

## The journey through and beyond mental health services in the UK: A typology of parents' ways of managing the crisis of their teenage child's depression

**Objectives:** Depression is a common mental illness experienced by young people. Yet, we know little about how their parents manage their symptoms at home, and how parents may experience their treatment at child and adolescent mental health services (CAMHS). Thus, the aim of our study was to create a typology of parents' experiences over a two-year period, beginning with their teenage child's referral to CAMHS in the United Kingdom (UK). **Method:** Eighty-five interviews were conducted with one or both parents of 28 adolescents at three timepoints, and qualitatively analysed using ideal-type analysis. **Results:** Three distinct 'types' or patterns of parental experience were identified: the 'learning curve' parents; the 'finding my own solutions' parents; the 'stuck' parents. **Conclusions:** These patterns of parental experience could perhaps provide a basis for clinicians working in CAMHS to reflect on the families that they see and to adapt their ways of working accordingly to best support these families.

Depression is a common mental illness experienced by young people during adolescence, with estimated prevalence rates exceeding 5% (Costello, Erkanli, & Angold, 2006). The latest statistics for the United Kingdom (UK) indicate that approximately 62,000 young people are suffering from severe depression (Green, McGinnity, Meltzer, Ford, & Goodman, 2005; Young Minds, 2016). Depression is more prevalent among adolescent girls than adolescent boys, at a ratio of about 2:1 (Thapar, Collishaw, Pine, & Thapar, 2011). While there have been advances in the treatment of depression in recent years, research indicates that relapse-recurrence rates are still relatively high among young people diagnosed with depression (Cox et al., 2012), ranging from 34 to 75% within the first five years following an initial episode of depression (Kennard, Emslie, Mayes, & Hughes, 2006).

In contrast to depression in adults, the responsibility for managing many young people's depressive symptoms on a daily basis, as well as managing their treatment attendance and adherence, is likely to fall to their parents (Nock & Ferriter, 2005). However, few studies have actually examined what it is like to be the parent of an adolescent suffering from clinical depression, especially those who are accessing mental health services. Thus, we know little about how parents cope with and manage their child's depressive symptoms at home, and how parents may experience their child's treatment at child and adolescent mental health services (CAMHS). Such a study could crucially provide insight into the support needs of these parents, who are arguably one of the best sources of help for young people suffering from depression, as emphasised in the UK National Institute of Health and Care Excellence guidelines for the treatment of depression in children and adolescents (NICE, 2013).

In a recent study in the UK exploring parents' responses to their teenage child's depressive symptoms, Authors (2015) found that these parents can experience distressing feelings of helplessness, guilt, sadness, and stress in relation to their child's symptoms, as well as disruption in their social, family, and work lives, and parenting behaviour. This study explored parents' experiences specifically at the point of their child's referral to CAMHS and diagnosis of depression. Thus, a next step would be to explore these parents' experiences over the course of their child's treatment at CAMHS and afterwards. In general, few previous qualitative studies in this area have longitudinally explored parents' experiences of living with and responding to their child's mental illness over time. Previous studies have instead often tended to ask parents to think back to the time of their child's diagnosis, reflect on their child's treatment, and describe where the family is now, all in one interview or focus group at a fixed point in time (e.g. Milliken, 2001; Richardson, Cobham, McDermott, & Murray, 2013).

A small number of cross-sectional, qualitative studies like the latter have identified particular patterns of caregiving behaviour and experiences that parents of children with mental health issues can describe (e.g. Chesla, 1991; Kendall & Shelton, 2003). For instance, through interviews with 21 parents in the United States of America (USA) about their experiences of caring for their adult children with schizophrenia and observations at the families' homes, Chesla (1991) identified four distinct patterns of caregiving behaviour: 'engaged care'; 'conflicted care'; 'managed

care'; 'distanced care'. The 'engaged care' parents, for example, were those parents who had found ways to support their ill child, while managing to maintain their own wellbeing (Chesla, 1991). On the other hand, the 'conflicted care' parents were those parents who tended to be relatively angry and dissatisfied as they tried, with difficulty, to manage their situation (Chesla, 1991). Establishing patterns in parents' caregiving behaviour and experiences could have important implications for clinicians working with these families at CAMHS, in terms of the particular kinds of individualised support that these families may benefit from. However, to date and to our knowledge, no study of this nature has been conducted to explore the caregiving experiences of a sample of parents of adolescents diagnosed with depression, in particular looking at their experiences over time.

Consequently, the aim of our study was to add to the existing literature in this area by longitudinally exploring the patterns or 'ideal types' of parental experiences that could exist over time among parents of adolescents diagnosed with depression. Specifically, our study sought to create a typology of parents' ways of managing and dealing with the crisis of their teenage child's depression over a two-year period, starting at the point of their child's referral to CAMHS in the UK and diagnosis of depression, after their child had received treatment at CAMHS, and one year later.

## **Method**

### **Setting for the Study**

The Improving Mood with Psychoanalytic And Cognitive Therapies study (IMPACT; Goodyer et al., 2011) was a large randomised controlled trial (RCT) of three types of time-limited, outpatient treatment for adolescent depression. The Short-Term Psychoanalytic Psychotherapy (STPP) treatment arm of the IMPACT trial consisted of 28 therapy sessions with the young person, plus seven separate parent work sessions with their parent(s), over 28 weeks (Cregeen, Hughes, Midgley, Rhode, & Rustin, 2016). The Cognitive Behavioural Therapy (CBT) treatment arm consisted of 20 therapy sessions with the young person, plus four family or marital sessions, over 28 weeks (IMPACT Study CBT Sub-Group, 2010). The Brief Psychosocial Intervention (BPI; a form of enhanced treatment as usual or specialist clinical care) treatment arm consisted of 12 therapy sessions with the young person, plus four family or marital sessions, over 20 weeks (Kelvin, Dubicka, & the IMPACT Group, 2010).

The young people and their parents or carers who took part in the IMPACT trial were recruited from selected National Health Service (NHS) CAMHS across the UK. To be eligible to take part in the trial, the young people's symptoms had to meet the criteria for moderate to severe depression as described in the fourth edition of the Diagnostic and Statistical Manual for Mental Disorders (DSM-IV; American Psychiatric Association, 1994). The young people's depressive symptoms were assessed using the Kiddie-Schedule for Affective Disorders and Schizophrenia for School-Age Children Present and Lifetime version (K-SADS-PL; Kaufman et al., 1997), a semi-structured, diagnostic interview. The K-SADS-PL was also used to assess for the comorbidity of other mental health disorders. Young people presenting with

generalised learning difficulties, a pervasive developmental disorder, pregnancy, and a primary diagnosis of an eating disorder, bipolar Type 1, or schizophrenia were excluded from the trial. However, the pragmatic nature of the trial also meant that the exclusion criteria did not include drug and alcohol use.

The IMPACT-My Experience study (IMPACT-ME; Authors, 2014) was the qualitative, longitudinal arm of the IMPACT trial. As part of the IMPACT-ME study, the young people and their parents or carers were interviewed during their baseline research assessments for the trial (Time 1; pre-therapy). The young people and their parents or carers at the London site of the trial were then also interviewed at two further timepoints: 36 weeks after their first therapy session (Time 2; post-therapy), and then one year later (Time 3). The interviews conducted with the parents in London as part of the IMPACT-ME study were the focus of our study, as only the London families were interviewed at all three timepoints.

## Participants

The sample in our study consisted of 85 interviews conducted with one or both parents of 28 adolescents, 17 girls (60.7%) and 11 boys (39.3%), at Times 1, 2, and 3 as part of the IMPACT-ME study. The young people's ages ranged from 11.3 to 17.8 years old ( $M = 15.22$ ,  $SD = 1.81$ ) at Time 1. In terms of ethnicity, 18 (64.3%) of the young people described themselves as White British, three (10.7%) as Mixed: White and Black African, three (10.7%) as Any Other White Background, two (7.1%) as Black British, one (3.6%) as Mixed: White and Black Caribbean, and one (3.6%) as Mixed: White and Asian.

The families in the IMPACT trial were invited to choose whether one or both parents would be interviewed. Twenty-one interviews (75.0%) were conducted at Time 1 with the young person's biological mother, two interviews (7.1%) with the young person's biological father, four interviews (14.3%) with the young person's biological mother and biological father, and one interview (3.6%) with the young person's biological mother and stepfather. Twenty-four interviews (85.7%) were conducted at Time 2 with the young person's biological mother, two interviews (7.1%) with the young person's biological father, and two interviews (7.1%) with the young person's biological mother and biological father. Twenty-four interviews (85.7%) were conducted at Time 3 with the young person's biological mother, three interviews (10.7%) with the young person's biological father, and two interviews (7.1%) with the young person's biological mother and biological father. In all cases, at least one of the parents interviewed at Time 1 was the same parent interviewed at Times 2 and 3.

The mothers' ages ranged from 33 to 56 years old at Time 1 ( $M = 45.17$ ,  $SD = 6.40$ ), and age data was missing for three mothers (11.1%). The fathers' ages ranged from 41 to 64 ( $M = 53.60$ ,  $SD = 9.61$ ), and age data was missing for two fathers (28.6%). Thirteen parents (38.2%) described their employment status at Time 1 as unemployed, 19 (55.9%) as employed, one (2.9%) as retired, and employment status data was missing for one parent (2.9%). In 12 families (42.9%), the parent(s) described their marital status as separated from their son or daughter's biological parent, in five families (17.9%) as living with their son or daughter's stepparent, in 10 families (35.7%)

as living with their son or daughter's biological parent, and in one family (3.6%) as widowed. The parent(s) in 16 families (57.1%) reported having an annual household income that was below the mean annual household income for London (Greater London Authority, 2014), and annual household income data was missing for six families (21.4%). Finally, in 14 families (50.0%), either one or both of the young person's parents (biological or step) reported having experienced mental health issues themselves, predominantly depression.

Ethical approval was granted by the Cambridge 2 Research Ethics Committee (REC Ref: 09/H0308/137). Fully informed consent from the young people and their parents was sought for them to take part in the IMPACT-ME study (see Authors, 2015, for further details about the informed consent procedure). [Names of institutions] and local NHS Trust policies on data protection and confidentiality were followed. In order to protect confidentiality, any identifiable details given by participants during their interviews were anonymised in the interview transcripts, some details were changed to protect confidentiality, and participants were assigned pseudonyms.

### **Data Collection**

The development of the semi-structured interview schedules used in the IMPACT-ME study at Times 1, 2, and 3 (Authors, 2011a, 2011b, 2011c) was informed by the Change Interview (Elliott, Slatick, & Urman, 2001), and the Private Theories Interview (Werbart & Levander, 2005). At all three timepoints, the parent and young person interview schedules mirrored each other. The interview schedules were used to instigate discussion with the young people and parents about a range of topics including: 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) in the young person's difficulties over time. As the interview schedules were semi-structured, this allowed the researcher to guide the conversation, while still giving participants the freedom to tell their stories in their own words.

The interviews were conducted with the young people and parents separately at each timepoint, either at participants' homes or at the CAMHS. Given that the Time 1 IMPACT-ME interviews were conducted as part of participants' baseline research assessments for the IMPACT trial, during which a number of other assessments needed to be completed, the Time 1 interview schedule was designed for the interview to take approximately 15 minutes. In practice, the Time 1 parent interviews ranged from 7 to 43 minutes in length. The parents also completed a demographics questionnaire during their baseline research assessments. The interviews at Times 2 and 3 were conducted separately to participants' assessments for the main trial. Consequently, the Time 2 and Time 3 interview schedules were designed for the interviews to take approximately 60 minutes. In practice, the lengths of the interviews conducted with the parents at Times 2 and 3 ranged from approximately 30 to 103 minutes in length.

## Data Analysis

We used ideal-type analysis to facilitate the construction of a typology of parents' experiences over time, drawing on their interviews at all three timepoints of the IMPACT-ME study. A concept originally introduced by Max Weber (1904/1949), an ideal type is essentially a hypothesis about a particular social phenomenon (Stuhr & Wachholz, 2001). Thus, in ideal-type analysis, the term 'ideal' refers in philosophical terms to "*something that exists only in the mind*", rather than to something conceived of as 'perfect' (Philips, Werbart, Wennberg, & Schubert, 2007, p. 217). The intention was for ideal types to be used in empirical research as methodological tools (Marcelino, 2014), or "*yardsticks for measuring similarities and differences between concrete phenomena*" (Werbart et al., 2011, p. 101).

Drawing primarily on Gerhardt's (1994) methodology for ideal-type analysis, case reconstructions were created for each of the 28 families in our study. This involved the first author summarising the content of each parent's interviews at Times 1, 2, and 3 under four headings: 'Initial perspective on young person's difficulties'; 'Expectations of CAMHS'; 'Experiences of CAMHS'; 'One year later (approximately two years after referral)'. The first author then systematically compared the 28 case reconstructions with each other to explore the similarities and differences between them (Gerhardt, 1994). The first author discussed the emerging patterns of similar cases with the second and third authors at this point, and changes were made to ensure that the analysis was fully grounded in the data. The first author's establishment of a clear audit trail of their data analysis process was key in aiding these discussions. The authors' discussions were a reflexive process, which ultimately resulted in the delineation of three overarching case patterns or clusters of similar cases. These case patterns were homogenous within themselves but distinct from each other (Stuhr & Wachholz, 2001; Wachholz & Stuhr, 1999). Single cases were then picked out, which represented each case pattern in a particularly pure or optimal form (Gerhardt, 1994). An ideal type description was formulated based on the optimal case for each pattern, which then became the orientation point for comparing all of the other cases in the cluster (Stuhr & Wachholz, 2001). According to Kühnlein (1999), the cases in each cluster (including the optimal case) do not necessarily need to include every aspect of the ideal type description, but represent it to varying degrees.

In line with previous research (Philips et al., 2007; Werbart et al., 2011), an independent co-judge then sorted the case reconstructions using the descriptions created of the ideal types, in order to assess the credibility of the case patterns. While the first author and the project lead had expertise in this area and the first author was able to verbally brief the independent co-judge on the essential tenets of ideal-type analysis and the aims of the study, the independent co-judge did not have any prior experience of conducting ideal-type analysis or of working with parents of adolescents diagnosed with depression. Although such expertise would have been valuable, prior knowledge and experience of ideal-type analysis and this research area were not viewed as essential to enable the co-judge to categorise each case description using the ideal type descriptions. Care was taken by the first author to ensure that the descriptions were jargon-free and accessible to those outside of the

research field. Indeed, the co-judge's lack of expertise in this area was deemed as a further credibility check on any potential biases that the authors could have brought to the development of the types, given their experience of working with families and in mental health research.

The percentage agreement between the co-judge and the first author was 75%, with seven of the 28 case reconstructions being sorted into different ideal type clusters by the co-judge and the first author. Cohen's kappa for pairwise comparisons was also run ( $k = .62, p < .01$ ), which indicated substantial agreement (Landis & Koch, 1977). Further minor refinements were made to the descriptions of the ideal types following discussions with the independent co-judge, until agreement could be reached on the seven cases where there had initially been a difference in sorting.

## Results

The three patterns or types of parental experience that were derived, using ideal-type analysis, from the parents' interviews across all three timepoints in the IMPACT-ME study are presented below in three sections. Each section provides the ideal type description and presents the optimal case for that pattern or cluster of cases. The final section then summarises the demographic data for each ideal type.

### Ideal Type 1: The 'Learning Curve' Parent

Twelve cases represented the 'learning curve' parent ideal type to varying degrees.

**Ideal type description.** The 'learning curve' parent recognises that their child has recently been experiencing some difficulties, although they are often unsure about how significant these difficulties are. Nonetheless, the 'learning curve' parent sees the value of getting professional help for their child, as well as for them as a parent to support their child. The 'learning curve' parent then tends to find the help that they receive from professionals at CAMHS to be life-changingly helpful for both them and their child, as they develop a new perspective over time in relation to their child's difficulties and/or in relation to themselves as a parent, and adapt accordingly.

**Optimal case.** The optimal case for this ideal type was Ms Draper, whose son was randomised to the BPI treatment arm as part of the IMPACT trial. In her Time 1 interview, at the point of her son's referral to CAMHS, Ms Draper struggles to describe what she means by her son having 'difficulties', "*I don't know how to put it*", but refers to her son as being very aggressive, angry, and unreasonable, particularly when he is not getting his own way. Ms Draper knows that she is not capable of managing her son's difficulties herself and feels that both he and she need professional help to deal with his behaviour, "*How we can also help him is important to me because often I feel like I'm failing him*".

In her Time 2 interview, Ms Draper states that her son's difficulties have now very slightly improved, as a result of his therapy at CAMHS. However, the biggest change that Ms Draper describes is that she now understands from her son's

therapist that her son potentially has an underlying disorder to do with “*his mental state*”, of which his depression was a manifestation, which potentially explains lots of his challenging behaviours. This new understanding of her son’s difficulties has helped Ms Draper to realise that her son is not just often deliberately being “*a naughty child*”, which in turn has helped Ms Draper to cope with his difficulties. Ms Draper’s son’s therapist has also given her some coaching in how to manage her son’s difficulties at home, which has been helpful.

A year later, in her Time 3 interview, Ms Draper states that professionals at CAMHS have now officially diagnosed her son with attention-deficit hyperactivity disorder (ADHD), alongside his original diagnosis of depression. Ms Draper’s new understanding of her son’s ongoing behavioural difficulties, in light of this, has been a relief for her. The family are still receiving ongoing support from CAMHS and Ms Draper states that the whole family are now making a conscious effort to adapt in such a way as to enable them to manage the young person’s difficulties in the long-term.

*“I mean when we first met you we were sort of struggling and didn’t quite understand, you know, understood him, and you know it’s quite difficult for all of us, but now we sort of know where his thinking and his understanding, and mentally where he’s at, it’s much easier for us all to sort of accommodate him in a way”*

## **Ideal Type 2: The ‘Finding my Own Solutions’ Parent**

Six cases represented the ‘finding my own solutions’ parent ideal type to varying degrees.

**Ideal type description.** The ‘finding my own solutions’ parent recognises that their child has recently been experiencing difficulties that are out of character. The ‘finding my own solutions’ parent initially sees a value in getting professional help for their child, though not necessarily for them as a parent to support their child. However, the ‘finding my own solutions’ parent then later tends to express their disappointment in CAMHS as a source of help for their child, and reports that they ultimately ended up finding their own solutions to the problem of their child’s difficulties.

**Optimal case.** The optimal case for this ideal type was Mr and Ms Woods, whose daughter was randomised to the STPP treatment arm as part of the IMPACT trial. In their Time 1 interview, at the point of their daughter’s referral to CAMHS, Mr and Ms Woods hope that their daughter’s therapist will be somebody who their daughter can talk to, and who will give their daughter some coping strategies, as well as “*sensible*” feedback and suggestions that “*are not too far different*” from those that they, as her parents, have already given her.

In their Time 2 interview, Mr and Ms Woods state that their daughter’s emotional difficulties are still ongoing, primarily as a result of the issues that she is still experiencing academically and socially at college. Mr and Ms Woods do not feel



that their daughter's therapy was helpful for her, as her therapist was unable to engage with her. After a small number of therapy sessions, their daughter decided that she did not want to go to CAMHS anymore. Mr and Ms Woods also do not feel that the small number of parent work sessions that they attended at CAMHS were necessary or helpful either, *"I've always had family and friends give me reality checks"* (Ms Woods).

A year later, in their Time 3 interview, Mr and Ms Woods state that their daughter is no longer experiencing any difficulties, which is a big source of relief and happiness for them as parents. Mr and Ms Woods see this improvement as being primarily due to their daughter's new college, which they recently made the decision to move her to and which she is *"thriving"* in. Mr and Ms Woods state that ultimately they just kept trying, through a process of trial and error, until they found a way to solve the problem of their daughter's difficulties.

*"And you've got to go back to the drawing board and think how else am I going to tackle it, and keep going until you find you know a solution or something that helps"* (Ms Woods)

### **Ideal Type 3: The 'Stuck' Parent**

Ten cases represented the 'stuck' parent ideal type to varying degrees.

**Ideal type description.** The 'stuck' parent recognises that their child has been experiencing serious difficulties and sees the value of getting professional help for their child, as well as for them as a parent to support their child, although they do not necessarily expect miracles to happen as a result of this. Following their child's treatment at CAMHS and often when their child's difficulties are still ongoing, the 'stuck' parent ultimately concludes that CAMHS has not been particularly helpful for either them or their child, and does not know where to turn next for further help for them and their child. Essentially, the 'stuck' parent appears to be caught in an unchanging situation or in a problematic cycle.

**Optimal case.** The optimal case for this ideal type was Ms Ford, whose son was randomised to the STPP treatment arm as part of the IMPACT trial. In her Time 1 interview, at the point of her son's referral to CAMHS, Ms Ford states that she has had enough of having to live with her son's extreme anger, moodiness, and disrespect towards her. Thus, Ms Ford took her son to see their family doctor or general practitioner (GP) to see if anything could be done to help him and pull him out of the *"pit"* of his depression, as *"enough's enough"*.

In her Time 2 interview, Ms Ford states that her son's difficulties have now improved to some extent. Ms Ford describes how although she could see that her son was *"making progress"* and that his therapy sessions were helping him, her son decided to stop going to his therapy sessions because he said that they were making him feel worse. Ms Ford decided to support her son in making this decision, as if he did not feel that he was being helped then despite her own views on this, she did not see the need for him to keep going to his therapy sessions. Ms Ford did not attend

her parent work sessions because she did not have time, but Ms Ford's sister attended a small number of parent work sessions on Ms Ford's behalf.

*"When you're a single parent and you've got one that needs to go to the doctor's and one that needs to go here and one that needs to go there and there's only one of you, you have to delegate"*

A year later, in her Time 3 interview, Ms Ford states that her son's difficulties have grown worse. Ms Ford acknowledges that although she suffers from depression herself, she cannot understand her son's utter lack of motivation and interest in doing anything useful at all in life. Ms Ford has reached the end of her tether in terms of her feelings of helplessness in relation to her son's difficulties, *"I'm mentally, cannot take no more, I've had it"*. Ms Ford does not think that anyone or anything can solve her son's problems, as clearly his therapy did not actually help him, he will not help himself, and nothing that Ms Ford says or does helps him, *"There is nowhere to go from here, he's had the support, he's had it all"*.

## **Demographic Data**

A summary of the demographic data breakdown for each ideal type is presented in Table 1.

[Insert Table 1 here]

Table 1 shows that for both the 'learning curve' parent and 'finding my own solutions' parent ideal types, a higher percentage of cases had been assigned to the STPP treatment arm of the IMPACT trial (42% and 50% respectively), whereas for the 'stuck' parent ideal type, a higher percentage of cases had been assigned to the BPI treatment arm (40%). Table 1 also shows that the ideal type with the highest percentage of parents who described their employment status as employed was the 'learning curve' parents (67%), and the lowest percentage could be seen in the 'stuck' parent ideal type (50%); the ideal type with the highest percentage of parents who had undertaken some form of higher education was the 'finding my own solutions' parents (71%), and the lowest percentage could be seen in the 'stuck' parent ideal type (42%); the ideal type with the highest percentage of parents who described their marital status as either living with their child's other biological parent or living with their child's stepparent was the 'learning curve' parents (75%), and the lowest percentage could be seen in the 'finding my own solutions' parent ideal type (17%). Finally, Table 1 indicates that 17% of the 'learning curve' parents had experienced mental health issues themselves or described their child's other parent as having experienced mental health issues, compared to 33% for the 'finding my own solutions' parents, and 70% for the 'stuck' parents.

## **Discussion**

The aim of our study was to create a typology of parents' ways of managing and dealing with the crisis of their teenage child's depression over a two-year period, starting at the point of their child's referral to CAMHS in the UK and diagnosis of depression, then after their child had received treatment at CAMHS, and one year later. Three distinct case patterns or types of parental experience were derived from interviews with parents at these three timepoints using ideal-type analysis. The 'learning curve' parents were those parents who indicated in their interviews that over time they had learned about themselves as parents and/or about their child's difficulties, and adapted accordingly. The 'finding my own solutions' parents were those parents who described how they had ended up solving the problem of their child's difficulties themselves, often outside of CAMHS. Finally, the 'stuck' parents appeared to experience difficulties over time in moving forward and managing the situation.

The proportions of families assigned to each treatment arm of the IMPACT trial did not greatly differ across the three case patterns, although the 'stuck' parent ideal type contained the highest percentage of parents assigned to the BPI treatment arm of the trial, whereas the 'learning curve' parent and 'finding my own solutions' parent ideal types contained the highest percentages of parents assigned to the STPP treatment arm. Nonetheless, the patterns of parental experience found in our study did not seem to primarily depend on the type of treatment that the families had been randomised to receive as part of the IMPACT trial. Rather, these patterns seemed more pertinently to reflect how the families used the services that CAMHS had to offer, regardless of treatment arm or degree of severity of the young person's symptoms (from the parent's perspective). For instance, the 'learning curve' parents who were assigned to the STPP treatment arm tended to attend as many parent work sessions as deemed necessary by professionals at CAMHS, whereas the parents in the 'finding my own solutions' and 'stuck' parent case patterns did not, instead these parents tended to prematurely stop attending their parent work sessions.

Looking at the demographic data for the parents in each of the three case patterns, the 'learning curve' parents were more likely to be employed and had the lowest rate of parental mental health issues, compared to the parents in the other two case patterns. On the other hand, the 'stuck' parents were least likely to be employed and had the highest rate of parental mental health issues. From this, it may be possible to conclude that those parents who were able to have a 'learning curve' over the two-year period of our study were perhaps those with more initial 'strengths', whereas those who experienced difficulties in moving forward may have been the most disadvantaged to begin with.

The 'stuck' parent case pattern in our study seems to resemble aspects of the 'conflicted care' pattern of caregiving behaviour, as identified by Chesla (1991) in a sample of parents of adult children with schizophrenia in the USA. This is because, similarly to the 'stuck' parents in our study, the 'conflicted care' parents in Chesla's (1991) study struggled to care for their child and were particularly emotionally distressed and dissatisfied, both with themselves and with their child. In turn, the 'learning curve' parents in our study perhaps most closely resemble aspects of the

'engaged care' pattern of parental caregiving behaviour in Chesla's (1991) study, as these parents likewise sought to understand their child's schizophrenia, and adapted their lives and parenting behaviour accordingly. Moreover, the 'finding my own solutions' parent case pattern in our study appears to reflect aspects of the 'managed care' pattern in Chesla's (1991) study, in the sense that these parents similarly viewed themselves as the managers of their child's care, felt that their own efforts to help their child were 'treatment', and thought that ultimately they had the knowledge necessary to help their child. The fourth pattern of caregiving behaviour, 'distanced care', in Chesla's (1991) study does not really resemble any of the patterns of parental experience in our study. This could be because all of the parents in this case pattern in Chesla's (1991) study were fathers, whereas relatively few fathers were involved in our study.

Our study has added to this previous literature by exploring parents' experiences over the course of their child's depression; a disorder that has been relatively sparsely focused on in qualitative studies conducted with parents of young people with mental health issues. Our study also longitudinally explored parents' experiences as they unfolded over time, rather than relying on parents' retrospective accounts of their experiences over the course of their child's mental illness given at one fixed point in time, which has often been the case for the typologies developed and themes derived in these previous studies.

### **Clinical Implications**

The types or patterns of parental experience found in our study could perhaps provide a basis for clinicians working in CAMHS to think about and reflect on the families that they see, in terms of how much or how little these families seem to echo the types of family found in our study. Indeed, by their nature, ideal types are hypotheses about a particular social phenomenon that are there to be tested (Lindner, 2006). Thus, in the context of our study, for example, at the point of a young person's referral to CAMHS, a clinician could consider whether their parent's perspectives may be more reflective of those of a 'learning curve' parent, a 'stuck' parent, or a 'finding my own solutions' parent at this point in time. This could then lead the clinician to think accordingly about how they will approach, manage, and support this family. In particular, certain approaches, such as motivational interviewing, could be used at the start of treatment when clinicians identify the fact that parents may be likely to develop a 'stuck' or 'finding my own solutions' pattern. Motivational interviewing can be used to address clients' feelings of ambivalence towards therapy, and to enhance clients' treatment motivation and commitment (Walitzer, Dermen, & Connors, 1999). Treatment plans could also be modified accordingly by clinicians, such as to help 'finding my own solutions' parents to make use of CAMHS more explicitly to support their own work of finding solutions, and by thinking with them about if and how CAMHS could best be a solution to the problem of their child's difficulties.

The varying degrees of supportiveness of the home environments of the families in each of the case patterns in our study also has some implications for clinicians working with families in CAMHS. For instance, the home environments of

the parents in the 'stuck' pattern were especially difficult, with a high incidence of parental mental health issues, relatively high levels of parental marital separation and unemployment, and a comparatively low socioeconomic status (SES). This implies that potentially the 'stuck' parents, in particular, may need help at the outset of their child's treatment from professionals at CAMHS in addressing the difficulties in their home environments, which could be contributing to their child's difficulties and perhaps affecting the 'stuck' parents' abilities to support and help their children, as well as their capacity to make full use of the services that CAMHS has to offer.

Nonetheless, when making clinical recommendations in relation to the 'surviving family' type in their typology of caregiving behaviour developed from interviews with families of young people with ADHD in the USA, Kendall and Shelton (2003) cautioned that just because a family appears to be relatively 'high functioning', 'compliant', and able to 'survive' the problem of their child's difficulties, this does not necessarily mean that they need any less support from professionals at CAMHS. This could also be relevant for the 'learning curve' parent type found in our study, as these parents, despite seeming to be relatively high functioning and engaged with their situation, still tended to greatly benefit from receiving support from professionals at CAMHS.

### **Limitations**

The sample in our study consisted solely of the parents who had chosen to be interviewed at all three timepoints as part of the IMPACT-ME study. Thus, how far the types of parental experience found in our study extend to those parents who chose not to be interviewed at all three timepoints or who were uncontactable by the research team when the time came for arranging their research interviews, is an interesting question, and one that cannot be answered in our study. Our sample also consisted solely of parents of adolescents who had been referred to CAMHS and diagnosed with depression. Epidemiological evidence indicates that the proportion of children and adolescents who require treatment from mental health services and who tend to receive treatment is relatively low (e.g. Leaf et al., 1996; Merikangas et al., 2011). Thus, the degree to which our typology may reflect the experiences of parents whose children suffer from depression but who have not been referred to CAMHS and received an official diagnosis, is currently unknown.

In addition, approximately 60% of the parents in our sample were parents of adolescent girls, potentially reflecting the fact that depression is more prevalent among adolescent girls than adolescent boys (Thapar et al., 2011). Thus, the level of transferability of our typology to a sample composed of a higher number of parents of adolescent boys is uncertain. Moreover, the majority of the parents in our sample were mothers. In general, studies involving parents have often tended to focus more on mothers than fathers (e.g. Brannen & Nilsen, 2006; Brumariu & Kerns, 2010; Connell & Goodman, 2002). This could be because in Western society the majority of everyday parenting tasks are still more likely to be conducted by mothers, who tend to be seen as children's primary caregivers, than fathers (Bianchi, 2000; Fraser & Warr, 2009), although national trends suggest a significant increase in fathers' involvement in their children's lives since the 1970s (Bianchi, 2000; O'Brien &

Shemilt, 2003). Thus, this could imply that unless one deliberately seeks equal representation of mothers and fathers in one's study of parents, which was not the case in the IMPACT trial, mothers may inevitably form the majority of such a sample.

It is also important to consider the limitations of ideal-type analysis as a method of qualitative data analysis. While enabling a focus on individual cases, as well as the commonalities that exist between them, which is arguably a strength of this method (Gerhardt, 1994), the more minute details in participants' interviews may be lost within the ideal-type analysis process. This is because in the initial stage of the analysis, large amounts of in-depth interview data are condensed into relatively brief case reconstructions summarising the content in that interview relative to the study aim.

## **Conclusions**

The aim of our study was to explore the patterns in parents' experiences of managing and dealing with the crisis of their teenage child's depression over time, beginning with their child's referral to CAMHS in the UK, followed by their child's participation in a treatment intervention, and including the parents' immediate and subsequent experiences after their child's course of treatment. Using ideal-type analysis, our study showed that distinct patterns of experience can exist over this two-year period for parents of adolescents diagnosed with depression. Specifically, some parents seemed to experience a learning curve over time whereby they learned about themselves and about the nature of their child's difficulties, and adapted accordingly, other parents appeared to end up finding their own solutions to the problem of their child's difficulties, often outside of CAMHS, and finally some parents appeared to experience difficulties in moving forward. In this way, our study has added to the sparse qualitative literature exploring the experiences of parents of adolescents with depression in dealing with and responding to their child's depression, as well as the sparse literature exploring the caregiving experiences of parents of children with mental health issues longitudinally, as they unfold over time.

Overall, while the ideal types or patterns of parental experience found in our study do not exactly replicate any of the typologies of caregiving behaviour developed in previous studies conducted with parents of children, adolescents, and adults diagnosed with schizophrenia (Chesla, 1991; Jungbauer, Wittmund, Dietrich, & Angermeyer, 2003) or ADHD (Kendall & Shelton, 2003), characteristics of the ideal types in our study do seem to resemble characteristics of some of the patterns found in these previous studies. Therefore, it is perhaps not unreasonable to speculate that our typology could apply to parents of other client groups, as well as other parents of adolescents diagnosed with depression. Future research could explore, for example, whether the typology developed in our study could also apply to parents of adolescents suffering from a range of mental health issues, or to parents of depressed adolescents in other social and cultural contexts. A more fine-grained understanding of how parents of adolescents with mental health problems experience their role as parents, as well as their participation in mental health services, could help us to better address the needs of this very vulnerable group of young people.

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Table 1

*A summary of the demographic data for the families included in our study, organised by ideal type*

<b>Demographic Variable</b>	<b>Ideal Type (Total N of Cases)</b>		
	<b>Learning curve (N = 12)</b>	<b>Finding my own solutions (N = 6)</b>	<b>Stuck (N = 10)</b>
	<b>%</b>	<b>%</b>	<b>%</b>
Treatment arm			
STPP	42	50	30
CBT	33	33	30
BPI	25	17	40
Currently employed	67	57	50
Undertaken higher education	60	71	42
Currently living with partner	75	17	50
History of mental health issues	17	33	70