‘How does the magic work?’ Exploring the experience of the wait in the waiting room of parents with a child in once-weekly psychotherapy, an interpretative phenomenological analysis”

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Abstract

Individual psychoanalytic psychotherapy is one of the treatments offered to children by qualified and trainee child psychotherapists in CAMHS, but little is known about the emotional impact this has on parents. This project aims to investigate what meaning parents give to the fact that their child is engaged in such treatment and their experience of waiting for their child in the waiting room. The data for this project was collected through semi-structured interviews with four parents whose child engaged in once-weekly psychoanalytic psychotherapy in the generic CAMHS where I was based while training as a child psychotherapist. The data was analysed using Interpretative Phenomenological Analysis. The following themes emerged from the analysis: '*The referral to CAMHS', 'Managing the transitions', 'In the waiting room', 'The impact of psychotherapy'.* The findings show how hard it is for parents to think and talk about the traumatic experiences that brought their child to be referred to CAMHS and the emotional turmoil parents go through while waiting for their child to be offered treatment; the waiting in the waiting room also triggers strong ambivalent feelings and fantasies about what happens in the therapy room behind closed doors. The findings also show that parents manage their child's transitions to and from the therapy room in different ways; some might find ways not to get in touch with their feelings and thoughts, while others feel contained by the therapeutic framework. The findings also shed some light on the positive impact having a child in once-weekly psychotherapy can have not only on the child, but on the whole family system; parents reported that they noticed an improvement on their child's ability to self-regulate and progress in development, while feeling contained with their anxieties and feel like a "normal family".

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Introduction

This project is a required part of the Child and Adolescent Psychotherapy professional training and was conducted in a generic CAMHS where I worked for four years. The CAMHS is situated outside of London and covers a large area of Surrey. The team is quite big and diverse and referrals into the service usually come from GPs or social services in the area. Psychotherapy is a much appreciated discipline in the team, which has a good representation of child psychotherapists, including several trainees and qualified clinicians. The population my team and I usually worked with were working class and middle class White British families, some of them from very deprived backgrounds, often presenting with a history of domestic violence and complex trauma. Psychotherapy was frequently seen as "the last resort" for patients who had already been offered a number of treatments but seen very little—or even no—improvement with their presentation. It is important to clarify that considering psychotherapy as the last resort did not come with negative connotations; on the contrary, colleagues would consult with the psychotherapy team when feeling desperate and stuck with their cases and believed that more long-term and in-depth work would help.

It was not easy to come up with a topic for my research and for some time I felt completely lost about what I wanted to investigate. Some of my fellow trainees seemed to have very clear ideas about their research projects, which was extremely anxiety-provoking for me. However, an episode occurred in my clinical practice which brought to mind Newton's experience with the apple.

According to legend, a young Isaac Newton was seated beneath an apple tree when an apple fell and struck him in the head, which brought an "aha moment" that led him to develop his law of gravity. My "aha moment" occurred after a session one day, when I was accompanying one of my weekly patients to the waiting room, where his mother was waiting. She looked visibly distressed, and so I asked her if she was ok. She shared that she had felt completely overwhelmed while waiting for her son to finish his session, to the point that she felt that she was going to have a panic attack. This episode stayed in my mind for a long time. It initially triggered some reflections and made me wonder why this specific mother had had such a strong reaction. I brought this to supervision and discussed it with the parent worker at the time. However, I soon began to wonder whether other parents were going through the same experience. I wanted to find out more about this.

Talking through this idea with my research teacher and my year group helped me develop my research question, "*What is the emotional experience of parents with a child in ongoing once-weekly psychoanalytic psychotherapy treatment at CAMHS?"*. Here, the word "parents" rerefers to the adults identified as a child's main carers. Formulating an appropriate research question proved to be a time-consuming and stressful task, as it required careful consideration to strike the right balance between being too narrow or too broad. As time passed, I refined my specific interest, which was exploring the experiences of parents while waiting in the CAMHS waiting room. My search for relevant studies revealed that there was no existing literature on this particular topic. While this finding excited me as I reflected on how this made it even more important to pursue my interest, it also made me feel completely lost. The guidance I received from my supervisor proved to be quite valuable for improving the calibre of my literature review and preparing me for conducting similar research in the future.

For my literature review, I conducted searches across a range of databases, such as PsychInfo, PsychArticles, the PEP Archive, and the Psychology & Behavioral Sciences Collection, which are among the most comprehensive databases for psychology and related disciplines. I also made use of the Google Scholar and the Association of Child Psychotherapy (ACP) databases, while other studies were found via reference lists from related studies. Most of the literature I was able to find focused on investigating parents' levels of satisfaction with the support received by CAMHSs or specialist services, with the aim of improving service evaluation and facilitate patients' access to them (Bone et al., 2015; Teggart and Linden, 2006; Hilton et al., 2012; Hackett et al., 2009; Jameel et al., 2017; Wolpert et al., 2014; Brown, 2018). A few interesting studies focused on researching the experience of parents in different contexts: Louise O'Dwyer (2014) explores, from a trainee child psychotherapist's perspective, parents' experiences of having their child hospitalised for an eating disorder; Stapley, Midgley, and Target (2017) explore the experience of being parents of an adolescent with a diagnosis of depression, while Wendy Carolyn Woodhouse (2006) investigates how parents experience and manage the waiting period before their children are offered treatment by CAMHS. Given the nature of my question, it also seemed relevant to explore the relevant literature on the different types of intervention offered to parents in mental health settings (Sutton & Hughes, 2005; Widener, 1998; Midgley & al., 2017; Desmarais, 2006; Barrows, 1997; Reynolds, 2003). Provided that the topic of my interest was investigated through a psychoanalytic lens, it seemed important to include an overview about parent work as an intervention offered by trainees and qualified child psychotherapists in CAMHS (Novack and Novack, 2000; 2002a; 2002b; 2002c; Rustin, 2000; Frick, 2019; Holmes, 2018; Horne, 2018; Whitefield & Midgley, 2015; Klauber, 1998). It was emotionally very hard to go through some of the literature I had to read for my chapter, as some of these studies provided a very vivid idea of some very painful experiences endured by the parents that child and adolescent psychotherapists work with.

As my aim was to investigate the emotional experience of parents, the IPA method seemed the best choice—I will explore this further in the Methodology chapter, where I will also explain how I designed each part of the research project, reflecting on ethical issues and limitations. I shall describe how it proved hard to find participants for my study, especially in the context of the Covid-19 pandemic, which affected and delayed some aspect of the research.

In the Findings and Discussion chapter, I will give an overview of the data that I gathered. It took me some time to establish a flow in the analysis of the interviews: immersing myself in the material was not always easy, especially when listening back to parents talking about the traumatic experiences that had led their children to be referred to CAMHS. This sometimes required me to listen to and “stay with” painful material, while noticing and wondering about the non-verbal communication. The whole process was one of trial and error and it was very interesting for me to notice that I could find something new or make different reflections each time I returned to the material. The data analysis shed some light on participants’ experiences of being referred to CAMHS; their child’s transition to and from the therapy room; how they managed the waiting in the waiting room, and what they believed the benefits of their engagement with CAMHS to be.

The Discussion chapter includes a paragraph on reflexivity where I aim to self-consciously critique, appraise, and evaluate how their subjectivity and context influence the research processes (Olmo-Vegas et al., 2022). In the Conclusions chapter, I proceed to summarise the key findings and how I believe the that data answered my research question and aims. I will also make links with the existing literature and discuss how my study fits with the existing body of knowledge, while highlighting the gaps that I believe my research addresses. I will also reflect on the limitations of my study and suggest possible future research.

Literature review

My initial interest was to investigate the emotional experience of parents of children in once-weekly psychoanalytic psychotherapy treatment at CAMHS. At the beginning my interest and research question were quite broad, as I was not sure what exactly was that I wanted to focus on. With time, I came to develop an interest in focusing specifically on understanding the thoughts and feelings that waiting in the waiting room provoked in parents. When I first started to investigate what literature was available on the experience of parents in the waiting room, the results of my search suggested that, to the best of my knowledge, no studies had had been conducted on this topic.

I therefore broaden my initial search and conducted a more comprehensive search for studies investigating parents' experiences of having a child in psychoanalytic psychotherapy. In order to achieve this, searches were conducted across a range of research databases, including PsychInfo, PsychArticles, the PEP Archive and the Psychology & Behavioral Sciences Collection, which are among the most comprehensive databases for psychology and related disciplines. Initially, I conducted a search using the following terms:

S1	**S2**	**S3**	**S4**
Child*	Paren*	Therap*	Exper*
Adolesc*	Fam*	Treatment*	Feedback
Youth	Carer*	Psych*	Evaluat*
		Ther*	Assess*

I firstly conducted S1, S2, S3, and S4 separately, using the Boolean operator OR. I subsequently performed a combined search of S1, S2, and S3 using the Boolean operator AND to find papers that contained the keywords of the three searches together. This produced 75.904 results; to narrow my search, I used the following limiters: *childhood birth-12, school age 6-12, adolescents 13-17, outpatients*, resulting in 780 studies. In addition, searches were carried out using Google Scholar and the Association of Child Psychotherapy (ACP) database. Other studies were identified via reference lists from related studies.

The database searches produced a number of interesting studies, among which I selected those—eleven in total—that seemed to be more relevant to my research topic. Some of these papers investigate parents' experiences of generic and specialist child and adolescent mental health services (CAMHS); one paper investigates parents' experiences of waiting for their child to be offered treatment, while other studies focus on parents' experiences of their child being diagnosed with a mental health issue; I will discuss these papers in the first section of this chapter.

The second section considers studies on the different types of therapy work that may be offered to parents' whose child accesses CAMHS; seven papers were identified and selected by conducting a search on the ACP database. It also includes papers that explore some of the unconscious thoughts and fantasies that parent project onto the therapist and the institution. The third section will focus on parent work, which is an intervention offered to parents who have a child in psychoanalytic psychotherapy. Ten relevant papers on this topic were identified by conducting a search using the words *parent work* in the Tavistock library, and by material provided to students during the clinical doctorate. Although my research is not specifically on parent work or work with parents, these are relevant to providing a coherent context for this study.

Providing the interest of my research, in the last section I will introduce a few papers which examine some of the unconscious fantasies, thoughts, and emotions that parents may unconsciously project onto the professionals they collaborate with and the institution they interact with.

Parents' experiences of CAMHS services

The majority of qualitative research studies in CAMHS that select parents as a source of data collection mainly consider parents' experiences of accessing mental health services for their children, with the aim to improve patients' access to services. The common results emerging from these studies are parents and children worrying about what accessing CAMHS might entail; a need to improve accessibility to Tier 3 services, and improved evaluations not only the needs of service users but also those of their parents/carers and other family members (Bone et al, 2015; Teggart and Linden, 2006). Some studies explore parental expectations and satisfaction with national specialist CAMHS services (Hilton et al., 2012; Hackett et al., 2009; Jameel et al., 2017); overall, parents reported a positive experience with services, which helped them feel less desperate when dealing with difficult situations and to acknowledge that it is understandable to find it hard to take care of their children (Jameel et al., 2017). However, they also identified some areas that needed improvement, such as communication about their child's strengths, waiting times for the assessment, access to material they could read to increase their understanding of their child's issues, and access to resources and professionals outside of the set appointments (Hilton et al., 2012, p. 34). Parents also expressed the need to have access to more information about availability of services, follow-ups, and what the diagnosis given to their children actually meant (Hackett et al., 2009, p. 131). Some parents mentioned that they had come to realise how their own mental health might impact their children, and how they were supported to develop strategies to better handle stress (Jameel et al., 2017).

In their paper, Wolpert and her colleagues (Wolpert et al., 2015) try to address this issue by exploring the experience of parents and their children attending the Kidstime programme, with the intent of addressing the needs of children and young people who have parents with mental illness. In the interviews, parents explained that they tried not to discuss their mental illness at home for fear of overwhelming their children or being asked questions that they felt unable to answer. Parents also talked about how anxious they were before taking the decision to attend Kidstime for the first time and how their sense of guilt about the impact of their mental illness and its consequences—such as separation, divorce, loss of job, or lack of economic stability—could have on their children fuelled this decision. Attendees reported how the combination of the possibility of sharing their experience and the psycho-educational activities helped to reduce their anxiety and the long-term impact this had on the way they related to their children; moreover, parents believed that attending the programme provided an opportunity for their children to learn but also to have fun. Participants particularly welcomed the opportunity to meet other people who shared the same experience, as this reduced the sense of isolation and increased the willingness to openly talk about it.

In her study on parents' experiences of their adolescents' mental health treatment in the Redbank House Adolescent and Family Unit in Sydney, Jenny Brown (2018) shifts the focus from parents' satisfaction with their child's treatment programme to the parents' experience of involvement in their child's programme, aiming to investigate the impact of the parents' involvement in their child's treatment on his/her recovery. Brown interviewed a sample of fourteen sets of parents using semi-structured interviews at admission, discharge, and six months following their child's discharge, the interviews were then analysed with Grounded Theory Methodology (Glaser, 1978; Glaser & Strauss, 1967). What emerged from this analysis was what the author calls a "meta theme" (pg. 649) of hope and hopelessness. Brown identifies three different groups of parents: *high-hope*, *moderate-hope*, and *low-hope parents*; the differences between these three groups being the level of optimism about the potential positive impact of the programme on their children, and their ability to maintain the improvements over time. Another important difference was the shift from seeing their child's problem as merely a mental health issue to a broader problem which was also influenced by the environment and the consequent changes to their parenting style. Overall, the results of this study demonstrate that symptom-improvements and an alliance with the workers of the program constituted necessary conditions for the development of parental hope.

As previously discussed, one of the main issues identified by parents when interviewed about their experience of CAMHS services, is having to wait a long time before their child is offered treatment. In her research, Wendy Carolyn Woodhouse (2006) tries to gain an in-depth understanding of how parents experience and manage the waiting period before their children are offered treatment by CAMHS. The author explains the rationale behind her interest in this topic as twofold: firstly, to reduce children's and young people's non-attendance rate, and secondly her experience, as a trainee counselling psychologist, of the long wait yielding negative beginnings with families. Woodhouse used semi-structured interviews to interview six parents whose child was currently on the waiting list at the Child and Family service where she was based. Using the grounded theory methodology to analyse the interviews (Glaser and

Strauss, 1967), the researcher identified the following main themes: *states of self, the passive self, the active self, need for answers/diagnosis, how the professional is viewed,* and *DNA intentions*. Results showed that while waiting for their child's treatment, parents went through a journey of positive and negative experiences of their concept of themselves and their self-efficacy; parents seemed to move between a passive and an active position towards their children's difficulties, which seemed to be affected by "a wish to make things better" and not knowing "what was wrong with their child". What seemed to be the main factor causing the shift between these two positions was the level of stress experienced in the family system (pg. 97). The results of the research suggested a correlation between increased parental self-blame and the expectations of the professionals; moreover, the need for answers/diagnosis appeared to be caused by a desire to diminish self-blame. Parents described the waiting experience as a time of desperation, but also as a symbol of hope, as the waiting suggested that there were many other parents experiencing difficulties with their children. The results of the research show that a lack of clear and consistent communication from services to parents to keep them informed of their child's position on the waiting list might contribute to the non-attendance once an appointment has been offered (pg. 100).

Louise O'Dwyer (2014) explores, from the perspective of a trainee child psychotherapist, parents' experiences of having a child hospitalised for an eating disorder. This is a qualitative study based on clinical parent work sessions conducted in Woodlands, an inpatient unit which treats young people between eight and eighteen years old with an eating disorder, including anorexia nervosa, bulimia nervosa, and pervasive refusal syndrome. The author states that her particular interest was to explore the impact that the child's admission to the unit had on parents' perception of their role, both in terms of their internal and their external world (pg. 3). The data was collected from unstructured parent-work sessions with six parents, and analysed using Interpretive Phenomenological Analysis (IPA) (Smith, et al. 2009). Three main themes were found: *transitions, states of mind*, and *relationships.* Parents initially experienced loss, grief, and feelings of bereavement when their child was admitted to the unit and really struggled with different transitions. The author found that these losses were both external and internal, such as the loss of their child when admitted to the unit, the loss of their idealised child, and the loss of their identity as parents. As the admission progressed, another transition that parents experienced was separation. O'Dwyer once again found a link between an external aspect, such as the separation from their child at the unit, and an internal aspect, such as parents' previous experiences of separations. The final transition that parents experienced was when their child was discharged from Woodlands, which involved processing feelings about endings.

When exploring parents' states of mind, the author found that they were preoccupied with guilt, blame, envy of the care their child was receiving, helplessness, and a loss of confidence in their parental capacities. O'Dwyer described the parents' relationship with the unit and the staff, including herself, as ambivalent and full of complicated feelings, such as envy, rivalry, and exclusion, as well as feelings of being contained and supported. However, due to issues of power and authority, parents seemed to find it difficult to express their feelings about the staff and the researcher. This complicated relationship seemed to reflect the struggles that these parents also found when relating to their own parents and other children outside the unit, which led the author to wonder if some of the patients may have been carrying a conflict for the family (pg. 191).

A more recent qualitative study, relevant to filling the literature gap in understanding parents' perspectives, is Stapley, Midgley, and Target's research (2017). The authors interviewed forty-three parents with the aim of exploring the experience of being parents of an adolescent with a diagnosis of depression. The data they used was part of the IMPACT-My Experience study (IMPACT-ME, Midgley et al. 2014) which is a qualitative, longitudinal study linked to the main Improving Mood with Psychoanalytic and Cognitive Therapies (IMPACT) trial (Goodyer et al. 2011). The IMPACT study is a large randomised controlled trial (RCT) conducted across England, where adolescents with depression were randomised to receive one of three manualised treatment interventions—cognitive-behavioural therapy, short-term psychoanalytic psychotherapy, or a brief psychosocial intervention—with the aim of comparing the effectiveness of these three types of treatment for adolescents with a diagnosis depression. In the IMPACT-ME study, young people, their parents, and therapists were interviewed at three different timepoints—before treatment, at the end of treatment, and one year after treatment—and the data was analysed using thematic analysis (Braun and Clarke, 2006). Four main teams emerged from the findings: *lack of awareness, emotional turmoil, helplessness,* and *parenting in overdrive.* Three-quarters of the parents interviewed talked about how they noticed some changes in their child's feelings and behaviour—in contrast with a quarter of parents who did not notice any change between their child's current behaviour and how he/she used to be before. The majority of the parents talked about how worrying, upsetting, and depressing it was to see their child in such a state, which linked with a sense of guilt and self-blame for their child's issues; a small number of parents reported being horrified and frustrated by their child's extreme anger and, sometimes, abusive behaviour.

Parents felt helpless and powerless about their children, finding it very difficult to understand what their child was experiencing and feeling, or differentiating it from normal adolescent behaviour, which led to a breakdown in communication; this seemed to link with the fact that the illness of depression was unknown to these parents before their child was diagnosis by CAMHS. Among the reasons which led to feelings of helplessness in the parents, the authors found that financial issues, their own mental health issues, and lack of support in parenting their child were the most relevant. Parents talked about how they had to change their parenting style in order to meet the needs of their child, which sometimes meant that they deliberately avoided confronting him/her for fear of upsetting him/her even more.

Moreover, as part of the IMPACT-ME study, Stapley, Target, & Midgley (2017) investigated a range of topics—the difficulties that had brought the young person to CAMHS; the impact of the young person's difficulties on their life, the parent's life, and on the family; the young person's and parent's understanding of how the young person's difficulties came about; expectations of, perspectives on, and experiences of treatment at CAMHS; perceptions of change (or lack of change) in the young person's difficulties over time (pg. 5)—to facilitate the construction of a typology of parents' experiences over a two-year period, beginning with their teenage child's referral to CAMHS in the United Kingdom. Three patterns or types of parental experience were derived, using ideal-type analysis, from the parents' interviews across all three timepoints in the IMPACT-ME: *ideal type, finding my own solution,* and *stuck parent*. All the parents across these groups were able to recognise that their child had recently been experiencing some difficulties and they sought help, however their experience of services differed greatly; parents in the first group perceived professional help as life-changing for themselves and their children, while parents in the other two groups were disappointed with the support offered by CAMHS and, as they did not know where to turn next, ended up finding their own solutions.

Work with parents in CAMHS

Sutton and Hughes (2005) discuss the current work with parents of a child being offered individual psychotherapy in CAMHS. The authors affirm that the main tasks of this work are assistance in the care of the child, and providing the child with what the parents cannot offer at that specific moment. Despite the focus being on the child's wellbeing and parents not consulting the professionals as 'patients', professionals working with parents might identify some of the child's issues as being closely related to difficulties the parents present, either as individuals or as a couple. The authors suggest five areas of work with parents:

1. *information exchange*, where both parents and the therapist agree to inform the other party of any relevant issue relating to the child and their wider family
2. *general child guidance and specific communication about the child's therapy*. This is especially relevant when two different clinicians are involved, as this creates a need for the two professionals to develop a particular relationship between each other and with the parents. The therapist working with the parents needs to have sufficient information about what is going on in the child's treatment to be able to make a meaningful use of this when working with the parents or any other relevant person involved with the case
3. *supportive examination of day-to-day parenting*. Parents' descriptions of what is it like for them to take care of their child every day can provide the clinician with an idea of the demands that parents have to respond to daily
4. *exploration of, and therapeutic interventions directed towards, family and other relationships*, which suggests consideration of the fact that the wider circle of relationships may have an impact on the care of the child

5. *exploration of, and therapeutic interventions directed towards, the current impact of parents' earlier relationships.* This refers to the gathering of information about parents' own childhood and adolescent experiences. The professional will explain to the parents how the way they were parented and educated inevitably influences their expectations of themselves as parents and of their child and that reflecting on those experiences can help the current situation.

The authors discuss the importance of establishing a "therapeutic contract" with parents, where the professionals keep in mind what is useful for the child and the parents, and take into consideration what they, as professionals, can actually offer.

We could summarise that the main role of the clinician working with a parent is to support them in maintaining their parental function, so that they can respond to their child's needs. In order to do so, the parents need to be supported to adapt to the changes the treatment will have on their child's development and the challenges that this presents. The authors also reflect on how, due to a lack of resources in CAMHS, the child's therapist often also undertakes the role of working with the parents. This inevitably has a detrimental impact on the work, as it prevents intense contact with parents and becomes less essential than the work with the child.

Drawing on the concept of the "triangular space" created by the connection between parents and the child (Britton, 1998), Gvion and Bar (2014) view the triadic parent-child-therapist connection as serving a similar function. The authors discuss how, in the therapeutic situation, each participant assumes the role of the observer of the connection established between the other two elements of the triangle and can gain from this observation. However, this condition can only happen if one or more of the parties has the ability to bear the existence of a link to which he/she is only a witness, and not a participant (pg. 62). In the therapeutic situation, all the parties have to acknowledge and allow the connection between the other two. The authors debate that the creation of the therapeutic situation as described can be particularly difficult due to the feelings elicited in the parents by the fact that their child's therapy takes place behind closed doors, leaving the parents feeling rejected and excluded by the process. When the child enters the therapy room, the "closed doors" can assume a symbolic meaning of the child's mind being off-limits; among other things, parents might get preoccupied with the fragility of their connection to the child, which can elicit a strong need to be inside the room (pg. 65). Likewise, the child/adolescent can experience the same feelings of rejection and it is not always easy for him/her to observe the relationship between the parents and his/her therapist. Part of the therapeutic process is to allow the child/adolescent to accept that the therapist can assist him/her and the parental couple at the same time.

A very a good example of how useful parallel parent-child work can be, is given in Anmarie Widener's paper about the importance of therapeutic work with parents of children with a diagnosis of ADD or ADHD (1998). The author describes her work with a seven-year-old boy she calls Jack, and his mother, who sought help for her son under suggestion of his teacher. Jack had a diagnosis of ADHD and was prescribed Ritalin; Widener's talks about the many different reasons behind a parent's decision to medicate their child, such as protection from humiliation and ostracism, which also applied to Jack's mother. However, in her individual work with Jack's mother, Widener was able to explore cross-generational dynamics that might have contributed to this decision, such as Jack's mother's relationship with her own mother, and with her husband. The author talks about her experience of working with children with ADHD/ADD and she had found underlying depression, sadness, and loneliness in every case she had treated. In Jack's case, these feelings also belonged to his mother and their relationship, and Jack's presentation could only change when his mother began to accept them and allow herself to feel them.

Midgley and his colleagues (2017) make the same reflection when introducing their work with parents using a mentalisation-based treatment alongside direct work with children. The authors talk about how parents can find it extremely difficult to talk or even admit to themselves that they have negative feelings towards their child, which can lead to denial and hinder their capacity to mentalise and approach problems in a constructive way. Starting from the basic assumptions that most parents have a deep wish to be the best parents they can be, the authors affirm that the first aim of this work is to create a space where parents can feel safe to explore their mental states. The therapist will then help parents to look past their child's behaviour, mentalise their own feelings to better understand their reaction to their child's challenging behaviour, and encourage interactions where the child feels secure and understood. However, the therapist should refrain from offering solutions to the problems that parents present, while validating their wish to find an answer as to what to do. In order for the work to be successful, it requires what the authors call "reasonable flexibility" (pg. 309), which refers to the recognition that there is no fixed approach to working with parents.

There is no expectation that parents talk about their own childhood experiences, as the focus is on the parental reflective function in the here and now, but they may spontaneously refer to them. Therapists also use video feedback with parents, which can be useful for pointing out what the parents are doing well, and to look back at a heated interaction in a moment when the parents are not so emotionally involved, in order to understand the sequence of interaction that triggers the child's difficult behaviour. Video feedback is also useful for increasing parents' curiosity about what might be triggering the child's behaviour, and their awareness of the impact of their behaviour on their child. When it is not possible to use videos—e.g. because parents refuse—the therapist can suggest that parents keep a journal to facilitate the development of self-awareness. The authors also reflect on how working with foster- or adoptive parents might prove more complicated due to the fact that the children's behaviour can be extremely challenging, as they might not have had an experience of a parent who was able to notice them and think about them; parents of adopted or fostered children might find it particularly hard to see past the child's behaviour. Midgley and his colleagues believe that these parents should be educated about attachment, trauma, and the impact that early maltreatment and abuse can have on how children see the world.

Sarah Desmarais's (2006) interesting paper on adoptive parent-work analyses material drawn from parent-training groups run as part of the Parenting Skills for Adopters Programme, for parents of adopted children. Clinical literature has demonstrated that the play of children with a history of neglect and abuse can present a high level of inhibition, regression, and catastrophe, which might make it very hard for parents to engage with it. The data represented a total of twelve families, with a varied combination of birth and adopted children and were analysed using Interpretative Phenomenological Analysis (IPA) (Smith et al., 2009). The data showed that when asked to talk about their ideas about play, its importance and values, parents initially talked about play as "helping to make sense of the world", providing opportunities "to be a baby again" or to "be imaginative and creative" (pg. 355). This, however, did not seem to reflect their current experiences. In fact, parents expressed a high level of frustration and dissatisfaction when playing with their children, as the play was challenging, uncomfortable, boring, and anxiety-provoking, leading them to avoid it as much as possible; parents, therefore, tended to try to direct the play by, for example, removing a toy, showing disapproval, or directing the narrative of the play as a way of coping with the level of anxiety aroused by their children's chaotic play. Through parents' therapist-led discussions on topics such as play, praise, limit setting, and the tasks given to practice at the end of each sessions, they were helped to shift towards relinquishing avoidance and control and gain a new capacity to 'see the child' by allowing their play.

One of the interventions that child psychotherapists can offer in CAMHS is parent–infant psychotherapy, which Paul Barrows wrote an extensive review about (1997) with a special focus on Daniel Stern's work (1995). The author defines this work as an early intervention with the aim of modifying relationships that present as already seriously distorted (pg. 264). The focus of this therapy is on the mother's transference onto the baby, with the aim to reduce the projections from the parents onto the infant. In successful cases, the mother re-introjects the projections and their "intrapsychic elaboration" takes place in the mother (pg. 260). According to Stern, the best way to deliver this therapy is in a series of brief treatments, as the work has to take place in time (1995). It is important, however, that the therapist keeps in mind that the improvement of symptoms in the mother-baby dyad does not necessarily indicate that the treatment is successful, and that the therapist 'keeps the door open' in case problems resurface. A common feature of this work is a focus on the positive transference, even though the transference is never directly addressed, as the primary focus is on the parents' transference onto the baby rather than onto the therapist. According to Stern, the main aim of this work is not to change the parents' internal representation, but to work on the pathological one which is projected onto the baby and reflects a conflict of the mother acted out through the infant (1995).

Cramer and Palacio-Espasa (1993) distinguish three modalities of projections. The first—*externalising*—refers to normal parental functioning, where the infant represent the parents' own loved child self and allows parents to see the baby as a separate individual. The second—

externalising with a constraining quality—refers to the infant being forced to take on certain parental projections. These two modalities represent a chance to work through early conflict, and parent–infant work is believed to be more successful when these projections are present. The third modality is characterised by a predominance of aggressive projections, which involves those of negative aspects of the self onto the baby; this is usually harder to treat with short-term parent–infant work and may require long-term treatment.

Combining contemporary psychoanalysis, infant observation, attachment theory, developmental, infant and brain research, and affect regulation, Diane Reynolds developed 'Mindful Parenting Groups' (2003), an intervention for parents consisting of weekly one-and-a-half-hour group meetings. Parents commit to a minimum of eight weeks, but it can be ongoing for as long as useful. Reynolds assumes that a secure attachment, which depends on the mother's capacity to reflect on the affective experience of her child, is fundamental for the development of adaptive infant mental health, and that the prevention of psychopathology in early childhood should be based on an enhancement of parents' capacity to mentalise (pg. 360). The groups welcome mothers and their infants/toddlers but are also open to fathers and members of the extended family with low to moderate risks; they offer a space where parents and infants can play and learn from the experience of being together. The infants are gathered in groups of four to six according to their developmental stage, from the age of two months to three years; groups are facilitated by two members who observe and might direct the attention of the parents to special events that take place between adults and their babies. Every session starts with a quiet observation, which lasts between twenty to thirty minutes, where parents and facilitators sit quietly and follow the infants' lead; the facilitators then ask parents what they noticed, allowing the group to have an open discussion to reflect on what they have seen, both in the babies and in themselves. The facilitators then introduce two structured activities with older toddlers, some of which follow the toddler's development, such as snack time or circle time. This reflective group allows the parents to "encounter the unknown" in the self and the other (pg. 10), functioning as a container of the anxieties that might arise. The aim of the intervention is to help parents develop an "active observational stance" (pg. 364) by being patient, alive to, and curious about themselves and their child both, and learn to follow and respect the child's lead.

Work with parents from a psychoanalytic perspective

In this section, I will present some papers on parent work, which is identified as the work offered to parents of children who are seen for individual psychoanalytic psychotherapy in CAMHS. Most of the following are theoretical papers that make use of clinical vignettes or brief clinical studies to reflect on some of the main psychoanalytic concepts informing the clinical work. Towards the end of the section, I will present some recent empirical papers that investigate some specific aspects of parent work.

In their series of papers about parent work, Novack and Novack (2000; 2002a; 2002b; 2002c) analyse the tasks of the parental therapeutic alliance in different phases of treatment, highlighting how every age group of patients presents parents with different anxieties, resistances and, hence, tasks. According to the authors, the evaluation process is extremely important in order to assess not only the child, but also the parents and to think about how to develop a therapeutic alliance with them.

One of the main defences that parents can present is denial. Parents may feel helpless and seek help only because someone else sees their child as needing psychological intervention. These parents can be difficult to engage, as the need to avoid feeling overwhelmingly guilty could lead them to blame others, such as professionals or the child him/herself, for the presenting issues. However, their wish to do right for their child can be a powerful tool to rely on when establishing a therapeutic alliance and help them realise that the therapist is not a rival or a substitute parent, but an ally who can help restore the child on his developmental path. One main parental anxiety is that the analyst will steal away their child's loyalty to them (2002a, pg. 4); parents might therefore struggle with the idea that the child's sessions are confidential; these worries can be contained by explicitly explaining that one of the main goals of the treatment is to restore the parents' relationship with the child. According to the authors, another concern that parents usually express is their fear of stigmatising their child, which is fuelled by their own underlying sense of shame for failing at being what they consider to be good parents. A further resistance can emerge when practical arrangements are put in place; in order to avoid this issue, it is important that the therapist acknowledges the reality of what the parents can and cannot commit to, trying to come up with a schedule that is mutually convenient.

Novack and Novack (2002a) discuss how, in the early phase of treatment, the main parental task is to allow their child to be with another person; regular meetings with parents are the best space to explore any feelings that this task might trigger, such as sadness, exclusion, and negative or idealising feelings towards the therapist, but also to reinforce positive parental feelings and convey the idea that parents' knowledge of their child is immensely helpful to the therapist. The shift from the beginning to the middle phase of treatment is marked by changes in the tone of work, where the therapist and the patient feel comfortable in their relationship and develop a shared interest in working on the patient's mind and feelings (2002a, pg. 20). In this phase, parents' task is to support and enjoy the growth and development their child achieves through the treatment.

The transition from the beginning to the middle part of treatment can be endangered by the parents' decision to prematurely end the treatment. In this phase parents begin to see the child as separate from them and their main task is to allow her/his separation, individuation, and autonomy (2002b, pg. 20). When allowing this process, parents are confronted with their own limitations and past painful issues; this is a very delicate phase, as parents' personal difficulties could be so painful that they might sabotage the treatment in order to maintain the status quo. It is important that the therapist does not avoid addressing these issues and encourages the parents to see the impact of the past events, accepting what cannot be changed and working on what can be changed.

With time, the child's treatment will eventually enter a termination phase, and with it, also the parent work. In this phase, parents' task is to allow the child to mourn the ending and internalise the relationship with the therapist, while the therapist will support parents in fostering their capacity to use the positive parenting skills they have developed in parent work. In the termination phase, it is important that the therapist remembers that the ending will evoke complex feelings and defences associated with separation and loss (2002c, pg. 45). Some parents might particularly struggle with the ending and it is the therapist's job to assess if it is necessary to delay the ending or if the escalation is an acute reaction to the separation. Most of the time, acknowledging how painful the ending is can be sufficient for containing parents' distress. During the termination phase, the therapist discusses with the parents the inevitable disappointments they will have to face in the future, such as the need for continued work, or the struggles they might face when the child enters a new developmental phase. There may be cases where the therapist finds that there is a need for continued parent work after the child's treatment has come to an end, e.g., when parents show an incapacity to internalise what they have learnt and therefore cannot be able to support their children in sustaining the positive developments achieved during therapy. It is important that the therapist explores the child's feelings about this and explains what the work will be about. It might be necessary to think about a referral for individual psychotherapy for the parents. In the post-termination phase, parents may consult the therapist surrounding big life decisions; the capacity of the parents to return to seek help without shame is an important indicator of the solidity and the depth of the work done with parents (2002c, pg. 54).

In her paper 'Dialogue with parents' (2000), Margaret Rustin gives an overview of the psychoanalytically-informed work offered to parents by child psychotherapists working in CAMHS. Before the late 1970s, parent work was usually taken on by experienced social workers who were skilled at keeping the child in mind while finding ways to work on parents' anxieties; however, changes in the training for social workers led child psychotherapists to re-think how to approach parent work, as it was noted that long-term work with parents was fundamental for the child's treatment to be successful. Rustin identifies four main categories of the work undertaken with parents. The first group is where getting parent support is paramount to protect and sustain the child's therapy. The second group is where parents seek support with their parental functioning, to better understand their child, or due to struggles with difficult life circumstances. These parents see themselves as working in partnership with the professionals and their main focus is their role as parents, even when they might feel that they need help themselves. The third group is where the aim of the work is changing the function of the family, which the parents have agreed to as part of the treatment, while the fourth involves individual therapy for one or both of the parents. According to Rustin, there are two models of undertaking work with parents, one where the child's therapist also sees the parents—this is useful when parents are not keen to see anyone else—and the other where a different therapist works with parents. According to the author, child psychotherapists are well equipped to take on parent work, as they are able to address disturbances in the paternal function while staying attuned to their infantile parts (pg. 13).

Marianne Engelse Frick (2019) affirms that the first task in parent work is to try to establish a working alliance; the first step towards that is trying to help parents understand the child's presenting problems. The author explains that the work might be complicated by the parents' ambivalence towards it, as they want the child to improve, while they also feel a need to maintain their defences. The parental therapist might overcome this issue by empathising with the parents, make them feel understood in their struggle, while working with the ambivalence. According to Engelse Frick, part of the work of the therapist is to support the parents dealing with all aspects of the child's environments, e.g., home and school life. Parents might feel ashamed and guilty for their child's presenting difficulties, and the parental therapist has a delicate task in finding a balance between handling these feelings so that parents do not feel accused, while also not colluding with them. The author also suggests that the main focus of this work should be conscious material. However, with more difficult and disturbed parents, unconscious resistances and a referral for individual therapy might have to be considered. It is paramount for the child therapist and parental therapist to work together; the situation might occur that the child develops in his therapy, while the parents do not. In this case, the parental therapist will have to support parents to come into contact with what is not allowing them to progress, bearing in mind that parents' defences are often stronger and more rigid than in children, and that the change can therefore be more gradual (Engelse Frick, 2019: pg.82).

Reflecting on how parent work has historically been theoretically neglected, as the child's work has been the primary concern, Joshua Holmes (2018) interviews seven child psychotherapists—five qualified and two trainees—about their thoughts on the aims of parent work. The author chose the method of 'thematic analysis' (Braun and Clarke, 2006) for data analysis, and three main themes emerged: *fostering empathy for the child*, where the therapists talked about supporting parents to think about their child's feelings and his/her past experiences more fully and overcome their defences, which keep the pain associated with the child's difficulties at bay; *fostering independence and emotionally disentangling the parent from the child*, in order to support parents to see their child as a single identity and avoid the mistake of merging their own feelings with those of the child; *containment of parental anxiety*, where there is a need to do some work with parents about themselves and their difficulties to then allow the work to shift to more typical parent work, which focuses on thinking about the child.

In her theoretical paper about parent work, Anne Horne (2000) talks about the great flexibility of the work with parents that child psychotherapists undertake, and the long-standing debate around the nature of this work: is it psychotherapy for parents? Does it support parenting? Or does the psychoanalytic technique have to consider the unique experience of being a parent to a child with difficulties? (pg. 50). The author affirms that the work is a fine balance between holding the child in mind, while helping the parents separate their own childhood experiences from the needs of their child at present.

Perhaps wondering about this fine balance, Whitefield and Migdley (2015) investigate how therapists working with parents bring the past into their work. The researchers interviewed five professionals—four psychotherapist and one social worker—who took part in the IMPACT study to investigate the way they dealt with this issue. The analysis of the data showed that the interviewees thought that working with parents' childhoods could be an important aspect of the work, but the extent to which they did it needed to be looked at case by case. Many parents, in fact, might find it difficult to talk about their own childhood, and the clinician therefore needs to negotiate their permission to work on this aspect, bearing in mind that this work might not always be possible. Participants also talked about the importance of helping parents recognise their own needs, which may not have been met, and how these have an impact on but also differ from their child's needs; the clinicians interviewed highlighted the importance of managing the transference and using the parent-work relationship to help parents with their childhood difficulties. These finding suggest that working with parents' childhood experiences is not only an important part of parent work, but also necessary to help the child and his/her progress in his individual psychotherapy.

Managing the transference and countertransference is, according to Trudy Klauber (1998), particularly important when working with parents of severely disturbed or developmentally compromised children. The author affirms that the impact of the trauma and post-traumatic stress on these parents impinges their capacity to parent and their ability to work with professionals; the latter are indeed perceived as persecutors and a reminder of their traumatic experience when they try to make sense of the parents' experience. Parents of disturbed children may respond to trauma by developing an entangled relationship with them, distance themselves from the children, or give way to despair (pg. 90). They can feel that their child shows no particular affection for them, and lose their will to establish parental authority; there is trauma involved in recognising that something is wrong and seek help. Having to wait for professional help can also be traumatic, as it can be perceived as a judgment of their parental capacity. It can be helpful to explore the feelings that the child arouses in the parents and siblings, which can lead to a change. In the transference, the professional working with traumatised parents can feel hated, abandoned, and experience deep hostility; it is expectable that these parents make massive use of projective identification in order to get rid of unspeakable and terrifying experiences. Therefore, the professional needs to be ready to stay with and use the projection and the countertransference to understand what is happening.

Institutional transference

While developing my research question and reflecting on my clinical work, I often stopped to reflect about the thoughts and feelings that parents developed towards the CAMHS where I worked and the professionals that they came to work with. In psychology and psychotherapy, the term "transference to the institution" describes a phenomenon in which an individual unconsciously transfers their past feelings, emotions, and attitudes from one person or situation onto a current person or situation, often occurring within a therapeutic or institutional context. This phenomenon can profoundly affect the therapeutic process and how the individual engages with others in the institutional setting. In this paragraph, I will introduce some papers which explore some of the unconscious fantasies, thoughts and feelings that parents can transfer onto the professionals they work with and the institution.

In his paper "Re-enactment as an unwitting professional response to family dynamics" (1981) Ronald Britton argues that professionals and institutions working with families may become involved in underlying unconscious dynamics that reflect some situations in the relationship with the family itself; these dynamics are not recognised or talked about but rather expressed in actions. Britton explains that the phenomenon of *repetition compulsion* -as described by Sigmund Freud (1914)- takes place in the transference relationship that families build with professionals and institutions, where families tend to repeat unprocessed patterns which belong to past relationships. Britton also refers to the concept of *projective identification* (Klein, 1946) to explain that symptoms and feelings that professionals experience derive at times from the families' unconscious phantasy that the self or parts of the self are split off and located into another person; in response, the professionals and the institution appear to be the ones to whom feelings such as frustration, envy, helplessness or desire belong to (pg. 49).

In their paper “Making space for parents” (1981) Anna Halton and Jeanne Magagna present some observations and thoughts about parents’ experience of bringing their child to a clinic for an assessment for psychotherapy. The authors argue that the impact on parents of whatever outcome the assessment gives, is not always thought about as it should be. Halton and Magagna reflect on the state of mind that parents might be in when taking their child to the clinic; they refer to the anxiety parents experience, which can manifest in a reluctance to bring the child along, or in quietly waiting in the waiting room while the assessment take place. Parents might have unconscious phantasies of being blamed or criticized for their child’s difficulties, or unconscious feelings such as guilt, shame, ambivalence, or jealousy. Parents might experience resentment about the professionals who appear to take over responsibility for their child, jealousy for the relationship between the child and the therapist, or envy towards the child for the help received. The authors argue for the importance of clinicians carefully attending to these unconscious processes and paying attention to their own responses to them, which might inform the professional about what goes on in the parents’ minds.

Not only can professionals be invested with unconscious feelings and relational dynamics, but also institutions and organisations. This transference can influence patients’ perceptions, behaviours, and expectations within the institutional context. In his article “A type of transference to institutions”, Norman Reider (1953) talks about interesting observations of some patients who regularly attended clinical appointments. Reider touches on some of their verbal and non-verbal behaviour, which are, according to the authors, evidence of their transference towards the institution, rather than the professionals working with them. The author carries on explaining how the good qualities and fantasies of benevolent parental figures that the professionals represent for patients are idealised and diffused over the institution. Therefore, the institution is then invested with idealising fantasies of magical power. These dynamics seem to play an important part for patients in the acceptance of the transference of care from one professional to the other, for example when some members of staff leave. Reider argues that this type of transference occurs more frequently in individuals who struggle to show resentment towards the clinic practice in fear of losing the help needed; moreover, the transference to an inanimate clinic and permanent structure rather than to the clinicians, seems to be a compromise that patients find to manage this conflict.

Conclusions

This chapter has looked at studies and theoretical papers investigating parents' experiences of their child's accessing CAMHS, exploring their main concerns, expectations, and satisfactions.

Several studies show the journey of emotions that parents of children and young people with mental health issues go through, such as guilt, shame, hopelessness, and helplessness. These feelings are also present when waiting for their child to be offered treatment. Parents might be aware that their child is going through a difficult time and needs help from mental health professionals, however they can find it difficult to understand what their child experiences, and upsetting to see him/her in such a state. The data also show that parents' expectations towards services change depending on several factors, such as trust in their parental capacity, financial issues, their own mental health issues, and lack of support in parenting their child. The literature also highlighted the challenges and emotional turmoil that parents of children been seen in

CAMHS experience and how some of them are still actively processing the traumatic experience that led them to seek therapeutic interventions.

We also looked at different interventions that parents are offered in CAMHS, which all aim to restore their parental capacity; despite being moved by a wish to improve their children’s lives, parents may be ambivalent towards the support offered and find it difficult to engage with the process. Among these, parent work offered alongside the child’s individual psychotherapy treatment is extremely important, and often fundamental for the child’s treatment to be successful. We looked at the history of parent work and how it developed; the importance of establishing a therapeutic alliance with parents through working on the transference, and finding a good balance between exploring the ‘here and now’ and the parents’ own childhood experiences, which might have had an impact on their child’s current presentation. We also examined papers that delve into the unspoken desires, thoughts, and emotions that parents might unconsciously project onto the professionals they collaborate with and the institution itself.

As discussed in the introduction to this chapter, the aim of my research was to find empirical studies that investigated parental emotional experience of having a child in once weekly psychoanalytic psychotherapy in CAMHS, with a focus on their experience of waiting in the waiting room. While there are no specific studies addressing the experiences of parents waiting in a waiting room, the issue of children or young people waiting to be seen has been discussed in several places. In my research, I could only locate a single study, which was a doctoral thesis conducted nearly two decades ago by Woodhouse (2006), focused on the experience of parents whose children were waiting to be seen. However, the concern of parents about having their child on a waiting list emerged as a recurring theme across various studies. Parents report dissatisfaction regarding the waiting time for an assessment (Hilton et al., 2012, pg. 34), which makes it very difficult to access services (Bone et al., 2014, pg. 454). These concerns understandably create frustration in many of the people who are referred to CAMHS services (Teggart and Linden, 2006, pg. 38).

By contrast, in a recent study by Punton, Dodd, and McNeill (2022), the experiences of young adults waiting for mental health services in the UK were the focus. Here, the young people mainly reported negative psychological and behavioural effects associated with waiting lists in mental health services. These waiting lists have been linked to worsening existing physical and mental health problems, and they are currently perceived as excessively lengthy (Puton et al., 2022). Despite this recognition, there is limited insight into the personal experiences of such delays within mental health services. While the study I mentioned primarily explores the waiting list experiences of young adults, not parents, it underscores the fact that waiting lists are seen as obstacles to receiving mental health support and treatment by both patients and their families. It's crucial to note that waiting for treatment and waiting in a waiting room represent distinct forms of waiting. Existing literature indicates a scarcity of evidence regarding the former type of waiting and a complete absence of evidence regarding the latter.

Methodology

In this chapter I will explain the rationale behind the choice of method, participant recruitment process, data collection, analysis, ethical considerations, and the limitations of this research project.

Aim and objectives

The overall aim of this study was to investigate the experiences of parents of children in once-weekly psychoanalytic psychotherapy treatment at CAMHS. In this context, "parents" refers to the adults identified as the child's main carers.

The objectives were to investigate what meaning the parents gave to their child being engaged in once-weekly psychoanalytic psychotherapy, and to explore and understand the emotional impact of them taking their children for treatment at CAMHS. I was particularly interested in exploring parents' experiences of the child's transition between the waiting room and the psychotherapy room, and of being in the waiting room.

The rationale behind choosing my topic

My interest in this specific topic came from my contact with parents of children I used to see for treatment while I was in training, and noticing the varied were the ways in which parents approached their children's mental health.

I observed how some parents would be very anxious about separating from their child before the session, while others would be very relieved; sometimes parents would approach me to share their experience of letting the child go to the therapy room. However, I believe that it was a specific episode in particular that raised my curiosity about this topic, when the mother of one of my former patients shared that she had had a panic attack in the waiting room while waiting for her child to return from his session.

Many children are referred to CAMHS for trauma, and their experience can be traumatic for parents as well. This made me think about how child psychotherapists usually work—directly or indirectly—with parents' expectations and anxieties. We are highly reliant on parents bringing their children to CAMHS for treatment, and building a good therapeutic alliance with parents is fundamental to successful treatment.

A few studies—both quantitative and qualitative—investigate parents' perceptions and expectations of, and their satisfaction with, the care their children receive in generic or specialised children and adolescent services, with the aim to improve the service provided (Hilton et al., 2012; Bone et al., 2014). Although studies tend to focus on patients, parental involvement is increasingly recognised as an important factor in the child's prognosis. An interesting study explore parents' experiences of caring for a young person with mental health problems, their needs, and their relationships with health care professionals, revealing the emotional turmoil that parents experience alongside their child (Stapley et al., 2016). Child psychotherapy has always highlighted the importance of building a co-operative relationship between parents and therapists (Rustin, 2000). Further explorations of these and other studies can be found in the Literature Review chapter.

It appears, however, that there is no literature on the experience of parents of waiting in the waiting room. I believe that this gap in the literature offers up a starting point for the present study, which I hope will contribute to increase trainees' and qualified child psychotherapists' understanding of it, and inform their practice.

Interpretative Phenomenological Analysis (IPA)

As the aim of my research was to investigate the lived experience of the participants, a discussion with my research supervisor identified Interpretative Phenomenological Analysis (IPA) as the most appropriate methodology.

IPA is a qualitative research method that focuses on examining how individuals make meaning out of their experiences (Pietkiewicz & Smith, 2014). IPA was initially widely used in health and clinical/counselling psychology, and is now one of the most well-established qualitative approaches in the field (Eatough & Smith, 2017). IPA is grounded in phenomenology, hermeneutics, and idiography. The phenomenological standpoint focuses on how people perceive a certain phenomenon, rather than on descriptions of said phenomenon.

IPA assumes that individuals are "self-interpreting being[s]" (Pietkiewicz & Smith, 2014) and are actively involved in this process of making sense of what happens in their lives.

Hermeneutics has to do with "make meaning intelligible" (Eatough & Smith, 2017), and IPA attempts to step into the individual's shoes and make their experience comprehensible. IPA is described as a double hermeneutic process (Smith & Osborn, 2008), as first the individual makes sense of his experience, and then the researcher tries to decode that meaning, in order to make sense of the individual's meaning making (Pietkiewicz & Smith, 2014). IPA, however, acknowledges that the researcher inevitably brings their own biases and assumptions, and accounts for the need to reflect on how this influences the research (Eatough & Smith, 2017).

The ideographical standpoint values in-depth analysis of single cases in their unique contexts, and avoids making generic statements. IPA researchers take from idiography their interest on the particular, rather than the universal (Pietkiewicz & Smith, 2014).

As the aim of IPA is to examine a chosen phenomenon in depth, samples are generally quite small and homogenic, and IPA researchers favour the use of semi-structured interviews to collect their data.

The context

All the recruited participants were from the generic CAMHS clinic where I was working as a trainee child psychotherapist. The clinic is situated outside of London and welcomes patients between 0 to 18 years old, from very diverse backgrounds. The clinic is composed of different teams working in partnership, including a neurodevelopmental pathway and a specialist parent-infant service. It is a multidisciplinary team which includes clinical psychology, specialist mental health nurses and social workers as well as child psychotherapists and child psychotherapy trainees. Referrals come from a variety of sources, including social workers, general practitioners, schools, and Tier 2 services.

Recruitment process

Participants were recruited by requesting the support from the child psychotherapists and trainee child psychotherapists in the Trust via email, sending them documents containing information about the inclusion and exclusion criteria for the participants. I was also given the opportunity to present my project to all trainees and qualified child psychotherapists in one of the monthly child psychotherapy Trust meetings. This gave me the possibility to hear and respond to my colleagues' questions and possible doubts.

Trainees and qualified child psychotherapists employed by the Trust were encouraged to discuss the possibility of participating in my project with parents they thought might be suitable and interested. The clinicians would contact me to let me know if the parents had expressed interest and agreed to be contacted by me; first contact was made via email.

Once I had established contact with people interested in taking part in this study, I sent out a participant information leaflet via email, which explained in detail who I was, gave information about the research study, and answered potential questions. I also enclosed a consent form, and asked that potential participants read this prior the interview. These documents included information about how I would use the data I obtained from the interviews, which ensured that participants were comfortable with it, and were aware of the potential risks of identification resulting from publication. The participant information leaflet and the consent form were sent to potential participants at least 24 hours prior to making further contact, so that they could decide whether or not to take part in the study. Participants who confirmed their interest in taking part in the project were then given a telephone number via email, to give them a chance to ask any questions they might have and to schedule the interview. All mentioned documents that were sent to participants can be found in the Appendices.

My initial aim was to recruit parents of three to six children aged between six and eleven years old who was currently in once-weekly psychotherapy and had been in treatment for at least half a term. Difficulties with recruitment, and the impact that having too few participants might have on my research, precluded me to recruit as many as six participants. Although there is no rule regarding how many participants should be included in an IPA study (Pietkiewicz & Smith, 2014), my supervisor and I discussed and thought hard about the appropriateness of this sample size. Once a participant had agreed and consented to be interviewed, interviews were arranged at the clinic on a day and at a time convenient to the participants. In the context of the COVID-19 crisis, participants were provided with the option for the interviews to be conducted via Zoom video conference rather than in person, however they all preferred to be interviewed face to face. Despite the recruitment process being open to the whole Trust, the participants in my project were all parents of children who were seen at the clinic where I was based.

Inclusion and exclusion criteria

The sample was composed of four sets of parents to a child aged between six and eleven and who was currently in once-weekly psychotherapy. The rationale behind the decision not to interview parents of children over eleven was that young adolescents and their parents might have a very different experience of psychotherapy, due to the challenges associated with this developmental age.

In order to gain a more in-depth account of parents' experiences, I selected parents whose children had been attending individual psychotherapy for at least half a term. The idea was that the treatment should be settled and for the risk of a breakdown to be minimal. One of the inclusion criteria considered was that the parents were motivated to take part in the study. The participant information leaflet clarified that their access to the clinical service was protected, and that they were not obliged to take part in the study.

Parents of children I personally worked with as a trainee child psychotherapist were automatically excluded, both for ethical reasons and due to the impact this might have on my research and my role as a therapist. Engaging in parent work was not set as an inclusion criterion, however, all of the recruited participants did receive parent work from trainees or qualified child psychotherapists.

Data collection

I formulated and conducted a semi-structured interview in line with Holloway and Jefferson's (2008) Free Association Narrative Method (FANI). The interviews lasted between twenty minutes and one hour; if a participant decided to finish early, that was accepted without challenge. No participant felt that they needed longer than an hour. However, at the beginning of each interview I explained that I could accommodate this.

Interviews took place at a day, time, and place suitable for the interviewees. The interviews were conducted following my "Interview indicative schedule", which included nine questions and ensured adequate focus on the aspects I was interested in exploring, while providing opportunities for myself and the respondents to raise any other aspects relevant to their experiences of having a child in once-weekly psychoanalytic psychotherapy.

I deliberately avoided asking information from my colleagues or reading notes about the participants, their children, and their treatment, in order to minimise the possible impact this might have on my role as researcher and the anticipated data analysis. I informed participants about this process at the beginning of each interview; however, the interview did include a question about the reasons for the participant's child being referred to CAMHS, and participants could decide how much they wanted to elaborate on this topic.

Due to the topic of the study, it could be assumed that the interview questions might elicit some degree of anxiety in participants, and I relied on my skills as a trainee child psychotherapist to face the challenging process of interviewing. When noticing that participants struggled, I offered to take a break, and I allowed space for the participant to settle during and after the interview.

The interviews were audio-recorded using a voice recorder and the application Otter, and were then played back and transcribed in full with the use of a password-protected laptop computer. These transcriptions then formed my data set. Participants were informed and reminded via email that they had the possibility to withdraw their consent up to two weeks after the interview had taken place. However, no participant withdrew their consent.

After the interview I sent participants the "Debrief letter" via email, which offered specific post-interview information regarding support with any unforeseen impact of the interview, or concerns that might have arisen during the process. I also made participants aware of my availability to be contacted via telephone or email in order to respond to any potential post-completion queries or concerns, and accommodate a follow-up conversation after the interview, if requested, in order to minimise potential distress.

Ethical considerations

This research was presented as a study hosted by The Tavistock and Portman NHS Foundation Trust and the Trust where I was employed. The research project was discussed with my research supervisor, my service supervisor, and was approved by my service manager, the Tavistock Research and Ethics Committee (TREC), and the Research and Development Department of the Trust where I was employed. The TREC application was approved on the 6th of January 2021.

Consent

Prior to the interview, each participant was provided with a copy of the "Participant information leaflet", which included detailed information about the study, including the purpose of the research, who would have access to the data, and how it would be stored.

I ensured that participants had read and understood the document before starting the interview, and provided them with an opportunity to ask questions and share doubts about it. Participants were also asked to read and sign the "Participant consent form", which clearly stated the possibility for participants to withdraw their consent without giving a reason up to two weeks after the interview had taken place; all the forms were stored in a protected research file that only I have access to. No participant withdrew their consent.

Confidentiality

Participants were fully informed about the confidentiality and possible situations where this could not be granted, such as safeguarding concerns arising during the interview. The "Participant information leaflet" and "Participant consent form" provided details about the process of transcribing the interviews and anonymising the data; this included explaining that codes or pseudonyms would be used to replace their names, identifying information, or any other details that could reveal their identity. Participants were also informed that any personally identifiable information from research data would be removed before analysing or reporting it.

Interviewees were informed about the process of how the research data, including written records, audio or video recordings, and electronic data would be stored securely and that I would be the only person to have access to them. Participants were made aware that, due to the small sample, some data used in the study might be identifiable but that I would try to minimise this as much as possible.

Data storage

Participants were informed about how their data will be collected, used, and stored.

They were also made aware that the data generated over the course of the research would be retained in accordance with the University of Essex Data Protection Policy and the Tavistock and Portman NHS Foundation Trust. Participants were also informed that I would act as the data controller for this study, which made me fully responsible for looking after the information shared and using it properly, and that the data would be stored for two years after the study had been concluded.

Data analysis

The data analysis was conducted according to the processes described by Jonathan A. Smith, Paul Flowers, and Michael Larkin (2009). Using the application Otter, I listened to each recording multiple times and transcribed the interview, removing all identifying information. I numbered all the lines of each transcript, then printed and read each of them a few times before proceeding with the initial noting.

Jonathan A. Smith, Paul Flowers, and Michael Larkin (2009) identify three types of comments that the researcher can annotate while analysing the data:

- *Descriptive comments*, which focus on describing the context of what the participant has said
- *Linguistic comments*, which refer to each participant's specific use of language
- *Conceptual comments*, which refer to the researcher engaging at a more interrogative and conceptual level (pg. 84)

This process provided me with an in-depth analysis of each of the four interviews and produced a substantial data set before moving on to develop emerging themes.

Emerging themes

When looking for the emerging themes, the researcher has the hard task of simultaneously attempting to reduce the volume of the transcripts and the initial notes, while maintaining the complexity of the data set, looking for interrelations, connections, and patterns between exploratory notes; this stage reflects not only the participant's words but also the researcher's interpretation (Smith et al. 2009, pg. 91-92).

At this stage I decided to change from hard paper to Word documents, in which I annotated all the emerging themes chronologically, creating a different document for each interview. I came to this decision because at this stage I felt the need to move from what I found to be a rather messy—albeit interesting and thought-provoking—process, to a more ordered approach to the data; I also reflected on how this shift would allow me to revisit the processed data more easily when I reached the stage of looking for superordinate themes. After typing the themes, I moved them around to form clusters of related themes; I also decided to colour-code them as I realised that this helped me to identify and get back to them quicker.

After identifying all the emerging themes for each interview, I used abstraction, which involved putting like with like and find a name for each cluster (Smith at al. 2009, pg. 96), to identify patterns between emerging themes. The next stage involved looking for patterns across the whole data set to find similarities and differences between the interviews, to determine whether the already-identified superordinate themes were present in all interviews, or maybe some were particular to an individual case.

A detailed account of the outcome of this process can be found the Findings and Discussion chapters.

Validity and quality

There is a considerable discussion among qualitative researchers about how to assess the validity and quality of qualitative research, which is a result of growing dissatisfaction with qualitative research being evaluated according to the same criteria as quantitative research (Smith et al., 2009, pg. 179).

In order to assess the validity and quality of my research project, I referred to criteria highlighted by Lucy Yardley (2008), as discussed in the manual "Interpretative phenomenological analysis: theory method and research" (Smith et al., 2009). I will proceed to list the guiding principles with a brief explanation of the meaning that Yardley attributes to them, and provide evidence that my research meets the criteria.

The first principle is *sensitivity to context*, which is demonstrated by the study accounting for the socio-cultural milieu in which the research is situated, the existing literature on the topic, and the material provided by the participants (Yardley in Smith et al., 2009, pg. 180). In the Literature review chapter, I discussed the existing publications related to my topic of interest, demonstrating the emergence of a gap in the literature. While conducting this study, I have used research supervisions to reflect on my dual role as a child psychotherapy trainee and researcher, including my transference to every participant. For example, I was requested to offer parent work to one of the interviewees; I negotiated with my clinical supervisor that I could only take on this new role after I had completed the data analysis, and I used research supervisions to extensively reflect on how this could affect my role as researcher and my work with this parent. In the initial parent-work sessions, I allowed space for reflection on my change of role and the meaning and fantasies the parent attributed to it. Furthermore, I aimed to provide an inquisitive stance and genuine interest in my interaction with participants, paying particular attention to ethical issues during all phases of the study.

The second principle, *commitment and rigour*, refers to the level of attentiveness to the participant during data collection and the care put into carrying out the analysis, as well as scholarly thoroughness (Yardley in Smith et al., 2009, pg. 181). I have analysed data using IPA before, and I read a number of IPA studies before starting my research project to familiarise myself with the method. I consulted with peers and supervisors to reflect on various elements of the study, including the appropriateness of the sample size. and I showed drafts of my data analysis to my research supervisor and peer group to ensure that the analysis was coherent. Furthermore, in the interviewing process, I carefully kept the balance between prompting the participants and allowing them the space to share their narrative.

The third principle is *transparency and coherence,* which the researcher can demonstrate by clearly describing the stages of the research process and presenting a clear argument, leaving no contradictions in the paper. Coherence can also refer to how the methodological approach fits with the research (Yardley in Smith et al., 2009, pg. 182). I believe that the present chapter demonstrates transparency by offering careful descriptions of the recruitment process, the process of constructing the interview schedule, and the steps leading up to the data analysis. Furthermore, I believe that the aim of my research fits with my chosen method of data analysis; this was discussed at length with my research supervisor and peer group, all of whom shared my view.

The final principle is *impact and importance*, which refers to whether the research tells the reader something interesting, important, or useful (Yardley in Smith et al., 2009, pg. 183). I believe that in the Literature review chapter I demonstrate the gap in the literature on the present topic; I discussed my research project with my supervisor, peer group, clinical supervisor, and colleagues, all of whom expressed an interest in reading my thesis and commented on the relevance of my research not only to our profession but to all clinicians who work with parents, children, and young people.

Limitations

This study is a small qualitative exploratory study located in one clinic, so no statistical generalisations can be made to the experience of all parents with a child in once-weekly psychotherapy in a CAMHS setting. Despite there being no correct sample size in IPA (Smith et al., 2009, pg. 51), the difficulty with recruitment meant that the sample size can be considered small. Another limitation, as mentioned above, could be the fact that, due to limited resources, I had to take on parent work with one of the participants to my research. Despite the fact that I tried to reduce the impact of this event on my data analysis, it is possible that the information I later learnt about this parent, the child, and the treatment received, might have influenced my role as a researcher and the analysis of the data produced during that specific interview.

Findings

In this chapter I will discuss the analysis of the data selected from my sample, using IPA with a psychoanalytic lens. The sample is made up of three mothers and one grandmother, all with a child in once-weekly psychotherapy. Two children were in the first term of their treatment, while two were at the end of their treatment. Three out of the four participants received parent work at the time of the interview. As stated in the methodology chapter, I later offered parent-work sessions to one of the participants. My sense as a researcher was that the parents whose child was at the end of their treatment were more able to reflect on their experience and talk about difficult things that emerged during the interviews; I will talk about this in more details in the next chapter.

Three out of four participants were White British and had English as their first language, while one participant had migrated from South America. However, this did not seem to have a relevant impact on the interviewing or the transcription process.

A copy of the interview schedule can be found in Appendix D. The participants mainly talked about their first approach and current experience with CAMHS, mentioning the long wait before their child was offered treatment. Half of the participants were able to provide a detailed account of the traumatic experiences that had led to their child's referral to mental health services. Most of the participants were able to talk about the mixed feelings aroused by the transition between the therapy room and the waiting room. All the participants spoke about the positive impact of therapy and were able to identify some signs that their child's mental health had improved.

The table below shows the superordinate themes and subthemes that emerged from the data analysis.

Superordinate themes	**Subordinate themes**
Theme 1 **'The referral to CAMHS'**	'It's hard to talk about trauma'
	'CAMHS is the right place'
Theme 2 **'Managing the transitions'**	'Trusting the process'
	'An emotional process'
Theme 3 **'In the waiting room'**	'Wondering what happened in the sessions'
	'An anxious wait'
Theme 4 **'The impact of psychotherapy'**	'On the child'
	'On the family system'

The themes provide an interpretative account of the participants' experiences of having a child in once-weekly psychotherapy with a special focus on the transition from and to the therapist, and what goes on in the parents' minds while they are in the waiting room. Verbatim extracts from the interviews will be highlighted in italics, including minor hesitations, word repetitions, and utterances such as "erm". I will refer to the participants as Participant 1, 2, 3, and 4 respectively.

During the data analysis, other subordinate themes were identified, such as *'Guilt'*, *'It took a while to be seen'*, *'Referral as a distressing process'*, and *'Judgement'*. After a thorough work-through, I decided to discard the subordinate themes as they would not contribute to answering my research question.

1. Theme 1: ‘The referral to CAMHS’

This superordinate theme captures the participants’ understanding of the reasons that brought their child to be referred to CAMHS. Out of four participants, one was referred by school, two by their GPs, and the fourth by a hospital, following the child’s admission due to a mental health crisis. After a more generic question that explored what the participants knew about CAMHS as a service, the second question was designed to gently get at the participants’ lived experience.

1.1 ‘It’s hard to talk about trauma’

This subordinate theme captures how difficult it can be to talk about traumatic experiences, and was present in all of the interviews. However, there was a significant difference in the way participants elaborated on it. Participants 2 and 4 talked extensively about their respective child’s presenting problems and the impact of these, not only on the child but also on them as parents. They described the process they had been through, from realising that their child was struggling to understanding the importance of seeking professional help. Participant 2 talked about the difficulty, as a parent, to tell the difference between when a child is just “going through a phase” and when he is actually struggling. Both participants conveyed a sense of the hard time they went through and the emotional turmoil related to it. Participant 4 also touched on how hard it is to talk about trauma in children, even with people you feel comfortable with, such as friends. During the interviews, the pain related to the trauma these mothers and their children experienced came across very strongly. However, it was evident that they had had the possibility of working through it, as these extracts show:

> *‘He nearly died when he was three and… three…two or three…can't remember now it's such a long time ago… and I think... I went… didn't get support straightaway, because, we didn’t think there was a problem in that I thought “Oh it's just a kind of... he's young, and it's a typical thing to not want to be in your bed and just typical kind of maybe ghosts and monsters in his head”…and I think when it had gone on, I just thought, I need to address this, just to see if it's something else…’* Participant 2

What seemed to emerge from the data was that Participant 2 struggled to talk about the trauma in the here and now of the interview, which seemed evident, for example when she could not even bear to remember what age he was when the trauma happened. It seems that the question opens a reflection on her and her child’s journey to therapy, from the reasons behind not seeking immediate support or intervention to the moment she recognised the need to address the situation and explore whether there might be underlying issues beyond typical childhood fears. I wonder if this delay in addressing the issue may have been influenced by a difficulty of thinking about the potential psychological or emotional effects of the near-death experience.

> *‘Yes, because I'm a single mum…and I had bad experiences with my ex-partner… domestic violence… so that time he started to have some severe mental health, struggling… my child is… a bit different from other children… jumping… so active… so that was making him feel so different in school, and he was being bullied so badly because of his personality and his way to be… it's a very delicate situation and you don't feel comfortable to share it sometimes... even if you have your best friend or… it's difficult to say something, especially about your child…’* Participant 4

The biggest feature of Participant 4’s extract seemed to be the pain of her struggle as a single parent, and then finding the support of parent work and not being alone. She discusses the difficulty of sharing such personal and sensitive information, even with close friends. This reluctance to open up could be due to feelings of shame, fear of judgment, or the belief that others won't fully understand the situation. It seems that her experience sheds light on how complex and challenging is for families to face traumatic experiences.

> *‘Yes because he was very naughty… yeah… (pause) I mean… to start off with… the SENCO suggested that we get in touch with CAMHS and see if they could help him because he was running out of class, getting quite angry and aggressive, there was a bit of self-harm going on… so… that’s why…’* Participant 1

It appeared much more difficult for Participant 1 to provide a detailed description of the difficulties that lead to her child’s referral to CAMHS. She briefly referred to some early traumatic experiences the child went through but did not elaborate on that further. However, the mention of self-harm and the concerns with the child’s presentation conveyed a sense of urgency and required prompt intervention and assessment by mental health professionals. The pauses, silences, and non-verbal communication conveyed a sense of the trauma still being very unprocessed, and as the interviewer I felt too uncomfortable to explore it further.

It might be important to note that the children of the participants above were in the initial stage of treatment, which might have contributed to it being hard for these participants to answer this question. This was also the case with the child of Participant 3 who also seemed to find it hard to talk about her child’s presentation when he was unwell. She briefly mentions that things were so hard at home, with her child being violent, that he needed hospital admission and medical intervention.

> *'Erm… for my son was very unwell… erm… had a few hospital admissions and needed some PRN [pro re nata, medications taken when needed] when he was there… erm… (short silence) and he was quite… erm... he was really unsettled and unsafe at home (pause)… erm... through his behaviour and towards his brother he remained quite violent so... (pause) erm… we needed… erm… after one of the first hospital admissions...'* Participant 3

This participant conveyed a deep sense of it being extremely difficult for her to come in touch with the traumatic experience she and her child had been through. The silences and pauses in her speech may indicate emotional exhaustion or difficulty articulating her feelings. During the interview, it was evident to me that she had been dealing with a significant amount of emotional distress for a long time. The reference to the lack of safety and the need of a hospital admission convey a deep sense of anxiety, fear and desperation.

1.2 'CAMHS is the right place'

This subordinate theme describes the participants' lived experience of CAMHS services after the referral of their children and it was present in half the sample. Participant 2 described the process of realising that her child needed support (*something in my head clicked with that event*, 19) and of making her first appointment with CAMHS. She also talked about the divergent view she had from her partner about the need to seek professional help and the feeling of relief

(‘*I kind of felt I was kind of right’,* 22*)* that she experienced when realising that CAMHS was the right place for addressing her child’s issues.

> *‘I sort of threw it over to… to... to you guys and I almost realised at that point that I was so glad I had made that appointment… I kind of felt like I was kind of right… that's how it made me feel really… my husband was very much like “Oh he doesn't need that, it doesn't need that he's… you know… he'll just skirt out of it”… and I said “no, I think it's a bit deeper than that”, so I pursued it, even if nothing came of it I just thought I had nothing to lose... so, yeah, that's how I did it’* Participant 2

This participant conveyed a sense of validation for seeking for support for her child; she also mentions a sense of relief related to her worries being taken seriously. While analysing the data, I wondered if the difference in opinion between her and her husband about seeking help might have been a source of tension and which might have added more stress to the emotional burden this participant was carrying.

Participant 4 talked about how she had not known about CAMHS before her child was referred there by the GP. She described how she was going through her own trauma because of the separation from her partner, and feelings of loneliness—stemming from the lack of a support network and the belief that nobody else was going through the same experience—and helplessness—related to the lack of personal resources to support her child—which seemed to subside when she and her child were offered support by CAMHS. Participant 4 stated that she felt listened to by professionals and how she felt supported by CAMHS in understanding how to help her child. She also talked about how attending CAMHS made her realise that she was not the only parent who struggled.

> *'I was not able to help him as also I was in the middle of it… separations as well… and when I started to have CAMHS support the help was for… for my child, but at the same time they were helping me some way to help my child… and I didn't know about the service… so I was… (sigh)… I was kind of feeling so lonely to cope with the situation… and when I started to have CAMHS support I just understood "No I'm not the only one, that's so normal"… you know?'* Participant 4

This participant conveys feelings of isolation and loneliness when dealing with her own and her child's traumatic experiences, she also conveys a sense of feeling overwhelmed. She mentions not being able to help her child, which seemed to lead to feelings of inadequacy and guilt. The discovery of CAMHS and the support that it could provide seems to bring a sense of relief and validation, also previously expressed by Participant 2. The mentioning of her realisation that they were not the only family struggling seems to convey, again, a sense of relief and a shift in her perspective and her initial feelings of isolation and loneliness.

2. Theme 2: 'Managing the transitions'

This superordinate theme captures the participants' lived experience of their child's transition to and from the therapy room.

2.1'Trusting the process'

This subordinate theme captures what participants described as a sense of trust developed towards the therapist and the therapeutic framework when their child transitioned to and from the therapy room. Participant 1 stated that she never questioned the process as she did not want to intrude on the therapy. Despite my attempts to explore this further, it seemed that the participant did not have any relevant thoughts or feelings related to this topic. However, when transcribing the interview, the non-verbal communication made me wonder if there was, again, something uncomfortable that was too hard to talk about. The following is a brief extract from the interview, which I feel provides a good account of this:

> *'I don't really know, I've never asked him how he feels about it… I never questioned him about what's happened because I think the therapist explained it's… it's their time together… so, I don't really like to intrude on that so I just ask him if he's had good session… yes, it's all very smooth! (high-pitched tone and laughter)'* Participant 1

Despite her difficulty in elaborating on the answer to the question posed, this participant seems to convey a range of different emotions related to the child's therapy sessions and her role in facilitating them. Her statement, "I don't really know, I've never asked him how he feels about it," might indicate mixed feelings such as uncertainty and curiosity about psychotherapy. Despite she seems to maintain a respectful distance from her child's therapy by not asking too many questions, when going through the data I wondered if this was also a way to avoid connecting with more difficult feelings such as, for example, guilt and shame for having to seek support from mental health services.

Participant 2 shared that she had initially found the transition hard, as it was difficult to see her child going off with someone she did not know. However, she also stated that she then developed complete trust in the therapist and the process; the development of trust was possible thanks to the calming nature of the therapist and the consistency of the therapeutic framework. When talking about the child's transition from the therapy room back to her, she described a sense of relief to have her child come back at the time the therapist had previously agreed with her. It is interesting to note that this participant had already described an earlier sense of relief, which occurred when she realised that she was right in thinking that her child needed CAMHS' support.

> *'I am very confident in [the therapist] taking him away… she is very calm and her nature is very much like… made me feel calm and… like… it was going to be okay and that I could completely trust her… it was very… initially very hard though because it is someone you don't know at all… she's taking your child off to a building where, you know, you don't quite know where they're going to be… but just that nice experience that he's, I suppose, he's back… he's been there as long as the therapist said he would be'* Participant 2

This participant seems to convey the emotional journey that many parents and carers go through when their child begins therapy. She mentions the importance of building a trusting relationship and the therapist's ability to make parents feel comfortable and confident in the therapeutic process.

When talking about the transition, Participant 3 described how important it was for her child to have access to a private space for himself. She also mentioned how this had a positive impact not only on the child but also on the whole family.

> *‘Oh, it's so good because he's so happy… and it's almost, you can tell that he's had a space that's positive for him and everything… after everything that happened it's such a positive experience for us as a family… I feel closer to him again… so it's really nice (laugh) when he comes out to me, like my little boy again, it's really sweet’* Participant 3

This participant conveys a sense of relief and reassurance that her child has been offered therapy, which seems to have alleviate her worries and concerns. The description she makes of the child as being her “little boy again” conveys a sense of nostalgia and warmth. Although not explicitly mentioned, this participant's positive emotions seem to stem from a deep trust in the therapeutic process.

Participant 4 conveyed a sense of complete trust in the process and gratitude that seemed to come from the awareness of CAMHS’ long waiting list.

> *‘That was the feeling, confidence and… and hope and happy to be seen, because it's not easy to get an appointment is it? There is a long list and especially with the pandemic I was not able to see anyone anymore… so I was happy, happiness and hope (laugh)’* Participant 4

This participant mentions feeling confident, which seems to be connected to the sense of trust in the process of psychotherapy. The word hope is repeated a number of times, which is, interestingly, in opposition with the sense of hopelessness she described feeling before receiving CAMHS support. The phrase "happy to be seen" seems to convey a sense of gratitude by the acknowledgement on how challenging it can be to access healthcare services due to the pandemic and long waiting lists.

2.2 'An emotional process'

This subordinate theme captures the feelings participants described when talking about the transition. Despite all the participants having talked about how they trusted the process, most of them also conveyed a sense of it being very emotional. The pull of emotions they described was quite varied, and it was therefore necessary to keep this subtheme quite broad.

Participant 2 talked about experiencing a sense of relief in knowing that every therapy session was a step towards what she described as a "healing process": like a puzzle that the child and the therapist were putting together (line 102). Participant 3 expressed mixed feelings about the transition and how overwhelming this process could be. She talked about the sadness of not being able to join her child in the session, but also the happiness related to the idea that therapy was good for her child; despite it being hard to send him off with the therapist, she was able to see the positive effect that having access to a space of his own had on the child.

> *'I think I get a little bit… I don't know, I feel a little bit sad, because obviously he's so young as well… so it's a bit overwhelming… and then obviously I have to wait, but actually in some ways I also feel quite happy because I know that he's enjoying it and it's good for him and so it's a bit of a mixture of emotions… and I think because we're so close I feel like I need to be there for him for everything… and, like sort of almost hold his hand, not necessarily physically but just be there…'* Participant 3

This participant seems to be able to acknowledge the complex mix of emotions that stem from her child being seen for individual therapy. She mentions feelings of sadness and describes the situation as overwhelming, which might be linked to a sense of helplessness and uncertainty about how to best support her child. She mentions having to wait for her child in the waiting room, which might bring some anxiety related to not being join the child's session and anticipation about what will happen next, possibly related to the outcomes of the treatment.

Participant 4 described feelings of hope and happiness related to the idea that her child could get access to a private space just for himself, which she seemed to be ok with; she also described a twofold sense of accomplishment: her being able to stick to the process, and the child being able to stay in the room for the whole session with no interruption.

> *'Oh, I always have the same feeling like hopeful… I am happy to… to do my part, you know… how can I say? Complete the mission… that was the feeling when he leaves the room with no interruptions so… when the professional comes and says "It's done, it's finished" … good feelings to be honest… because he got something from that day, and… and he… he didn't ask to go before finishing'* Participant 4

This participant conveys a sense of satisfaction and good feelings when the therapy sessions conclude successfully, she refers to the process as "complete the mission." This might be linked to the sense of fulfilment and contentment in supporting her child's therapy. However, I also wondered if this was a way to avoid thinking about the difficult feelings raised by the fact that she could not physically join her child's sessions. This might be linked to how important it is for this mother that her child stays for the whole session, which seems to contain her anxiety and provide reassurance that her child is receiving valuable help.

3. Theme 3: ‘In the waiting room’

This superordinate theme captures how participants managed the wait. Overall, most seemed to convey that the wait elicited a lot of different feelings and thoughts.

3.1 ‘It’s hard not to know’

This subordinate theme refers to the participants wondering about what happened during their children’s sessions and was present in most of the interviews.

Participant 2 opened by saying that the wait was initially hard, as it felt very long, but moved on to talk about how this perception changed over time and how she appreciated having some time to herself. She explained that this change was also due to the therapist’s consistency and the therapeutic framework, which made her feel very contained. It is interesting to notice that she had previously mentioned this in relation to her child’s transition to and from the therapy room.

She carried on talking about a sense of protection towards her child, which sometimes seemed to turn into an anxious need to be in control (‘*people often say I'm sort of quite controlling in a nice way (laugh)’* 78-79). She then talked about how hard it was to not be able to join her child’s sessions, conveying a sense of feeling excluded. She openly talked about a wish to be able to look at what went on in the room through a two-way mirror, which seemed to be a way to express a wish to gain some control back on the treatment (‘*almost like a bit like in a room like this, you know, so you can see through a mirror, and you can watch what's going on and what your child is saying’* 90-91). While she understood the rationale behind the therapist not sharing details of the sessions, there seemed to be resentment for not being allowed to know and maybe, understandably, envy for the therapist’s skills, to which she attributed “magical” features.

> *‘I would just like to know what he's been saying, you know… you know, you are a therapist, you're not really saying anything much to me, and I'm just talking… so what's that all about? How do… as I say, like, how… how does the magic work? (laugh)’* Participant 2

The participant expresses curiosity about what her child has been saying during therapy. While she may be genuinely interested in understanding the content and progress of the sessions, she also conveys how hard it is to manage feelings of exclusion. The use of humour and her question, "how does the magic work?" could be her way to try to manage and express her feelings of envy and exclusion previously mentioned.

Participant 2 also talked about how emotional it was for her to not know what her child discussed with his therapist, conveying, again, a sense of being excluded from the process, which she described as “overwhelming”.

> *‘It’s quite emotional because I don't know, you know, that there's things that like obviously he could discuss that I could help him with and he might not share with me... so that makes me feel quite overwhelmed’* Participant 2

This participant seems to elaborate on the mix of emotions related to her child's therapy and the possibility that her child may share things in therapy that he does not share with her. She describes feeling overwhelmed, which speaks about the strong emotional reactions that the thought of her child discussing certain topics in therapy evokes in her.

When asked about the wait, Participant 4 talked about her thoughts of wanting to know what the child learnt in his sessions; this seemed not only related to a genuine curiosity but also to a wish to learn something about how to support the child when he struggled.

> *'The idea was to ask him how was, how was the... the session, and try to get something from him that I can learn… that can help me to help him, or something I can learn about how to improve my conversation with him when he is not having a good day… I am always kind of curious… what he really gets from that day…'* Participant 4

This participant openly talks about her curiosity for her child's therapy sessions and their content. When analysing the data, I also wondered if this positive way of describing her curiosity might also be linked to a deeper wish to take active part in the sessions and the more challenging feelings that being excluded from them might evoke in her.

3.2 'An anxious wait'

All the participants talked—explicitly or implicitly—about the anxiety that the wait elicited in them.

Although Participant 1 did not share any particular thoughts or emotions related to the wait, she talked about using her phone to manage it. When analysing the data, I wondered whether the use of technology helped her to not get in touch with potentially painful feelings or thoughts.

> *'Waiting is fine for me and I don't really know I've never asked him how he feels about it… I mess around with my phone really (laugh), that's about it… yeah… I think…'* Participant 1

It appears that this participant may have relatively neutral emotions about waiting during her child's therapy sessions, however there are some emotional aspects that can be inferred from her words and from the non-verbal communication such as pauses and laugh.

Her use of the phone as a distraction could be a way to occupy her time and keep her mind occupied while waiting, which is a could be a way to reduce potential anxiety and contain her during waiting periods.

Participant 2 talked about the overwhelming emotional turmoil that carers can go through while in the waiting room. She talked about the impact that her feelings had on her perception of time, making it feel like the wait would last forever. This participant seemed to manage the anxious wait for her child to be back from the therapy room by distracting herself. She also expressed a worry that the therapy might actually make her child "go backwards" (31-32), which seemed to trigger great anxiety. The non-verbal communication made me think about how hard it was for her to talk about the reasons for the referral to CAMHS and wonder about how difficult things must have been at the time.

> *'It's quite a long wait because I have one of those emotions and it feels like it takes forever… and so I'm sort of anxiously waiting to see him come back… it's quite difficult,*

> *I need a distraction… I read or play games and maybe call my mom if she's on a break… I'm kind of waiting to see if he's… if he's sad or if he's happy or… because I suppose with therapy… he could have a bit of a wobble and go backwards a little bit, because they're opening up new things…' (worried tone)'* Participant 3

Participant 4 expressed anxious worry that her child would be unable to sustain the whole session or carry on with the treatment; she conveyed a wish for her and her child to make the most out of the support offered by CAMHS, which might be related to the awareness of how hard it is to be seen, which she referred to in the section above.

> *'Sometimes I was having the feeling like "Mm… maybe he doesn't want to carry on, maybe the professional will come and ask me to bring him home"… I would sometimes think about that and worry and say "Oh I just hope he's going to finish all session with no interruption or crying or just be quiet, all the session" I was… yeah… to be honest I had that feeling…'* Participant 4

This participant voices her concerns about her child's behaviour during the session, that seem to stir up feelings of anxiety. It seems that she wonders about potential interruptions, crying, or other challenges that her child might face during the therapy session, which contribute to her anxious state. Despite her worries, the mother also mentions that she hopes that her child will complete the entire session without any disruptions or emotional distress. Her wish for her child to complete the session without interruptions could be a desire for continuity and consistency in the therapeutic process.

4. Theme 4: ‘The impact of psychotherapy’

This superordinate theme captures the participants’ perspectives on the impact of weekly psychotherapy on their children’s wellbeing. Despite half of the sample being at the beginning of the treatment, all participants mentioned having noticed some positive changes not only in the child but also in them and the whole family system. It seems relevant to clarify that despite the aims of my study—not including getting an understanding of parents’ satisfaction with the service received from CAMHS—it appeared important to include this theme as I believe that it helps capture the emotional impact that being seen by CAMHS had on the children and their families.

4.1 ‘On the child’

This subordinate theme refers to the positive changes that participants were able to see in their children.

Participant 1 and 3 had in common that their children were at the beginning of treatment; interestingly, they both talked about an improvement in their capacity to self-regulate, and were both able to give a few of examples to support their statements. Participant 3 described her child coming across as more “grown”, and how she had noticed that her child enjoyed attending the sessions, as well as development in his capacity to build a trusting relationship with his therapist.

> *‘He had a really bad half term because he went down and he was with his mum and that wasn't very... it didn't go very well, but he's got over it quite quickly…’*
>
> Participant 1

Although this participant does not provide many details, she mentions that the child experienced a difficult half-term, which suggest that there may have been issues or challenges that raised her concern or caused distress. Her comment about the child being able to recover quickly from this distressing experience, seems to allude to the positive impact that the therapy has on the child.

> *'He looks forward to it, I know that he's like built trust with her which is massive… and, yeah, he just seems to be growing… he's learned a lot of self-regulating… if things are a bit too exciting he will just take himself off, go and sit on the swing and he'll spend time on his own and then he'll sort of like dip in and out, which is quite nice'* Participant 3

Participant 3 conveys a sense of relief in their child's progress and growth. She mentions that the child has built trust with the therapist, which she considers to be a significant achievement; this also seems to ease the participant's anxiety. The participant's descriptions of the positive improvement of the child's presentation suggest a sense of contentment with the positive impact of the therapeutic treatment.

Participant 4 was able to provide an overview of how things have changed in the course of the year of treatment. She noticed a growth in confidence and motivation in her child, who was now more able to talk about his feelings and share them with his mother. This participant also noticed how her child was now more able to take pleasure in his daily life, such as school lessons. She also briefly mentioned that school was also able to notice a positive change in the child's presentation.

> *'He's more confident… and the school can say that, I had a meeting last week… he is more motivated… and he's saying "I quite like school now!"… because he started to get more interested in the subjects'* Participant 4

Participant 4 seems to convey a sense of relief, gratitude, and optimism which stems from the positive improvement that she and other people noticed in her child. This seems to reflect a sense of parental satisfaction and hope for her child's future.

4.2 'On the family system'

This subordinate theme captures the descriptions participants gave of the positive changes that their child being in therapy had on themselves and their family. Despite no specific question having been asked about them, this subtheme was present in half of the sample.

When talking about the wait, we saw how Participant 3 expressed some initial anxiety about therapy having a detrimental effect on the child ('*with therapy… he could have a bit of a wobble and go backwards a little bit'* 32-33). However, she then talked about feeling confident that her child would be able to overcome the traumatic experience he had been through. This shift in the participant's anxiety seemed to be a consequence of the positive changes she saw therapy as having on her child.

> *'I feel positive that he will… he will… he will get through whatever he was experiencing before'* Participant 3

This participant conveys a strong sense of hope for the future and a belief that her child will be able to overcome whatever challenges or difficulties he will face in the future. This shift in the parent's state of mind seems to be strongly linked with the child's positive experience of therapy.

Participant 2 defined her engagement with CAMHS as a "positive experience overall" (165). She then talked about the impact that being supported by CAMHS had on her whole family system; now that the child was at the end of the treatment, she could look back and recall how hard things used to be. She carried on talking about how it felt like they were a "normal" family now and elaborated on the positive impact the support had had on her own anxiety. In fact, despite mentioning a worry that things might go back to the way they had been before, this did not seem to elicit huge anxiety, as she also contemplated the possibility that such a setback might not happen.

> *'Overall it's been… you know… a very positive experience… and just… I suppose my anxiety now is… it's over… the therapist said it could be a sort of regression, possibly for a short period of time… but, again, that might not happen… and I think it's only really of late that I've looked back and I really hadn't realised how horrendous the situation was and how I think it's such… how things are so normal, as in how I imagined it is in every other household… and that's never happened in my house, I didn't know what that looked like…'* Participant 2

The participant conveys a sense of the value and benefit that the whole family received from the therapy process. The participant is able to name her anxiety about the possibility of a regression in the future and reflects on their past experiences. Despite this recognition seem to bring back difficult feelings, the participant also seems to express a sense of relief for having achieved a “normalcy” in their household, suggesting that they had been striving for a more typical and harmonious family environment for some time.

Discussion

This research project has aimed to explore and understand the emotional impact of taking their children for treatment at CAMHS has on parents. Using interviews, I have been particularly interested in exploring parents' experiences of the child's transition between the waiting room and the psychotherapy room, and of waiting for their child in the waiting room during their session.

In this discussion chapter, I shall explore the findings of my study in the light of the research topic and the psychoanalytic and empirical literature on the subject, as described in the literature review above. As a result of the interpretative analysis, some subjects called for additional literature references. The data gathered showed the emotional turmoil that having a child in once-weekly psychotherapy can elicit in parents; I will try to describe how I believe the data answered my research question, 'What is the emotional experience of parents with a child in ongoing once-weekly psychoanalytic psychotherapy treatment at CAMHS? An interpretative phenomenological analysis'.

Theme 1: The referral to CAMHS

This theme and the correlated subthemes '*It's hard to talk about trauma'* and '*CAMHS is the right place'* capture the participants' comprehension of the factors that led to the referral of their child to CAMHS. Although my research did not focus on investigating trauma, the findings strongly conveyed that all the participants found it very difficult to talk about their children's traumatic experiences; however, there was a significant difference in the way they elaborated on this.

Participants communicated the hardship and emotional upheaval they underwent. Some found it difficult to discuss the trauma in the interview, whilst others gave the impression that the trauma was very much still being processed, and as the interviewer, I was uncomfortable about going any further. This finding is consistent with what Trudy Klauber found when working with parents of severely troubled or developmentally delayed children (1998). Klauber affirms that it is especially critical to manage transference and countertransference when working with this population. According to her, these parents' capacity to parent is impacted by the trauma and post-traumatic stress that they have experienced, as is their ability to collaborate with professionals. When professionals attempt to make sense of the parents' experiences, they are often perceived as persecutory and serve as reminders of their traumas. Parents of troubled children may react to trauma by becoming entwined with them, keeping their distance, or giving into hopelessness (p. 90). They lose the will to impose parental authority when they perceive that their child does not particularly show them affection. Klauber holds that there is something traumatic in seeking treatment and admitting that something is wrong; waiting for expert assistance can also be traumatic, because it may be felt as a criticism of their parenting skills. It may be beneficial to explore the emotions that the child elicits in their parents and other family members, potentially resulting in a transformation. Dealing with traumatised parents can cause the professional working with them to feel loathed, abandoned, and experience intense hatred; it is to be expected that these parents will rely heavily on projective identification to get rid of unthinkable and horrific events. In order to comprehend what is happening, the professional must be prepared to continue working with, and apply, projection and countertransference.

There may be an analogy here with the process of the interviews in my study: despite the difference between my role as a researcher and the usual role of a professional in CAMHS, the interviewees knew of my professional role as a child psychotherapist, as I introduced myself at the beginning of each interview, which may have affected the way in which our relationship developed in the interview. I found myself feeling irritated by the lack of detail the more "defended" interviewees gave in their answers to my questions, and I perceived a sense of hostility when bringing up the topic of the trauma. Klauber states that in order to comprehend what is happening, the professional must be prepared to continue working with, and using, countertransference and projection. This was particularly hard to do in this context, as I felt pressured to achieve the fine balance between prompting participants and giving them enough space to elaborate on the answers in the way they were able.

Participant 4 talked about how she went from struggling on her own to finding support through parent work and feeling less alone. The way this parent reported feeling is in line with what Stapley et al. (2017) found when interviewing a group of parents about their experiences of having an adolescent child with a diagnosis of depression. In this research, parents reported being horrified and frustrated by their child's behaviour and talked about how worrying, upsetting, and depressing it was to see their child in such a state. This elicited feelings of helplessness and powerlessness about their capacity to understand what their child was going through. When exploring the experience of parents and their children attending a specialist programme, Wolpert and her colleagues (Wolpert et al., 2015) also confirmed that having a child in treatment had a positive impact on parents' anxiety and helped reduce the sense of isolation.

It may be crucial to remember that the children of Participants 1 and 3, who struggled the most with this question, were just starting their therapy, and that Participant 3 did not have access to parent work at the time of the interview. Talking about their mentalisation-based work with parents alongside direct work with children, Midgley et al. (2017) affirm that the first aim of this work is to create a space where parents can feel safe to explore their mental states. Joshua Holmes (2018) interviewed qualified and trainee child psychotherapists about their thoughts on the aims of parent work, and notes the importance of supporting parents to overcome their defences, which keep the pain associated with the child's difficulties at bay. In light of these findings I wonder if my experience of interviewing these two participants would have been different if the interview had taken place further along in the treatment.

Participants 2 and 4 described the steps they took between realising that their child was having difficulties to seeking expert assistance, emphasising how important it had been to do so. This confirms Stapley et al.'s findings (2017) that the interviewed parents were able first to recognise that their child had recently been having some problems, and to then seek help. Some of the participants in my study also talked about a sense of relief when their child started to engage with CAMHS, and feeling listened to by professionals. This is in line with research exploring parents' satisfaction with CAMHS services (Hilton et al., 2012; Hackett et al., 2009; Jameel et al., 2017), where parents reported a positive experience with services that assisted them in feeling less desperate when dealing with challenging conditions and to accept it as reasonable that they found it difficult to care for their children (Jameel et al., 2017).

Theme 2: Managing transitions

This superordinate theme and the subordinate themes *'Trusting the process'* and '*An emotional process'* capture the participants' lived experiences of their children's transitions to and from the therapy room. Overall, participants described the transition as a very emotional process, which accords with Louise O'Dwyer's (2014) findings when interviewing parents about their experience of having a child hospitalised for an eating disorder. The participants in her study experienced several transitions, each triggering different feelings. When the child was admitted to the facility and had to go through several adjustments, parents initially felt loss, grief, and bereavement: the loss of their child when admitted to the unit; the loss of their idealised child, and the loss of their identity as parents are only a few examples of such internal and external losses. Another adjustment parents went through after the admittance was that of separation. Once more, O'Dwyer discovered a connection between an external factor—e.g. being separated from their child at the unit—and an internal factor—e.g. the parents' prior experiences of separations. The final transition that parents went through was that of processing sentiments about endings when their child was released from the unit. While examining parents' mental states, the author discovered that they were preoccupied with shame, blame, envy of the care their child was receiving, helplessness, and a loss of confidence in their ability to be parents. In my interviews, the main feelings parents talked about were a sense of relief, hope, and happiness, linked with the idea that every session was a step towards healing. These finding are in line with Jenny Brown's research (2018), where, overall, it was shown that symptom improvements and a partnership with the professionals were prerequisites for the development of parental hope.

Participant 3 shared conflicting emotions and spoke of how demanding the process might be. She admitted that she struggled at first, finding it upsetting to watch her child leave with a stranger, and she talked about how sad it made her feel to not be able to accompany her child to the session. Novack and Novack extensively explored this difficulty in their series of papers on parent work (2000; 2002a; 2002b; 2002c), where they describe how hard it is for parent to allow their child to separate in order to be with another person, which can trigger feelings such as sadness and exclusion. According to the authors, it can help to support parents to develop a shared interest with the therapist in the growth that their child can achieve through the treatment.

Participant 1 claimed that she never questioned the procedure, as she didn't want to interfere with the therapy. Despite my efforts to delve deeper, it appeared that the she had no pertinent opinions or emotions on this subject. Novack and Novack (2002a) affirm that denial is one of the main defences that parents may present, serving the function of avoiding overwhelming feelings, which makes it difficult to engage with them. The non-verbal cues I observed while transcribing my interview with this particular parent led me to wonder if this unsettling topic might have triggered the interviewee's defences against getting in touch with difficult feelings and experiences.

Theme 3: In the waiting room

This superordinate theme and its subthemes *'Wondering what happened in the sessions'* and *'An anxious wait'* capture how the participants handled the wait in the waiting room. Overall, the majority of them seemed to indicate that the wait brought up a wide range of emotions and thoughts. With varying degrees of subtlety, all of the participants expressed feeling nervous while waiting and curios about what transpired during their children's sessions.

Participants 2 and 3 began by stating that the wait seemed to take forever; Participant 3 in particular elaborated on how her feelings affected the way she perceived the passing of time. When talking about the wait, all participants also alluded—although without elaboration—to how long they had had to wait before being seen by CAMHS. What emerged from the data was that the participants in my study experienced different types of waiting: the waiting before being seen for the first time; the important experience of *waiting with*—which includes the waiting parents did for their children, the waiting that parent work and CAMHS as a whole did for the parents themselves—and the literal and physical waiting for their child in the waiting-room, which elicited extremely strong feelings.

The *Waiting Times* project, a five-year interdisciplinary research project funded by the Wellcome Trust, offers one way of thinking about these findings. It explores, in a variety of ways, what it means to wait in and for healthcare (http://waitingtimes.exeter.ac.uk), including for young people in mental health care and for people with chronic conditions such as depression. Salisbury and Baraitser (2020) talk about how the sense of time is altered in people who experience depression, which can either elicit a sense of feeling stuck, paralysed, or suspended, or that time passes extremely quickly. The authors argue that the ability to stay with or alongside someone experiencing depression may be a key factor in the care provided to them: that psychotherapy is itself the offer of a significant period of time. Drawing on her experience of working with adolescents, Catty (2021) argues that young people suffering from depression and other forms of emotional disturbance seem to either try to slow time down or fast forward it in even more frantic ways, which is typical for adolescence.

Participants in my study extensively elaborated on their different experiences of waiting. Participant 2 talked about how the therapeutic framework, which made her feel quite contained, and the therapist's consistency were factors for a positive change of her experience of the wait. Participant 4 also conveyed a sense of having felt extremely contained by the clinic and the fact that her child was offered treatment. However, she also found it difficult to wait in the waiting room, where she needed to contain herself with fantasies about what was going on in the sessions. This seems to be in line with Salisbury and Baraitser’s (2020) argument that psychoanalysis can be seen as an offer of time, expressed in the rhythm of the sessions—their consistent timing, length, and structure as they take place over the course of the week. For Participant 2, perhaps, the containment lay in the idea of time being offered to her child, but she nevertheless found the waiting this meant for her to be painful.

Participant 2 also described experiencing a protective instinct for her child—which occasionally appeared to turn into a panicked urge for control—when she expressed her wish to be able to view what was happening in the room through a two-way mirror. She then expressed how difficult it was to be unable to attend her child's sessions, which triggered a feeling of exclusion. What this parent described seems to confirm Gvion and Bar's (2014) findings on the therapeutic situation. They highlight the challenging aspects of the feelings evoked in the parents by the fact that their child's therapy takes place behind closed doors. Parents might feel rejected and alienated by the process and become worried about, among other things, the fragility of their relationship with their child, which might trigger a strong yearning to be inside the room. According to Gvion and Bar, a good therapeutic relationship between parent, child, and therapist can only develop if one or more of the parties has the capacity to accept a connection to which they are merely observers and not participants; this seems to tally with Participant 2's account, when she talked about how this anxiety was contained by the calming nature of the therapist and the consistency of the therapeutic framework.

Although Participant 2 understood the therapist's reasons for withholding information about the sessions, there appeared to be resentment for not being told and, perhaps, appropriate envy of the therapist's abilities, which she described as having "magical" qualities. It is interesting to see how these findings are in line with O'Dwyer's (2014) when she describes the difficult relationships parents of children hospitalised with an eating disorder can develop with the staff in charge of looking after them. When interviewing this particular participant, I noticed how difficult it was for her to articulate such feelings. She conveyed a worry about being judged and not wanting to come across as ungrateful for the support received. When analysing the data, I wondered about my role and issues of power and authority which might have impacted on this mother's account of her experience—something that O'Dwyer also discusses. During this interview it was extremely difficult for me to stay in my role as researcher, as I found it hard not to be able to contain or support this mother thinking about her feelings as I would usually do during a parent-work session or a psychotherapy review.

O'Dwyer (2014) also draws attention to how complicated the relationship between parents and care-system staff can be, as it is embedded with ambivalent feelings, both negative and positive. When Participant 4 spoke of her desire to know what the child had learned during his sessions, I was struck by this mother's genuine interest in her child's wellbeing, and her desire to attain some knowledge about how to assist when he struggled. This parent came across as particularly grateful for the support received by CAMHS, which may have something to do with the realisation of how difficult it is to be seen, which she had alluded to earlier in the interview.

Participant 3 spoke about the intense emotional upheaval that caregivers may experience while waiting, and described her anxiety as she impatiently waited for her child to return from the treatment room, which she appeared to handle by keeping herself busy with her phone or calling her mother. Additionally, she appeared to express concern that the therapy would really cause her child to "go backwards", which seemed to cause a great deal of distress. This mother seemed to be very preoccupied with negative feelings, which made me reflect on how hard it was for her to talk about the traumatic experiences that led to her child being referred to

CAMHS, and how difficult things must have been for them at the time. Using Catty's (2021) words, I wondered if the "shadow" of a disastrous or merely unthinkable future in "the context of past and present trauma" pushed this parent into a "suspended state of withdrawal" (p. 194).

Participant 1 also talked about utilising her phone to manage the waiting and did not seem to express any specific ideas or feelings about it. As I was analysing the data, I questioned whether the use of technology prevented participants 1 and 3 from experiencing any potentially upsetting emotions or thoughts. In an interesting study about the role of technology, as experienced by child and adolescent psychotherapists in their work with young people (Gilhooley, 2019), participants described, among other things, how technology can serve as a defence against the therapeutic relationship, which left them feeling disconnected and excluded by the patients. Some clinicians also talked about how young people sometimes use electronic devices to communicate in many different ways. We saw how Participant 3 stated that she used to call her mother while her child was in his sessions; we could speculate that during these phone calls she might have shared feelings and thoughts later described in the interview.

Participants in Gilhooley's study talked about the use of technology as a sublimation and a way to deflect from real life challenges, indicating the overwhelming emotional and psychological experiences that young people struggle to cope with, and the role that technology might play in helping them. Participants also reflected on how their patients use technology to help them cope with anxiety when alone during times of transition. This seems to be in line with my countertransference when interviewing Participant 1, who seemed to find it very difficult to elaborate on her experiences and talked about using her phone while waiting for the child to come out of the sessions ("*Waiting is fine for me… I mess around with my phone really (laugh)", 30).*

Overall, it seems that my findings about these themes are in line with the ones highlighted by Wendy Carolyn Woodhouse's (2006) study of how parents experience and manage the waiting period before their children are offered treatment by CAMHS. Her findings indicate that parents waiting for their child to receive treatment have both positive and negative experiences related to their self-conception and self-efficacy. Parents appear to alternate between taking a passive and an active stance towards their children's difficulties, which appears to be influenced by a desire to make things better and not knowing what was wrong with their child (p. 73). The degree of stress experienced in the family system seems to be what was most responsible for the changes between these two perspectives. Woodhouse's findings suggest a connection between parental self-blame and professional expectations, as well as that the quest for explanations and diagnoses is motivated by a desire to lessen self-blame. Parents characterised the waiting period as a moment of desperation but also as a sign of hope, because it implied that there were many other parents having problems with their children. Woodhouse's study reveals a lack of clear and regular communication from services to parents regarding their child's status on the waiting list may be a factor in why some people fail to show up for appointments when they are offered.

Theme 4: The impact of psychotherapy

This superordinate theme and the subthemes '*On the child*' and '*On the family system*' encapsulate the participants' viewpoints on the effect of weekly psychotherapy on the wellbeing of their children. Despite half of the sample still being in the early stages of the treatment, all of the participants were able to report positive improvements that they had seen, not only in the child but also in themselves and the entire family system.

Half of the sample talked about noticing an improvement in the child's presentation, specifically in their capacity to self-regulate; they also mentioned noticing how their children began to come across as more "grown up". These outcomes seem to confirm what Stapley et al. (2016) found when they interviewed forty-three parents with the aim of exploring the experience of being a parent to an adolescent with a diagnosis of depression. Participants were interviewed at three different timepoints: before treatment, at the end of treatment, and one year after treatment, and most of them were able to see some positive changes in their child's feelings and behaviour.

Two participants in my study talked about the positive impact that having their child seen by CAMHS had on their anxiety and—one in particular—on the whole family system. These findings seem to confirm Joshua Holmes's (2018) data when interviewing trainees and qualified child psychotherapists about the aims of parent work. Holmes's participants discussed the important function of parent work in containing parents' anxiety. It might be relevant to remember, though, that one of the parents who noticed a shift in her anxiety was not receiving any parent work at the time. It is possible to speculate that the psychoanalytic framework itself might have served this containing function, as highlighted by Salisbury and Baraitser (2020) and as discussed above.

Reflexivity

In this section I will reflect on the concept of reflexivity in order to allow the reader to have a deeper understanding of my research. I will include reflections about what lead me to choose this topic and the impact that being a trainee child psychotherapist inevitably had on my role as a researcher.

Definition of reflexivity

I believe that before moving on to talk about my own reflections, it is important to define reflexivity in qualitative research. The concept of reflexivity has been part of qualitative research methods for a number of decades—it is not a new phenomenon. However, as this research project was my first opportunity to approach qualitative research, it required me to gain some knowledge about this concept.

Kathryn Haynes (2012) defines reflexivity as "an awareness of the researcher's role in the practice of research and the way this is influenced by the object of the research, enabling the researcher to acknowledge the way in which he or she affects both the research processes and outcomes" (p. 2). She goes on to explain that reflexivity entails considering how our ideas are formed, how prior knowledge is constantly altered in light of new knowledge, and how this affects our study. Reflexivity in qualitative research therefore includes the necessity of considering the intricate connections between knowledge production (epistemology), its procedures (methodology), and the participation and influence of the knowledge producer or researcher (ontology). Reflexivity is an ongoing process that extends across the entire duration of a research endeavour and makes it possible for research procedures and findings to be flexible and adaptable in response to these many levels of reflection (Haynes, 2012, p. 3). The interpretative nature of IPA—the methodology chosen for this study—necessitates reflexive engagement as the researcher makes sense of the participants' experience in order to make sure that the interpretations are driven by and arise from the participants' words (Smith et al., 2009); for this reason, reflexivity was a crucial factor throughout this study.

Purposes and limitations of reflexivity

When researchers use reflexivity, they may have a variety of objectives in mind, such as minimising the impact of their subjectivity, acknowledging it, clarifying it, or making use of it (Olmos-Vega et al., 2022). It was initially believed that, in order to achieve reflexivity, researchers had to adopt a tabula rasa strategy, i.e., a blank slate; an objective, distanced perspective from which they could investigate a phenomenon anew, in order to mitigate the impact of their own subjectivity. However, developments in qualitative research has shown that not only can subjectivity not be eliminated, but it is the primary function of reflexivity. Indeed, many contemporary scholars believe that the above-mentioned efforts to minimise subjectivity are harmful to research studies; on the contrary, as subjectivity is a positive outcome of every human contact, it can be beneficial and serve as a tool for making use of the knowledge and identities of the researcher (Olmos-Vega et al., 2022).

Despite being a fundamental process of qualitative research, reflexive research is not exempt from criticism. These include seeing reflexivity as narcissistic or considering the risk that the process of conducting reflexive research may become more central than the content of the research itself. As a result, a researcher conducting reflexive research could have conflicts between the degree of self-disclosure and the emphasis on research methods. However, reflexivity makes it possible for research to be perceptive, inquisitive, intersubjective, and transparent on a variety of levels (Haynes, 2012, pp. 7-8).

Reflexivity in my research project

According to Haynes (2012), when selecting research topics, questions, procedures, methodologies, and results, researchers should aim to be conscious of how their ontological, social, and political positions may influence their work (p. 9). She argues that, in order to consider reflexivity, the researcher has to reflect on the following points:

1. The motivation for undertaking the research
2. The underlying assumptions that the researcher brings to the research
3. The theoretical, experiential, and emotional connections the researcher has with the research and the effect that all three points may have on his/her approach

My motivation for choosing this area of study comes from my experience of my work placement as a trainee child psychotherapist in a generic CAMHS over a number of years, through which I came into contact with several parents of children who had been offered individual once-weekly psychoanalytic psychotherapy. Based on observations and conversations with parents and my colleagues, I was left feeling that there was something very difficult about the process of bringing one's child to CAMHS for therapy and having to trust an initially unknown professional to take the child away for individual sessions that they were not necessarily a part of. I developed a desire to look into and investigate the recurrent dynamics I was observing at work when interacting with parents in the waiting room and during their children's transitions to and from the therapy room. Furthermore, I wanted to concentrate on understanding these dynamics from the parents' point of view, rather than thinking about it from the child's perspective as I usually did in my role as a child therapist. I was disappointed by the lack of clinical papers available to help guide my thinking; I believed that these parents had the right to honestly explore their own difficult feelings in relation to having a child in therapy, in a non-judgmental environment where, unlike parent-work sessions, the main focus was on this topic. Alongside these theoretical and academic goals, I also had some much more personal objectives. Being in personal analysis and in an effort to learn more about myself, I wanted to try to understand the link, if any, between the struggles that I navigated with my commitment to personal therapy and the ones experienced by the participants in my study. I also developed a curiosity about how I had come to develop an interest in working much more with parents, which I believed had an impact on the search for my first job as a qualified child psychotherapist. While undertaking my study, I became aware of a connection between my research topic and the hunt for my first qualified role; in fact, I eventually accepted a job in a specialist service that provides joint work to parents with severe mental health problems and their children.

The experience of being in personal analysis at the same time as interviewing the participants in my study and thinking about their experience provided a fundamental connection that helped me in the process of analysing the data. I reflected on the parallel process of the experience of being in analysis for training purposes and supporting a child's therapy. The mandatory requirement of being in analysis during the training can at times make the student more defended and unclear about the purpose of analysis. Similarly, parents may be defended towards the therapeutic process as the idea is that the therapy is for the child and not for them; this can lead to high anxiety being experienced and not contained. Both students undergoing analysis for training purposes and the parent with a child in therapy may employ defences to cope with their anxiety and uncertainty about the purpose and process of the therapy. Resistance might be one of them; in the case of the student, resistance to the training analysis may arise due to the dual purpose of the analysis (for training and personal growth). For the parent, resistance may manifest as a reluctance to fully engage in the therapeutic process (including parent work sessions) because it is perceived as primarily for the child. Moreover, transference dynamics can be at play in both situations. The student may transfer feelings about their training analyst onto the analysis itself, and the parent may transfer feelings related to their own parental experiences onto the therapeutic relationship. These also implies the importance, as therapists, of being aware of our own countertransference reactions to these dynamics.

While developing my research project I assumed that parents would welcome an opportunity to finally have their voices heard; I was very surprised when I realised that it was actually proving very difficult to find participants for my study. The first crucial step in my personal reflexivity involved reflecting on how I usually work with parents and managing my assumptions around how they think about and experience contact with professionals. During data generation and analysis, I started to uncover some of the many nuances of this process. I came to understand how re-traumatising and deeply uncomfortable it can be for parents to talk through their and their children's experiences of engaging with psychotherapy and the powerful dynamics at stake in these encounters. Being contextually reflexive entailed understanding the unique setting of my study: I was not only a researcher but also a trainee child psychotherapist in the same CAMHS in which these parents and children were seen for treatment. It was thus necessary to reflect and report on how this context uniquely shaped interactions between myself, the participants and my colleagues, while reflecting on how the context impacted the research and vice versa. This particular set-up meant that the participants in my study were referred by colleagues I worked alongside every day. Consequently, my interactions in the research space were influenced by these pre-existing relationships; I had to think carefully about how these and my position in that context impacted my data and the context itself. For example, having been in placement for four years gave me access to participants, however, through the interviews, I had access to some information that the clinicians working with these families might not have access to, for example regarding how they felt towards the therapist and the therapeutic framework. In order to minimise this issue, my colleagues and I refrained from exchanging any type of information regarding the participants in my study.

At the same time, because of my double role as researcher and professional, I became fertile ground for projections from the participants. An example of this was my interview with Participant 2. When this mother strongly expressed her frustration about feeling excluded from her child's sessions, she mentioned that I, as a child psychotherapist myself, might have an idea of what would happen in the therapy room. I felt some sense of obligation to respond and contain her feelings, but was at the same time concerned about the implications of becoming too involved in the interview process. I had to find a way to stay in my role as researcher and to remain in control of myself and my conduct. It also seems extremely important to reflect on the historical context of my research, as it took place during the Covid-19 pandemic. Stubley and Young (2022) talk about a specific fit between complex trauma and the pandemic, highlighting the significant level of re-traumatisation caused by the pandemic and lockdowns experienced by people who have suffered trauma (p. 267). It is hard to fully know the extent to which these external circumstances impacted on my research. However, considering what emerged from the data about how difficult it was for participants to talk about their traumatic experiences, it is possible that this might have contributed to the challenges I encountered in the recruitment process.

I also had to consider how existing power dynamics influenced my interactions with participants and colleagues, e.g., the participants refraining from talking about the more negative experiences they had with my colleagues. Participant 2, for example, talked about her very different experience of parent work with two different clinicians; she conveyed that she did not feel supported enough by the first parent worker but seemed to refrain from elaborating further on her negative experience. Furthermore, the process gave rise to an ethical issue when I was asked to start parent work with one of the parents I had interviewed for my research. This issue needed to be sensibly thought through. When I later sensed disengagement in the parent work with this parent, I wondered whether this was a result of our previous encounter in a different setting.

Haynes (2012) points out that engagement in research may lead to revision of theoretical presumptions and affirms that reflexive research acknowledges that all research is influenced by the theoretical, methodological, and ontological preconceptions that the researcher brings to the research and its interpretation; social reality does not simply exist "out there", waiting to be discovered by the researcher. More crucially, the fresh insights discovered through research will lead to the revision of understandings and theoretical presumptions, which in turn will lead to the development of new theoretical knowledge (p. 12). As a Child and Adolescent Psychotherapist in Doctoral Training, my research has been strongly influenced by my psychoanalytic background, which was also the lens I used to analyse my data. Furthermore, my interest in working with trauma came to the fore when going through the data, especially when listening to the recording of participants talking about the traumatic experiences that had triggered a referral to CAMHS for their child. As a psychoanalytic clinician, I also made extensive use of my transference and countertransference responses to the data; I found the process of analysing the interviews, finding emergent themes, and writing my findings extremely overwhelming. I had to pay great attention to identifying my own emotional reactions to the participants' emotional experiences and recognised how they were connected to my separate role as a clinician working with children and their parents. Acknowledging this triggering of my own anxious feelings was challenging, but it also added complexity to my interactions with the data, making it clear that understanding the work I was doing required a close examination of these emotional dynamics.

Conclusions

The analysis of the data shows that when asked about their experience, parents produced a vast breadth of responses.

The data shows how difficult it is to talk about trauma, even when parents have had the opportunity to work through the traumatic events. I have discussed how these findings link with Trudy Klauber's (1998) paper about the work with parents of severely disturbed or developmentally compromised children.

The findings show how the waiting and the children's transitions to and from the therapy room elicit an enormous amount of ambivalent feelings in the parents, together with thoughts about what might be going on in the room. Among these feelings are envy for the therapist's skills, and gratitude for the support received.

One theme that emerged from my interest in parents' experiences of bringing their child to CAMHS was the topic of waiting, which seemed to be largely three-pronged: the positive impact that parent work and CAMHS as a whole have on parents' emotional states, which we might see as containment (Bion, 1962) and which has also been conceptualised in terms of *being alongside* or *waiting with* (Salisbury and Baraitser, 2020); the literal waiting that parents do for their children in the waiting-room, which elicits such strong feelings—both positive and negative—about what is happening in the therapy room; and finally, there is the long wait that has taken place before they are seen by CAMHS, which parents also talk about, and which can be agonising.

Parents seem to deal with these feelings and thoughts in different ways; some might use technology as a defence. The therapeutic framework and the work done with parents in parent work seem to help create a positive shift in parents' anxieties.

The Literature Review described the difficulty I encountered due to the very limited number of existing studies relevant to my research topic, while the Discussion highlighted how some of my findings are in line with studies included in my literature review. For example, Louise O'Dwyer's (2014) findings about how difficult transitions and separations can be for parents who have a child hospitalised for an eating disorder seems to share important similarities with the emotional turmoil my study's participants talked about when asked about their child's transition to and from the therapy room. Moreover, Wendy Carolyn Woodhouse's (2006) findings when interviewing parents about their experience and management of the waiting period before their children are offered treatment by CAMHS seemed to overlap with the anxiety and wondering expressed by the participants in my study.

I believe that my research has contributed to filling a gap in the literature about the first-hand experiences of parents that child and adolescent psychotherapists work with. I believe that my findings make a good contribution to and can inform the work of clinicians working with this population.

Implications of the findings

From a psychoanalytic perspective, conducting this research project highlighted several important aspects related to the experience of waiting for parents of children in therapy.

During the interview process and the data analysis, it became evident to me that the experience of waiting brought a lot of trauma close to the surface for parents. The acknowledgment of the high level of anxiety experienced by parents while waiting suggests that there may be unconscious conflicts and anxieties at play, which can be explored in therapeutic settings.

This process made me think about the possible implications for the practice of child psychotherapists and the way we work with parents. I wonder if the experience of waiting in the waiting room should become an explicit topic in parent work sessions; asking questions to parents such as “What is it like for you to wait for your child?” might open interesting conversations that can inform our practice. The waiting experience seems to evoke transference and countertransference dynamics between parents and therapists and it is essential to our work that that these dynamics are explored and understood within the therapeutic relationship. I believe that it could be important to reflect on how therapists communicate at times of transitions, using verbal and non-verbal language, and how we can provide parents with an experience of holding and containment in these moments of high anxiety. The moments of transition, such as when parents wait for their child, are significant in the therapeutic process and should be explored in depth. Observing non-verbal cues and behaviours, can enhance our understanding of how parents react when are asked to wait for the child while they have their sessions and how they manage it. For example, can they wait in the waiting room as requested? How do they spend this time? It could be helpful to share these observations with parents during parent work sessions or psychotherapy reviews, as an opportunity to offer a space to elicit some thinking about what might be going on for them in those moments. Waiting can represent a period of anticipation, uncertainty, and potential transformation. Exploring what waiting means to parents on a symbolic level can provide insights into their deeper unconscious processes. The parents' waiting experience may be linked to parent-child dynamics; understanding how parents react to being separated from their child during sessions and how they manage this time can shed light on these dynamics. It might be important to reflect on whether offering parent work sessions at the same time as the child's could be one of the ways to contain this anxiety.

Limitations

Despite the interview data producing a range of interesting themes, due to the qualitative and explorative nature of this research study on the lived experience of a small number of participants recruited in a specific generic CAMHS, the results cannot be generalised. Moreover, the results cannot be representative of the view of all parents. Another limitation is my pre-existing relationship with the clinic and the fact that, later in the year, I offered parent work to one of my interviewees. As much as I have tried to distinguish between my role as a researcher and my role as a clinician, it is possible that the knowledge I later acquired about this mother and her child might have biased my interpretation of the data.

The study I conducted had the aim of investigating the emotional experiences of parents having a child in once-weekly psychotherapy and the data set was analysed using IPA. The choice of the methodological approach was extensively discussed in research supervisions and research workshops. It was agreed that IPA perfectly fitted the aim of my study; however, being methodologically reflective required that I recognised the benefits and drawbacks of my decision and explicitly state these implications, as discussed in the Methodology chapter.

Possible future research

The research leaves a question unanswered: do parents talk about the thoughts and feelings elicited by the transitions and the waiting in their parent-work sessions? In fact, although my research was not specifically about parent work, this seems to be the best space to discuss these issues.

As child and adolescent psychotherapists, we know that parent-work sessions do not follow an agenda and that, as regular sessions, we do not bring up specific topics; they should come from the patient. As there is some interesting research about how therapists working with parents bring their past into the work (Whitefield and Midgley, 2015), it would be interesting to further investigate how much clinicians allow parents a space to talk about feelings and thoughts specifically related to how it feels for them to have a child in therapy. One of the parents I interviewed shared how she was not sure if she was allowed to do this, and felt relieved when the parent worker reassured her that she could.

As stated above, the children of two out of four parents were at the beginning of their treatment; interestingly, the interviews with these parents were the hardest, as the participants came across as particularly “defended” and found it hard to answer the questions. I believe that it would be important to gain further understanding of the possible correlation between the two phenomena, perhaps by interviewing parents at different stages of their child’s treatment.

I also believe that further research is needed regarding the impact of the containing function of the therapeutic framework on parents. Indeed, some of the participants in my study shared how contained they felt by the consistency and reliability of the therapist and the therapeutic structure, which had a positive impact on their anxiety.

As previously discussed, when asked about their experience of waiting, all participants mentioned the long wait they had to bear before they and their child were seen and offered treatment, but none of the participants elaborated on this. I believe that this was due to the fact that my research did not focus on this specific type of waiting, and it seems that further research is needed in this field.

Participation in my study was open to both mothers and fathers. However, due to a number of circumstances, I was only able to recruit three mothers and a grandmother. I believe that it would be interesting to set up a similar study only involving fathers to understand if gender has a bearing on the topic of this study.

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Appendix A, B,C and D retain the original title of this research project before it was revised, as this was what was used at the time of recruitment

Appendix A

NHS
The Tavistock and Portman
NHS Foundation Trust

Dear colleagues,

I am about to embark on my Doctoral Research Project as part of my Child and Adolescent Psychotherapy training and I am contacting you to seek your support with the recruitment process.

The project title is: ***What is the emotional experience of parents with a child in ongoing once-weekly psychoanalytic psychotherapy treatment at CAMHS? An interpretative phenomenological analysis.***

In this context, the word "parents" refers to the adults identified as the child's main carers.

I am looking to recruit and interview the parents of 3 to 6 children (for a maximum of 6 interviews) who meet the following inclusion criteria:

- have a child aged between six and eleven who is currently in once-weekly psychotherapy
- the child has been seen for treatment for at least half a term

I attached a participant information leaflet for your information. Please do not hesitate to get in touch with me if you are currently working with a case which meets these criteria and you believe that parents might be interested in taking part in my research study.

Kind regards,

Laura

Appendix B

The Tavistock and Portman
NHS Foundation Trust

Participant information leaflet

ProfDoc Research Title: *What is the emotional experience of parents with a child in ongoing once-weekly psychoanalytic psychotherapy treatment at CAMHS? An interpretative phenomenological analysis"*

Thank you for expressing an interest in participating in my qualitative research study which will form part of my professional doctorate. This information sheet describes the study and explains what will be involved if you decide to take part.

Who am I?

My name is Laura De Micco and I am a Child and Adolescent Psychotherapist in Doctoral Training at The Tavistock and Portman NHS Foundation Trust employed at Surrey and Borders NHS Foundation Trust. The training is validated by Essex University.

What is the purpose of this study?

The overall aim of my research study is to investigate the experience of parents and carers who have a child who is currently receiving once-weekly psychoanalytic psychotherapy treatment at CAMHS. I am particularly interested in exploring the feelings that this situation might arouse in the parents and carers.

What will participating in the research involve?

If you decide to participate to this project, I will offer you a space to discuss any concerns or questions you might have; this can be arranged to be over the phone, face to face or a Zoom video conference.
I will then invite you for a face to face interview at Gatton Place in Redhill, which is the clinic where I am based; alternately, should you have difficulties with travelling to the clinic, we can arrange for the interview to take place to the CAMHS clinic closer to you. The interview will last one hour and will take place at a day and time convenient to you. The interviews will be audio-recorded using a voice recorder which I will use to playback and transcribe the interviews in full. In the context of the COVID-19 crisis, it may be necessary that the interview is conducted via Zoom video conference rather than in person, and this is also an option open to you if it would be more convenient.

Do I have to take part?

Taking part in the study is completely voluntary. If you agree to take part, you are free to change your mind up to two weeks after the interview has taken place. Volunteering or not volunteering for this study will not compromise your child's treatment or any support you are currently receiving from CAMHS.

What will happen to the data collected during the interview?

A transcript of your interview will be produced from the recording. Your name will be kept separately from the transcript, and any identifying details removed from the transcript. Any extracts from your interview quoted in my research dissertation, and any professional publications that arise form it, will be entirely anonymous.

How will my data be protected?
This research study has received formal approval from the sponsor of the research, the Tavistock and Portman Trust Ethics Committee (TREC). These processes ensure I conduct the study within legal and ethical standards. If you have any concerns or queries regarding my conduct you may contact Simon Carrington, Head of Academic Governance and Quality Assurance, Tavistock and Portman NHS Foundation Trust (academicquality@tavi-port.nhs.uk).

The data generated in the course of the research will be retained in accordance with the University of Essex Data Protection Policy. The Tavistock and Portman NHS Foundation Trust is the sponsor for this study based in the United Kingdom. I will be using information from you in order to undertake this study and will act as the data controller for this study. This means that I am responsible for looking after your information and using it properly. I will keep identifiable information about you from this study for two years after the study has finished.

To safeguard your rights, I will use the minimum personally identifiable information possible. I will use your name and the contact details you provide only to contact you about the research study. I am the only person who will have access to information that identifies you. I may be assisted in the analysis of this information by senior colleagues, but they will not be able to identify you and will not be able to find out your name or contact details.

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

What will happen to the results of the project?
The results will be used in my thesis for the professional doctorate, published academic papers and in academic presentations.

What are the possible benefits of taking part in this research?
By taking part in this project you could also contribute to increase trainees and qualified child psychotherapists' understanding of the parent's experience of having a child in psychoanalytic psychotherapy treatment, which could inform the way these professionals approach parents.

Are there any risks?
The interview is not likely to be upsetting. However, you may find that the interviews get you thinking about yourself and your child and the need he or she had for help from CAMHS in a way you may not have thought about before or recently. This may stir up some emotions or be unsettling and will be sensitively taken into consideration during the interview. At the end of the interview I will offer you time, if you require it, to talk about how you are feeling. After the interview, you will be provided with a letter with contact details of the professionals at your local CAMHS you can approach should you need further support.

Contact details
I am the main contact for this project. My contact details are:
Laura De Micco

Email: laura.demicco@sabp.nhs.uk
[CAMHS details removed]

You are welcome to contact my research supervisor at The Tavistock and Portman NHS Foundation Trust if you have any concerns about this project. The contact details are:

Dr Jocelyn Catty
Email: JCatty@tavi-port.nhs.uk
Department of Education and Training
Tavistock and Portman NHS Foundation Trust
120 Belsize Lane
London NW3 5BA
Tel: +44 (0)20 8938 2511
Web Site: www.tavistockandportman.nhs.uk

Appendix C

The Tavistock and Portman
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Participant Consent Form

ProfDoc Research Project Title: *What is the emotional experience of parents with a child in ongoing once-weekly psychoanalytic psychotherapy treatment at CAMHS? An interpretative phenomenological analysis"*

Name of the Researcher: Laura De Micco

Please tick the boxes on the right below:

- I_______________________________________voluntarily agree to participate in this research project. ☐
- I confirm that I have read and understood the information leaflet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
- I understand that my participation in this study is voluntary and that I am free to withdraw, without giving a reason, at any time up to two weeks after the completion of the interview. ☐
- I understand that the interview will be recorded and transcribed as described in the participant information sheet. ☐
- I understand that my name and personal information linked to my participation in this project will be anonymised and held securely by the researcher. ☐
- I understand that direct quotes from the audio recording and transcription will be used in this research study but will be made anonymous to the reader and held securely by the researcher. ☐
- I understand that the results of this research will be published in the form of a Doctoral Research Thesis and that they may also be used in future academic presentations and publications. ☐
- I understand that assurances about confidentiality will be held except in the case of any disclosure of imminent harm to self and/or others occurs. ☐

- I understand that being interviewed might involve some risk of emotional upset or discomfort and that I can stop the interview at any time. ☐

- I understand that after the interview I will be offered time, if needed, to talk about how I feel. ☐

- I understand that after the interview I will be provided with a letter with contact details of the professionals at my local CAMHS I can approach should I need further support. ☐

Participant's Name (Printed):____________________________________

Participant's signature:_____________________________ Date:____________

Contact details:

Researcher: Laura De Micco Email: laura.demicco@sabp.nhs.uk

Supervisor : Jocelyn Catty Email: JCatty@tavi-port.nhs.uk

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

Appendix D

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Indicative interview schedule

ProfDoc Research Title: *What is the emotional experience of parents with a child in ongoing once-weekly psychoanalytic psychotherapy treatment at CAMHS? An interpretative phenomenological analysis"*

Researcher name: Laura De Micco

Greet the interviewee

Introduction:
Thank you for agreeing to take part into my research study. My name is Laura De Micco and I am a Child and Adolescent Psychotherapist in Doctoral Training. The aim of my research study is to investigate the experience of parents and carers who have a child who is currently receiving once-weekly psychoanalytic psychotherapy treatment at CAMHS. The interview will last one hour and will be audio recorder; you can request to take a break or stop at any time should you find it hard to answer some of the questions I will ask you. I will transcribe the interview and use the transcription for my doctorate thesis; any extracts from your interview quoted in my research paper will be entirely anonymous. Taking part in my project is not going to affect your child's treatment and the support you currently receive from your local CAMHS.

Questions:

1. **Can you tell me about what you know about CAMHS?**

2. **What led you to bring your child to CAMHS?**

Possible prompts:
Can you tell me about your child's story? What did they need help with?

3. **What was it like for you when your child was offered once weekly psychotherapy?**

Possible prompts:

Can you tell me about the meeting/discussion you had with your child's therapist before the treatment started?
Did you talk to someone about it?
Can you tell me how you felt when your child was offered once weekly psychotherapy?

4. **What is it like for you when the therapist comes to collect your child to take him/her to the therapy room?**

Possible prompt:
Can you describe how you feel when you take your child to the clinic for his session?

5. **What is it like for you to wait for your child while he/she is in his/her session?**

Possible prompts:
Can you describe what you think happens in the room while your child is in his/her session?
Can you describe how you feel while your child is having his session?
Do you do anything in particular while you wait for your child?

6. **What is it like for you when you collect your child at the end of his/her session?**

Possible prompt:
What do you do when you collect your child at the end of his session?
Can you describe what happens after your child leaves the therapy room?
Do you notice any immediate change in your child emotion and/or behaviour?

7. **Have you got anyone to talk to about the fact that your child is undergoing psychotherapy?**

Possible prompt:
Tell me about who you feel you can approach to talk about your child's therapy

8. **What kind of impact do you think that the treatment is having on your child?**

Possible prompt:
Tell me about any differences you might have noticed since the beginning of your child's treatment
What are the best and worst thing about having your child attending psychotherapy?

9. **Is there anything I did not ask that you would like to mention?**

Appendix E

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Dear….

I am writing to thank you for your contribution to my Doctoral Research Project.

I hope this study will help us understand what it was like for you to have a child in once weekly psychoanalytic psychotherapy. Additionally, I hope your valued contribution might be of help to future families being referred to CAMHS and enhance future trainees and qualified Child Psychotherapists' understanding of parents' experiences and inform their practice.

If following taking part there are any issues that are concerning you, you can contact me at the contact details provided below. Additionally, should *child's care coordinator/therapist/parent worker details*.

Should any concerns about my conduct over the course of this interview or any other aspect of this research study, please feel free to come in touch with me (laura.demicco@sabp.nhs.uk), my Research Supervisor Dr Jocelyn Catty (JCatty@tavi-port.nhs.uk) or Simon Carrington, Head of Academic Governance and Quality Assurance, Tavistock and Portman NHS Foundation Trust (academicquality@tavi-port.nhs.uk).

Kind regards,

Laura De Micco
[CAMHS details removed]