherapy*, *43*(3), pp. 307-329.

Mishler, E.G. (1986). *Research Interviewing: Context and Narrative.* Cambridge, MA: Harvard University Press.

Murray, L. and Trevarthen, C. (1985). Emotional regulation of interactions between two-month-olds and their mothers. In: T. Field and N. Fox, (eds.). *Social Perception in Infants*. Norwood, NJ: Ablex, pp. 177-197.

Neven, R. S. (2018). Impact Study Response. *Association of Child Psychotherapists Bulletin*, 269 (Summer), pp. 12-13.

Novick, J. and Novick, K.K. (2000). Parent Work in Analysis: Children, Adolescents, and Adults. *Journal of Infant Child Adolescent Psychotherapy*, 1(4), pp. 55-77.

Novick, K. and Novick, J. (2005). *Working with parents makes therapy work*. New York, NY: Jason Aronson.

Pantone, P.J. (2000). Treating the Parental Relationship as the Identified Patient in Child Psychotherapy. *Journal of Infant Child Adolescent Psychotherapy*, 1(1), pp. 19-37.

Personal Narratives Group (1989). Truths. In: The Personal Narratives group (eds.). Interpreting Women's Lives: Feminist Theory and Personal Narratives. Bloomington: Indiana University Press, pp. 261-264.

Pick, I. (2019). *Message form the Chair: The ACP is 70- looking back and planning for the future*, ACP Newsletter- February 2019.

Polkinghorne, D. (1988). *Narrative Knowing and the Human Sciences*. Albany: State University of New York Press.

Potter, J. and Wetherell, M. (1987). *Discourse and Social Psychology: Beyond Attitudes and Behaviour*. London: Sage.

Reddy, V. and Trevarthen, C. (2004). What we learn about babies from engaging their emotions. *Zero to Three*, 24(3), pp. 9-15.

Renton, G. (1978). The East London Child Guidance Clinic. *Journal of Child Psychology and Psychiatry,* 19, pp. 309–312.

Riessman, C.K. (1993). *Narrative Analysis*. Qualitative Research Methods, 30. Newbury Park, CA: Sage Publications.

Riessman, C.K. (2008). *Narrative Methods for the Human Sciences.* Los Angeles: Sage Publications.

Rustin, M. (1998). Dialogues with Parents. *Journal of Child Psychotherapy*, 24(2), pp. 233-252.

Rustin, M. (2009). Work with Parents. In M. Lanyado, A. Horne, A. (eds.). *The Handbook of Child and Adolescent Psychotherapy: psychoanalytic approaches.* London: Routledge, pp. 206-219.

Ruszczynski, S.P. (1993). Thinking about and working with couples. In: S.P. Ruszcynski, ed., *Psychotherapy with Couples.* London: Karnac Books, pp. 197-217.

Salmon, P. and Reissman, C.K. (2013). Looking back on narrative research: An exchange (chapter 10). In: M. Andrews, S. Squire, and M. Tamboukou (eds.). *Doing narrative research in the social sciences*, 2nd. ed. London: Sage Publications Ltd., pp. 197 -204.

Salomonsson, B. (2015). Therapeutic action in psychoanalytic therapy with toddlers and parents. *Journal of Child Psychotherapy*, 41(2), pp. 112-130.

Shirk, S. R. and Russell, R. L. (1996). *Change Processes in Child Psychotherapy: Revitalizing Treatment & Research*. New York: Guilford Press.

Silverman, D. (ed.). (2016). *Qualitative Research*. London: Sage Publications Ltd.

Siskind, D. (1997). *Working with Parents: Establishing the Essential Alliance in Child Psychotherapy and Consultation*. Northvale, N.J.: Jason Aronson.

Slade, A. (2008). Working with Parents in Child Psychotherapy: Engaging the Reflective Function. In: F. N. Busch (ed.). *Mentalization: Theoretical Considerations, Research Findings, and Clinical Implications*. New York and London: The Analytic Press, pp. 207-234.

Smith, J. A. (2003). *Qualitative Psychology: A Practical Guide to Research Methods.* London: Sage Publications.

Smith, J. A., Flowers, P. and Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research.* London: Sage Publications.

Sorensen, P. (2005). Changing positions: helping parents look through the child's eyes. *Journal of Child Psychotherapy*, 31(2), pp. 153-168.

Stern, D. N. (1974). Mother and infant at play: the dyadic interaction involving facial, vocal and gaze behaviours. In: M. Lewis and L.A. Rosenblum (eds.). *The Effect of the Infant on Its Caregiver*. New York: Wiley.

Squire, C. (2013). From experience- centred to socioculturally- oriented approaches to narratives. In: M. Andrews, S. Squire, and M. Tamboukou (eds.). *Doing narrative research*, 2nd edn. London: Sage Publications Ltd, pp. 47-71.

Sutton, A. and Hughes, L. (2005). The psychotherapy of parenthood: towards a formulation and valuation of concurrent work with parents. *Journal of Child Psychotherapy*, 31(2), pp. 169-188.

Symington, N. (2018). *The Making of a Psychotherapist*. London and New York: Routledge.

Tischler, S. (1979). Being with a Psychotic Child: A Psycho-Analytical Approach to the Problems of Parents of Psychotic Children. *International Journal of Psychoanalysis*, 60, pp. 29-38.

Trevatt, D. (2005). Adolescents in mind. *Journal of Child Psychotherapy*, 31(2), pp. 221-238.

Trevarthen, C. (1976). Descriptive analysis of infant communicative behaviour. In: H. R. Schaffer (ed.). *Studies in Mother-Infant Interaction.* San Diego: Elsevier Science Publishing.

Trowell, J., Rhode, M., Miles, G. and Sherwood, I. (2003). Childhood depression: Work in progress: Individual child therapy and parent work. *Journal of Child Psychotherapy,* 29(2), pp. 147-169.

Tsiantis, J., Boalt Boethious, S., Hallerfors, B., Horne, A. and Tischler, L. (eds.) (2000). *Work with Parents: Psychoanalytic Psychotherapy with Children and Adolescent*. London: Karnac.

Tuffour, I. (2017). A Critical Overview of Interpretative Phenomenological Analysis: A Contemporary Qualitative Research Approach. *Journal of Healthcare Communications*, Vol. 2 No. 4:52, pp. 1-5.

Tydeman, B. (2011). Building a child psychotherapy community. *New Associations*, 6 (Summer), p. 7.

Wachs, C. and Jacobs, L. (2006). Introduction. In: C. Wachs, and Jacobs, L., eds., *Parent Focused Child Therapy: Attachment, Identification and Reflective Functions*. Lanham, MD: Jason Aronson.

Waggett, N. (2018). View from the CEO. *Association of Child Psychotherapists Bulletin,* 269 (Summer), p. 5.

Waggett, N. (2019). View from the CEO. *Association of Child Psychotherapists Bulletin,* 271 (Spring), p. 5.

Whitefield, C. and Midgley, N. (2015). And when you were a child? how therapists working with parents alongside child psychotherapy bring the past into their work. *Journal of Child Psychotherapy,* 41(3), pp. 272-292.

Willig, C. (2001). *Introducing Qualitative Research in Psychology: Adventures in Theory and Method.* Buckingham: Open University Press.

Willig, C. (2003). Chapter 8: Discourse analysis. In: J. A. Smith (ed.). *Qualitative Psychology: A Practical Guide to Research Methods.* London: Sage Publications Ltd.

Winnicott, D.W. (1960). The Theory of the Parent-Infant Relationship. *International Journal of Psychoanalysis*, pp. 585-595.

Winnicott, D. W. (1965). *The Maturational Processes and the Facilitating Environment.* London: Hogarth Press.

Winnicott, D.W. (1975). *Through Paediatrics to Psychoanalysis*. The Internationl Psycho-Anaytical Library, 100, pp. 1-325. London: The Hogarth Press and The Institute of Psychoanalysis.

Witherell, C. and Noddings, N. (eds.) (1991). *Stories lives tell: narrative and dialogue in education*. New York: Teachers College Press.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*, 15(2), pp. 215-228.

Yishay, R. and Oren, D. (2006). Releasing the "creative block" in parenting, through the provision of dynamic guidance. *Sihot*, 20(3), pp. 251-264.

Zetzel, E.R. (1956). Current Concepts of Transference. *International Journal of Psycho-Analysis*, 37, pp. 369-375.

Appendix 1 – E-mail requesting volunteers

'Dear xxxxx,

My name is Roni Bor and I am a child psychotherapist trainee at the BAP in my third year.
This new Doctorate level qualification involves carrying out Doctorate research, which is done in conjunction with Birkbeck, University of London.

I have chosen to research and write about the area of Parent Work, mainly when it's done alongside child psychotherapy.
The title of my thesis will be: *'How do we do parent work? Exploring the interplay between child psychotherapy and parent work in the context of theory and practice'.*

I am looking to interview child psychotherapists who work privately (but may work alongside or have backgrounds working in the NHS) in order to ask them about their experiences of working with parents and the way they understand, practice and make sense of this work.

I am writing to ask whether you would agree to take part in my research; this will require an interview of approximately 1 hour with me, at your private clinic (or any other confidential, convenient place). The interview will be tape recorded and will be then used for the doctorate.
This will be confidential and your details will not be identifiable.
You will be asked to sign a consent form upon agreeing to take part in this interview.

This research has been ethically approved by Birkbeck, University of London and is supervised by Dr. Lisa Baraitser.

Attached is a further information sheet.

I appreciate your time might be extremely limited, but I would be very grateful if you could contribute an hour of your time for this purpose.
If you are interested, please reply to this e-mail and I will contact you to arrange a time.

With many thanks in advance,

Best wishes,

Roni Bor'

Appendix 2 – Information sheet for interviewees

Information sheet

Department of Psychosocial Studies
BIRKBECK
University of London
Malet Street,
London WC1E 7HX
020 3073 8045

Title of Study:
Name of researcher: Roni Bor, Child and Adolescent psychotherapist trainee at the joint training program BAP and Birkbeck University.

The study is being done as part of my DPsych Child and Adolescent Psychotherapy degree in the Department of Psychosocial Studies, Birkbeck, University of London. The study has received ethical approval.

This study wants to explore the issue of Parent work alongside child psychotherapy. Its title is: 'How do we do parent work? Exploring the interplay between child psychotherapy and parent work in the context of theory and practice'.

If you agree to participate you will agree a convenient time and place for me to interview you for about an hour. You are free to stop the interview and withdraw at any time.

The interview will be tape-recorded and a code will be attached to your data so it remains totally anonymous.

The analysis of our interview will be written up in a report of the study for my degree. You will not be identifiable in the write up or any publication which might ensue.

The study is supervised by Dr. Lisa Baraitser who may be contacted at the above address and telephone number.

Appendix 3 – Consent form for interviewees

Consent form

Title of Study: How do we do parent work? Exploring the interplay between child psychotherapy and parent work in the context of theory and practice

Name of researcher Roni Bor

I have been informed about the nature of this study and willingly consent to take part in it.

I understand that the content of the interview will be kept confidential.

I understand that I may withdraw from the study at any time.

I am over 16 years of age.

Name _____

Signed _____

Date _____

There should be two signed copies, one for participant, one for researcher.

Appendix 4 – Interview schedule

Introduction:
'I am doing a research in the area of parent work alongside child psychotherapy and would like to ask you a few questions in this regard. The interview will last about an hour and I will be tape- record it'.

Background of interviewee:
Additional professional background alongside/ prior to the child psychotherapist qualification (e.g. social workers/ adult psychoanalyst/ family therapist/ group analyst/ nurse etc.)- Number of years of working experience as a child psychotherapist post qualification.

Research questions:
1. What is the place of parents in Child Psychotherapy?
How do you make sense of Parent work in your daily practice?

2. I am wondering what kinds of models or theories you draw on when you work with parents?

3. How do you understand the contribution of parent work to change in child psychotherapy?

4. If you were to write a set of guidelines to help psychotherapists in their work with parents, what would you include?

Appendix 5 – Ethics form

DEPARTMENT OF PSYCHOSOCIAL STUDIES
BIRKBECK, UNIVERSITY OF LONDON
PROPOSAL TO CONDUCT RESEARCH INVOLVING ADULTS (over 16yrs)
SUBMISSION TO DEPARTMENT ETHICS COMMITTEE

Do you have the right form?
There are 2 different forms. Answer each bullet point. Are you doing:

- Research with minors? (under 16 yrs) YES/**NO** If Yes, fill in 'minors' form on website
- Other research? **YES**/NO If Yes, complete this form

Is this application ROUTINE / **NON-ROUTINE**?

You (or your supervisor if you are a student) must delete either Routine/Non-Routine, as appropriate. If the proposed study is so close to a previous one which received ethics approval that no new ethical issue arises, the application is 'Routine'. It is filed in the School but not assessed by the committee. If the proposed study raises ethical issues for which the researcher/supervisor has not had previous approval, the application is 'Non-Routine' & must be considered by the ethics committee. If you don't delete one of these categories, the form will be returned to you.
Expand sections for answers as necessary. Do not remove any questions – you must answer them all.

1. Name of investigator: ___
Roni Bor_____

2. Status (e.g. lecturer, researcher, Phd student, undergraduate): _
Doctorate student_____

3. Name of supervisor (if investigator is student): ___
Dr. Lisa Baraitser_____
_____

4. Course/Programme (if student): __
DPsych Child and Adolescent
Psychotherapy_____

5. Contact address for investigator: __xxxxxxxx (confidential)
_____
_____

6. Telephone number: _____Mobile: _xxxxxxx (confidential)_____
Email: _xxxxxxxx (confidential)_____

7. Date of Application: _28th June 2010_____
Proposed starting date:____September 2010 _____

8. Reference Number(s) of any previous related applications:
_____None_____

9. Is any other Ethical Committee involved: YES/**NO**
If YES, give details of committee, stage of process/decision, enclosing any relevant documentation: __I am planning to do my research outside the NHS and so will not go through an NHS ethics procedure, which I understand tend to be quite long. The reason is therefore mainly technical and related to the time frame of my research project. I would like to have sufficient time for collecting and analyzing the data and working on the advanced stages of the research within the time frame of my training program.

10. Title of study (15 words max): _

'How do we do parent work? Exploring the interplay between child psychotherapy and parent work in the context of theory and practice' (original title).
_____

11. Aims/objectives of the study (20 words max): __

The aim of this study is to explore the sense making process of parent work by child psychotherapists; the gap between theory and practice; the contribution to change in child psychotherapy and the possibility of identifying a set of guidelines for this work.
_____

12. How will participants be selected?

Participants will be selected on the basis of them being qualified and supervising child and adolescents psychotherapists; who have extensive number of years of experience and who are known in this filed (this will be indicated by their publications and teaching in training courses, conferences and CPD's). _____

13. Any inclusion/exclusion criteria?

No Child psychotherapists' trainees will be selected.

13. Where will the study be conducted?

The study will be conducted in the child psychotherapists' private practices/ homes.

15. Briefly describe what participating in the study will involve. (Max 1 page)

Participating in the study will involve taking part in one hour long interview which will be tape recorded. During the interview, interviewees will be asked a few open ended questions and encouraged to discuss issues related to their work with parents.

16. Equipment/facilities to be used (if not included in answer to 15). Please provide details of questionnaires, interview schedules etc, & attach copies if they are not standard ones. Comment on content area of questionnaires, could any questions cause distress? How is this justified?
Attachment? YES/NO

The equipment that will be in use is a tape recorder and an interview schedule.
A copy of the interview schedule is attached.
The questions will refer to the area of child psychotherapy, clinical work with parents and child patients and theoretical psychoanalytic framework.

The questions might cause distress.
This is justified in the assumption that the issues that will be brought up are part and parcel of every child psychotherapist's practice. A discussion about clinical material and personal experiences is common in this profession and is an integral part of the learning and training at every professional stage and setting (i.e. supervision, clinical seminars, parallel papers workshops, written papers, case presentations etc).

17. How will you find/access potential participants? (Include copy of any relevant documentation e.g. letter to manager, advert, notice to go on notice board.)
Attachment? YES/NO

I will find participants on the basis of their familiarity among the community of child psychotherapists in the UK, recommendations from colleagues and supervisors as well as participants' geographical location. I will prefer to interview participants who live in the London area.
Attached are the information and the consent form for participants.

18. Potential participants must give free and informed consent. You need to provide relevant information about your study in an information sheet or note for participants. This needs to explain confidentiality and right to withdraw. Please modify the template information sheet at the end of the form so it is appropriate for your study, include it with your application, and tick one entry here to explain here how you will use it:

Compulsory Attachment

- **Information sheet distributed to each participant**
- Information sheet displayed on screen for all participants
- Information included in header of questionnaire
- Other (specify)

19. Participants must sign a consent form to indicate consent. They must sign two copies – they keep one, you keep the other. Please modify the consent form at the end of this application form so it fits your study. The only exception to this is if you do not meet your participants because you send a questionnaire through the post to participants or they respond to an online questionnaire, in which case their completion of the questionnaire signals consent. How will you obtain consent?

- **Signed consent form attached to end of this application form**
- Postal or online questionnaire study

20. It is important that you respect the confidentiality of your participants. You should only record identifying information if necessary and wherever possible it should be kept separate from the data. Possible ways of doing this are: data is coded and the key linking the code and the participant's identity is kept in a separate locked cabinet from the data. All data with identifying information must be kept in a locked cabinet. Particular care needs to be taken with interviews. Names should be changed on transcripts and tapes locked up.

Please describe here how you will maintain the participants' confidentiality in this particular study?

I will maintain participants' confidentiality by attaching a numeric code to each interviewee. This will enable me to work only with the coded interview transcripts and tapes and to keep interviewee's private names separately. I will shred any other identifiable details attached to the names, such as private addresses. I will keep the recorded material in a locked cabinet at my working place or at home and save all transcripts on encrypted computers and a memory stick.
I will remind participants not to use any identifiable details of patients and colleagues.
21. Does the study involve:

(a) Unpleasant stimuli or unpleasant situations? YES/**NO**

(b) Invasive procedures? YES/**NO**
(c) Deprivation or restriction (e.g., food, water, sleep)? YES/**NO**
(d) Drug administration? YES/**NO**
(e) Any procedure which could cause harm to the participant? YES/**NO**
(f) Any groups of participants whose physical/mental health could be put at risk? YES/**NO**
(g) Actively misleading or deceiving the participants? YES/**NO**
(h) Withholding information about the nature or outcome of the study? YES/**NO**
(i) Any inducement or payment to take part in the study YES/**NO**
(j) Any procedure that might *inadvertently* cause distress to the participant? **YES**/NO
(For in-depth interviews, the answer to 21j is always YES)

Give details of any item in 21 marked YES and outline **how you will ensure the participant's well being.** If the nature of the topic or the way you are collecting data means there is the possibility of a participant becoming distressed, you need to have information about support services available to offer to the participant in the unlikely event that they do indeed become very upset. Outline this here.

Since the interviewees will be asked about their clinical and personal experiences and beliefs, there may be risk to confidentiality of cases that might be mentioned as an example. Attention will need to be given to the anonymity and confidentiality of potentially identifiable details of patients. Another issue will be the risk to confidentiality of colleagues. Since the child psychotherapy community is a relatively small one, there will need to be great sensitivity to identifiable details that might expose other professionals.
Another potentially sensitive issue might be related to my personal involvement in the community of child psychotherapists as a trainee and future clinician. I may find myself involved in different types of professional relationship with the participants in the future (for example, they may turn to be seminar leaders, lecturers in conferences or supervisors). This may bring up an issue of mixed interest and some complexity into these potential relationships. In order to manage this distress, I will clarify the purpose of the research and my position as a researcher.
In order to maintain participants' well being and avoid distress, I will explain clearly the way in which the material will be collected, kept and used. I will stress my awareness and understanding of the sensitivity of the material that may come up.
I will remind participants, before commencing the interview, to avoid the use of names and other identifiable details of patients, working places and colleagues.
In case I notice that participants appear or express distress, I will stop the interview and if appropriate will try to understand the source of distress. If necessary, I will assure their confidentiality and debrief relevant information about the research project and its purpose. I will suggest to shred any evidences of the information

that they have given me and depending on their state cancel the interview all together or postpone it to another time.
I will offer them to contact my doctorate supervisor Dr. Lisa Baraitser for support and/ or extra clarification.

22. If you feel the proposed investigation raises **other ethical issues please outline** them here.

Another issue is related again to my personal involvement in both this research as well as the community of child psychotherapists. This may raise participants' sense of inconvenience at being exposed to an interviewer who is not an outsider to this field.

23. I consider my study conforms with the expectations of ethical psychological research:
YES/ NO

SIGNATURE of investigator Date

_____Roni Bor_____ __22.6.10_____

If this is a student project, the supervisor must read the application carefully, and answer the following questions and sign below.

I have read the application and/or discussed its ethical implications with the student and confirm that in my view all ethical issues have been addressed: **YES/ NO**

I consider the application routine because it does not raise ethical issues beyond those of a study which has already received school ethics approval: **YES/ NO**

I consider the application non-routine and believe it needs to be assessed by the ethics committee: **YES/ NO**

SIGNATURE of supervisor Date

_____ _____

Completed forms should be put in the pigeon hole of the Department Administrator plus an electronic copy should be sent to the Chair of the Ethics Committee.

Researcher should keep a copy of the form for your files.

Template information sheet and consent form

*** These should be completed/modified so they fit your own study***