Dissertation volume:

Literature Review

Empirical Research Project

Reflective Commentary

█████████████████████

University College London

Submitted in partial requirement for the Doctorate in Psychotherapy (Child and Adolescent)

DECLARATION
'I, Elise Gourbin Riley confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.'

███████████████

Date: 10th of October 2022

Signature: Elise Gourbin Riley

Acknowledgements

This dissertation volume has come to life thanks to several individuals who supported me and contributed to my research journey in many ways.

First and foremost, my utmost appreciation to Evrinomy Avdi, my research tutor and supervisor. Her assistance in the preparation and completion of this portfolio has been indispensable. I am ever so grateful for Evrinomy's professional guidance and invaluable support, her generosity in her feedback, her patience while I was fighting with research, and her enthusiasm and kind nature.

I am also very thankful to the IMPACT research team for their hard work and the Anna Freud Centre for allowing me to use the IMPACT-ME material for my project. Very grateful indeed. A general thank you to the IPCAPA staff and seminar leaders for their guidance and encouragement throughout the training.

I would also like to express my special gratitude to Sandra, my very supportive friend who has read my papers more times than should be allowed.

Table of Content

Part 1: Literature Review

Parent work offered by child psychoanalytic psychotherapists:

A literature review

Word Count: 8413

Abstract

Background: Born out of the traditional model of psychoanalysis for adults, child psychoanalytic psychotherapy was initially concerned with their young patients' inner world only. However, cultural, economic, and theoretical changes have led child psychotherapists to re-evaluate the importance of the environment, particularly of parents in the life of their young patients. Thus, especially since the end of the child guidance era, parents became closer to child psychotherapists' patienthood catchment area. Nonetheless, psychoanalytic child therapists have no unitary framework for working with parents.

Aim: This paper aims to overview the various ways child psychoanalytic psychotherapists currently engage with parents. These approaches' underpinning commonalities and divergence are discussed to clarify this area of work.

Method: This is a narrative review of the literature on the types of engagement and models of work with parents of children and adolescents currently offered by child psychoanalytic psychotherapists.

Findings: The literature reflects the absence of accepted formulation and practice in parent work. Despite the growing literature, the lack of cross-referencing and shared language using existing and new psychoanalytic ideas perpetuate the field's fragmentation.

Implications: With the current cultural and economic context, where other modalities thrive on evidence-based data, the survival of child psychoanalytic psychotherapy is uncertain. An integrated formulation is needed to help therapists in their work with parents and allow the evaluation of their work with families.

Introduction

'Parent work' in this paper refers to child psychotherapists' engagement with any of the child's primary caregivers -and therefore includes birth and adoptive parents, carers, and grandparents- within the context of a child being referred for psychotherapy. The terms 'therapists' and 'child psychotherapists' are used interchangeably and refer exclusively to child psychoanalytic psychotherapists.

Over the last three decades, with the shift from one-person psychology to a more relationally based understanding of child development, psychoanalysis has been increasingly interested in parents. Moreover, advances in neurodevelopmental and attachment research have contributed to child psychotherapists having to re-evaluate the importance of the environment, particularly of the parents, in the child's development (Jacobs & Wachs, 2002; Ruberman, 2009; Slade, 2008; Sisk, 2020). Besides, the end of the child guidance clinic era propelled parents into the patienthood catchment area of child psychotherapists, who were previously mainly concerned with the inner world of their young patients (Rustin, 1998, 2009). This change created 'a shift in professional identity' (Rustin, 1998, p.233) and brought to the fore challenges and debates as to the place of parents in the context of their child's therapy (e.g., Altman, 1994, 2000, 2002; Horne, 2000; Jacobs, 2015; Marks, 2020; Silber, 2015; Warshaw, 2015).

Slade (2008) suggests that the profession's resistance to engaging with parents stems from the fact that dealing with parents was initially considered 'hardly an intrinsic part of the therapy' in the child guidance culture and that 'the therapeutic frame of the work with the child, the engagement with his interior life, was sacred' (p.212). Moreover, the main argument against engaging with parents is that it could derail the analytic process

with the therapist becoming 'an arbitrator of family disputes, a lawyer of parental desires, a spokesperson of parental requests, and in some cases the parents' therapist instead of the child's' (Piovano, 2004, p.189). Thus, dealing with parents could potentially jeopardise the psychoanalytic framework offered to the child and add to the difficulty for the therapist to manage both boundaries and complex dynamics. Yet, if only to protect the child's therapy, many psychotherapists engaged with parents while often keeping them in a neglected secondary position. On the other hand, some advocated to 'approach parents with the same seriousness we invest in all other therapeutic endeavors' (Siskind, 1997, p.7), treating parents as patients and not as a 'special burden that the child therapist must bear' (ibid, p.4).

Despite the controversies, nowadays, 'what tends to differ among clinicians is their approach to parents rather than their conviction of the importance of the parents' involvement' (Ruberman, 2009, p345). The literature has grown and reflected this change, for example, in Rustin's alteration of titles for her authoritative papers on the subject: '*Dialogues with parents*' (1998) became '*Work with Parents*' (2009). The former paper is found in an important British reference in this area: '*Work with parents: psychoanalytic psychotherapy with children and adolescents*' (Tsiantis et al., 2000). The book is beneficial to the profession but remains a collection of therapists' reflections rather than a theoretical understanding of parent work. Drawing on the relational perspective, North American child psychotherapists have been more inclined to offer practice models. In their book '*Working with Parents Make Therapy Work*', Novick and Novick (2005) share their views on the history and challenges of this work, offering a specific model of simultaneous work. In '*Simultaneous Treatment of Parent and Child*', Chazan (2003) provides a similar dyadic model, yet she recommends also being trained in adult therapy to use it. Jacobs and Wachs (2002,

2006) wrote about working with parents but included many theoretical approaches differing from their 'original relationally informed psychoanalytic conception' (2006, p6). If these models help us learn about some types of parent work, they further emphasise the absence of a unitary psychoanalytic framework (Sisk, 2020).

Child psychotherapists are therefore left to find their own way as they go in the 'complex maze of working with parents' (Slade, 2008, p.211), leading to this work being conducted in various ways (Whitefield & Midgley, 2015). Piovano (2004) offers that the falling number of requests for child analysis is linked not only to the decline of psychoanalysis as a whole but also to the lack of training regarding parent work in the field. Emphasising the lack of formulation around parent work, Slade (2008) rightly qualifies the field as 'messy' (p.208), and Sielberg (2015) concludes that 'Children are depending on us to get our house in order' (p.383).

The lack of coherent formulation and the resulting disparity in practice in parent work is not only a potential struggle for therapists, it also renders research in this area difficult and thus prevents the emergence of robust evidence for it (Dardas et al., 2018; Haine-Schlagel & Walsh, 2015). Whereas some studies indicate that parent work in child psychoanalytic psychotherapy results in positive outcomes in children (e.g., Fonagy & Target, 1996; Trowell et al., 2007), much more research is needed for the profession which has fallen behind compared to other modalities (Sutton and Hughes, 2005). Therefore, if child psychotherapy is to survive and thrive in the current cultural and economic situation which favours evidence-based modalities, a clearer, coherent, well-formulated approach in parent work is crucial.

In this context, and without a comprehensive theoretical framework or handbook readily available to describe this wide-ranging work, it seemed essential to first shed

some light on this 'messy' field. This paper aims to review the literature on the different types of work currently offered to parents by child psychoanalytic psychotherapists in the context of the referral of a child who is old enough to be seen on his own. Thereafter, commonalities and differences between approaches are discussed to identify their shared underlying psychoanalytic ideas.

Method

The databases electronically searched were PsycINFO and Psychoanalytic Electronic Publishing (PEP). Various keyword combinations were used including 'child and/or adolescent psychotherapy', 'child psychoanalysis', and 'child psychoanalytic psychotherapy' with 'parent', 'parent work', 'parent therapy', 'parental therapy', 'parenting interventions', 'concurrent parent work', 'parallel work with parents'. Unfortunately, very few results were related to parent work in the context of psychoanalytic child psychotherapy. Thus, using the main texts of reference was necessary, and an extended search took place from there.

This literature review is limited to papers in English or translated in the last 50 years. It includes books, book chapters, and journal articles by psychotherapists describing practices and models they have developed and their general views on the topic. Papers exclusively concerned with tripartite work and with work with parents of/and infants, babies, and services specialised in under-fives were excluded. This exclusion criterion was justified by the lack of clarity on work with parents of older children - whose internalised objects are established and can therefore be seen in their own right- and because the practice and literature on work with under 5s are more established (Marks, 2020; Sisk, 2020). If an overlap exists with the psychodynamic

approach, only papers of psychoanalytically trained therapists have been included. In the current uncertain context for its survival, it felt necessary to specifically delineate the clinical, theoretical, and training value of psychoanalytic psychotherapists.

Parent work: current practice

The only point on which all child psychotherapists might agree is that the overall task of parent work is always to 'improve the situation of the child' (Frick, 2000, p.65). The literature reflects child psychotherapists' various views and ways in which they attempt to achieve this loosely defined aim. Classifying papers systematically has been unavoidable to give a comprehensive and comprehensible view of the current practice of parent work offered by child psychotherapists. The angle chosen for this review has been to differentiate the type of contact offered to parents by child psychotherapists. These contacts typically carry specific tasks depending on the therapist's view of the identified primary patient; they encompass distinct levels of agreed therapeutic engagement between therapist and parents and draw upon different techniques.

This approach has its limitations, and the reader should keep in mind that most models of parent work in the literature emphasise the flexibility of child psychotherapists' practice, depending on the situation with which they are presented. They must adapt to both the format and shape this work can take and closely monitor the vacillation between the width and depth of the actual work with parents, often within the same treatment, if not session. Thus, parent work is not only complex and wide-ranging, but it is also adaptive and flexible. For this reason, and given the sparse and fragmented literature, it is helpful to have Rustin (2000)'s notion of spectrum in mind throughout this classification.

On one side of the spectrum is parallel work with parents conducted by the child's therapist. Here the primary patient is solely the child, and the child's therapist offers meetings to parents to gain their support for the therapy and to help them make sense of the child's presentation. Further along the continuum are concurrent sessions, whereby a therapist who is not seeing the child works with parents to address and support their parental functioning. Thereafter are simultaneous models, whereby the same therapist provides separate sessions to the parents and their child, with the aim to address their relationship more directly. For simplification, the terms 'parallel work', 'concurrent work', and 'simultaneous work' are used to describe the three aforementioned practices. Finally, on the other end of the spectrum is the practice of seeing only the parents, with therapists addressing either them in their own right or their parental role and couple relationship.

Parallel work

With the end of the child guidance era and the common disruption of children's treatments due to parents (Baruch, 1997; Furman, 1999; Novick and Novick, 2005), therapists were led to have some contact with their young patients' parents. This has evolved in more systematic meetings with parents here referred to parallel work usually –but not always- carried out by the child's therapist. Three types of engagement in parallel work were found in the literature under the terms reviews, consultations, and supportive guidance.

Reviews and consultations

Nowadays, ad-hoc and regular meetings with parents, often called 'reviews', are considered fairly routine and 'remain an important part of good practice' (Rustin, 2009, p.210). The overall aim of these meetings is to ensure a basic alliance with parents to

gain their support and sustain the child's therapy. The patient is clearly and solely the child, and the therapist's work is directed to his inner world. These meetings are an opportunity for the therapist to gather information about and around the child and for both parties to discuss the treatment progress. No prescribed setting or regularity was found in the literature, although Rustin (1998) and Horne (2000) refer to termly reviews. Horne (2000) recommends this setting for younger children because they expect adults around them to be knowledgeable about them. She also recommends such reviews with cooperative and able parents of latency children, whose symptoms are of a more neurotic nature. On the other hand, Rustin (1998) recommends it for 'an unstable parent' (p.237) who might be threatened if feeling left out but is unable to engage meaningfully in therapeutic work.

Another type of work with parents found in the literature is called 'consultations' with parents. These include elements similar to the reviews but also allow the therapist to share information on child development and advise parents on adapting aspects of the environment to the child's specific needs. This hopes to facilitate a partnership relationship with parents and can include work with the network around the child and family, such as the school. The therapist's role 'might well become that of an "auxiliary ego" to parents, helping them to articulate their views and supporting this' (Horne, 2000, p.60).

In both reviews and consultations, the patient is the child, and therapists only interact with parents on the conscious or pre-conscious level. They address the 'adult' part of parents (Rustin, 2009), and interpretation based on transference and countertransference is rarely used explicitly. Although the child's therapist usually conducts these meetings in parallel to their work with the child, a third party such as a care coordinator might fulfil this role (Rustin, 1998). The latter option is thought to help

avoid contamination through contact between parents and the therapist and to protect the work with the child. However, despite its aim, this level of work can still result in shortened treatment for the child due to the absence of consideration of family dynamics (e.g., Baruch, 1997).

Supportive guidance

This type of work 'can be seen as an extension of the termly review meetings' (Rustin, 2000, p.6). Here, the parents openly seek support but do not engage in a deeper level of self-reflective work. The focus of the therapist's work is to help parents make sense of their child's presentation and to notice and highlight the dynamics between the parents and the child. Yet, this is addressed only from the child's perspective, and therapists do not directly address the parents' inner or unconscious lives.

This intervention, sometimes called 'psychodynamically-informed parent guidance' (Ruberman, 2009), is, therefore, particularly appropriate when parents struggle to make sense of their child's complex and obscure behaviour, as may be the case if they have special needs, autism, or psychosis (Rustin, 2000). The literature suggests that the child's therapist conducts this type of work. The latter might indeed be better placed to work with the parents due to their first-hand experience of the child's presentation (Rustin, 2000). Another rationale for this is when parents do not want to be in treatment themselves or when they are unwilling to see anyone else (Ruberman, 2009; Rustin, 2000). This work can be conducted in addition to other work, such as reviews and consultations with the network (Rustin, 2000). These meetings can also give therapists valuable information on the child and their external world.

Overall, the aim of parallel work is clearly defined, its necessity is established, and it is adequate for some families. It is usually conducted by the child's therapist, requiring

the least resources. Unfortunately, like with any other parent work in child psychotherapy, no systematic studies have been carried out on this work. Therefore no empirical evidence of the benefit or effectiveness of this type of engagement is available.

Concurrent work

Alongside the child's therapy, concurrent parent work is usually conducted by another child psychotherapist who is not directly involved with the child. Depending on the case, the therapist might see both parents together, alternatively, or solely engage with one. Concurrent work covers a wide range of practice with varying levels of engagement depending on the case. Moreover, it sits between consultations or guidance and individual treatment for parents depending on the agreement between both parties. This intervention encompasses the aforementioned practice's aims and supports parental capacity and functioning. It intends to help 'parents to start or restart a positive parenting process in order to accept and support the results of child psychotherapy' (Frick, 2000, p.65). To do so, child psychotherapists address the parents or, more accurately, their parenthood and parenting functions.

The literature referring to concurrent work reviewed here includes a book chapter from a manualised intervention, papers referring to 'parental therapy' (Frick, 2000) and 'psychotherapy of parenthood' (Sutton and Hughes, 2005), and 'parallel analysis of parents' (Piovano, 2004). These are reviewed separately to highlight important distinctions that illustrate the field's diversity.

Short-Term Psychoanalytic Psychotherapy (STPP)

STPP (Cregeen et al., 2016) is a manualised treatment for adolescents with depression within 28 individual weekly sessions and seven optional concurrent

sessions for their parents with a different clinician. Although manualised, the model does not impose a strict structure within the limited number of sessions for both adolescents and parents. The chapter on parent work is grounded in psychoanalytic principles and gives exhaustive information on the background and rationale for parent work. The latter is stated to be 'of prime importance' (Cregeen et al., 2016, p.135). Its aims are laid out as changing parental functioning, enabling the parents to be thoughtful, discussing the parents' state of mind and the functioning of the parental couple, and containing parents' anxieties.

Like many others, Cregeen et al., (2016) acknowledge the issues of blurred boundaries between parent work and therapy but encourage therapists to refer parents elsewhere for individual work if necessary. The adolescent remains the primary patient, which perhaps explains the low number of optional once-monthly sessions and the absence of recommendations to assess parents' suitability for this work. However, the authors share that parent workers must relate to the parent as 'people in their own right' (p.135) before adding that they need to be 'clear in their own mind… that the focus is on the parental thinking, experiences, and relating, rather than on the individual parent as a person or, for a parental couple, their relationship as an adult couple' (p.136). It is then recognised that the parental couple's way of relating is 'an important matter to be considered in their parenting and how their child experiences them as a couple' (p.136). The apparent inconsistency might reflect a need for flexibility but also the overall lack of clarity around parent work in child psychotherapy.

This chapter is the most exhaustive resource around concurrent work in the United Kingdom (UK) and is very helpful for the profession. STPP is now an evidence-based treatment, and the inclusion of parent work in such a model is encouraging in bringing

parents closer to the fore of children's treatment. Empirical research on STPP through IMPACT (Improving Mood with Psychoanalytic and Cognitive Therapy, see Goodyer et al., 2017) also gives hope for future valuable and much-needed data on parent work.

Parental therapy and Psychotherapy of parenthood

Although similar to the STPP description, some authors describe a practice in which the frequency and open-ended nature of the parent work contribute to the feeling that parents are given a more central place. This type of work has been named 'parental therapy' (Frick, 2000) or 'psychotherapy of parenthood' (Sutton and Hughes, 2005). In these instances, parents are seen weekly or fortnightly concurrently with their child's therapy and by a different therapist. This offer implies parents being willing -at least on a conscious level- and able to work with a therapist to make sense of their child's behaviour and improve their situation. It is also appropriate for 'parents who are struggling to cope with very difficult life circumstances - family illness, economic stress, disability, bereavement and so on' (Rustin, 1998, p.235).

The rationale for this work is that children are dependent on their parents, and parents are part of their environment. It requires 'for this interaction to be held in mind and to be actively managed as an integral part of the psychotherapy' (Sutton and Hughes, 2005, p.171). Sutton and Hughes (2005) insist that parents have, however, usually not offered themselves as patients when referring their child. Thus, the nature and depth of the work will depend on the agreement between both parties and is likely to evolve in time. Their weekly sessions with 'parents-not-patients' (Sutton and Hughes, 2005, p.171) involve 'taking account of both the parents' ongoing life in relation to their child and family and their unconscious mental life, especially in relation to transference to the therapist' (ibid, p.173). They refer to some essentially psychoanalytic concepts,

and their clinical examples demonstrate the crucial importance of the therapist's use of their transference and countertransference to help families. In their view, parents are likely to have unconsciously split and projected difficult parts of themselves into their children to protect their own ego functioning. Thus, Sutton and Hughes offer that parenthood therapists attend to the parents' difficulties but always return to the child.

A key difference between 'psychotherapy of parenthood' and 'parental therapy', as described by Frick (2000), exists around the flexibility of the therapist's work. Frick distinguishes between different aspects of parental therapists' tasks, such as between 'psychotherapeutic interventions within parental treatment' (p.69) - similar to the psychotherapy of parenthood - and 'individual psychotherapy with parents' (p.70). Unlike Sutton and Hughes (2005), Frick advocates for parental therapists to take on these different aspects of the job heartedly -with parents' agreement- and to be ready to vacillate between them.

Frick (2000)'s and Sutton and Hughes' (2005) papers are important because they give a name to the practice of concurrent parent work and draw attention to it. However, although the aim and format might be similar, the authors seem to disagree on the works' scope. Sutton and Hughes' paper is also a rare clinical-based account of parent work within Child and Adolescent Mental Health Services (CAMHS). Pointing out the lack of training specific to this work and the lack of child psychotherapists in the public sector, they acknowledge that parent work might often have to be carried out by other practitioners. This poses a real practical challenge as it assumes that other clinicians will be knowledgeable in, and receptive to psychoanalytic thinking.

Parallel analyses

Piovano (2004) formulates a similar model for concurrent work with different therapists, which she developed and used in private and public practice. She considers parenthood a 'transformative process' (p.188) and reflects that 'the request for consultation for the child… often concealed a personal request for help, either denied or not yet recognized by one or both parents' (p.191). This therapeutic work provides parents with a safe and containing space in which they can make sense of their difficulties and disentangle between their projections and what belongs to the child. The therapist's capacity to reflect and contain is gradually internalised, becoming a 'reactivated or new parental object of development' (p.196) for the parent(s). A crucial element in her model is the regular supervision for the therapists provided by a third psychotherapist. This aspect of the set-up not only facilitates a separating and thinking third between therapists, but it also mirrors the healthy triangulation hoped for between the participants of the different triads (i.e., the two parents and the child, or the parents and their therapist) as well as within the dyads with a third thinking position being internalised. Using examples, Piovano demonstrates the benefit of this supervision in thinking about the complex dynamics at stake. Her model is insightful and gives a clear psychoanalytic framework for working with parents. Unfortunately, there is no reference to outcome measures, and the need for three psychoanalytic therapists might not always be realistic in private and public settings.

The literature on concurrent work shows that attempts are being made to think more of the parents in child psychotherapy and that it can be helpful for some families. However, the scope of what concurrent work can entail remains unclear and parents being seen by a different therapist might also 'experience the communications about their child's therapy as remote and hard to engage with' (Marks, 2020). In line with the British tradition, parents are seen by a different therapist to protect the child's therapy

and alleviate the likely burden of managing the many unconscious dynamics at play. In STPP, this is also justified by the idea that the child's therapist seeing the parents could impede adolescents' working through their individuation away from their parents. With a greater emphasis on the relational aspect and, at times, a different viewpoint on adolescents' development and their parents' role, some child psychotherapists, mostly North American, practise simultaneous work with parents.

Simultaneous work

In simultaneous work, a sole therapist 'occupies the middle ground between the two' (Ruberman, 2009, p.356), treating both parents and child separately. Nilsson (2006) believes that a sole therapist gives the parents one coherent and reliable safe base and prevents the potential split between two therapists. It can also help therapists develop a deeper knowledge and understanding of parent and child and their relationship (Barth, 1998, Nilsson, 2006; Novick and Novick, 2005, Marks, 2020; Ruberman, 2009). It gives direct access to parents' and child's realities as well as their unconscious fears and fantasies (Ruberman, 2009) and helps therapists to understand better 'the intense projections of each into the other' (Barth, 1998, p.29). Having these mutual representations in mind, Ruberman (2009) feels more 'able to intervene to address directly their attachment' (p.354).

To determine suitability for simultaneous work, the therapist might initially meet the parent(s) only for one or more sessions before a joint session with the child to assess their relationship (Nilsson, 2006). A joint meeting might again be offered at the end of treatment 'as a way of returning to where one once began, with family sessions' (Nilsson, 2006, p.223). Parents must be willing to engage with their own difficulties that are thought to impinge on their relationship with their child and be emotionally

balanced enough to bear sharing a therapist. This approach is not recommended if the parents' feeling of rivalry with the child or narcissism is too great (Nilsson, 2006). Moreover, Nilsson (2006) does not recommend it in very complex cases, such as when children have been abused or when a parent has an illness significantly impacting the child. The child's age appears to be a controversial factor in deciding on this intervention. Indeed, some authors advise against it if the child is in late latency and adolescence and see this approach as more appropriate for younger children, where the alliance with the therapist is likely to be less complicated due to their developmental stage (e.g., Ruberman, 2009). On the other hand, Novick and Novick (2005) have developed a model they advocate using with adolescents. The latter is also applied to much younger children (Goodman, 2017), whereas Chazan (2003, 2006) offers a similar model to children of different ages. This difference of opinions might reflect the divergence of the authors' views on the development of both child and parents and the dynamic between them, especially in terms of individuation and separation. Novick and Novick (in Dowling et al., 2013) state that the 'standard of psychoanalytic model of adolescent development is flawed' (p.142). For them, the goal of adolescence is transformation towards separateness – and not separation - and the therapist taping into the parents' primary love to support the latter to facilitate this is crucial. Thus, they believe adolescents' parents can benefit as much as parents of younger children from simultaneous work.

Dynamic simultaneous parent work

Moreover, seeing parenthood as a developmental phase, Novick and Novick (2005, 2013) aim to restore both parents and children in their respective developmental paths, as well as repair their relationship. In addition to supporting parents through guidance, validation, facilitation, and modelling, they encourage therapists to use the full range

of psychoanalytic thinking and techniques, that is 'analysis of defences, verbalisation, insight, reconstruction, interpretation and the use of transference and countertransference' (2013, p.131). To manage challenges around confidentiality, Novick and Novick (2013) distinguish privacy from secrecy which they see as 'motivated withholding' (p.112) and is explained to both parties. Through many examples, Novick and Novick (2005, 2013) exemplify the transformation from what they call a close to open regulatory system of functioning between the two parties in parallel to their individual journeys.

Novick and Novick have been the most prolific writers and defenders of simultaneous work with parents of older children. Their model is extensively laid out in terms of phases and technical advice to sole therapists. Yet, some find it too schematic (e.g., Brady, 2006), and it has been criticised for its lack of attention to the countertransference and overall complexity of the unconscious forces at play in this setting (Brady, 2006; Yanof, 2006).

Supportive-expressive psychoanalytically oriented psychotherapy

Chazan (2003, 2006) describes a similar model, which she calls 'Supportive-expressive psychoanalytically oriented psychotherapy'. She warns that this type of work is not for the novice, and training in both adult and child therapy is preferable. Her model also requires the parents to be 'firmly allied with the goal of treatment' (2006, p.72), that is, to transform the relationship between them and their child, which Chazan hopes will subsequently change 'the inner subjective experience of personality structure of each participant' (2006, p.70). Like Novick and Novick, her model focuses on the parent(s)-child issues that impinge on their respective development. It is 'not a completely individual treatment' (2006, p.73) as here, the

patient is the relationship. She uses this simultaneous approach as part of a range of settings she mixes (e.g., simultaneous work before further individual treatment with the child). Despite using her transference and countertransference, and 'playing with' the parents' projections in her parent work, the 'reality' of the relationship also largely figures in the treatment.

Chazan's writing exemplifies the flexibility required and employed by therapists. Her model is not dissimilar to the Novick's one. Here again, one can wonder about the weight and pressure put on the sole therapist and their ability to manage this simultaneous and flexible context. It is also regretful to notice the lack of cross-reference and common language between these two similar models.

The literature on simultaneous work appears to come from North America exclusively. This might be partly explained by the more relational approach found there compared to the UK. It might also reflect the primary contextual setting of American therapists working in private practice, where the availability of other clinicians to do parent work might be less likely.

Interventions with parents only

Similar to Chazan (2006)'s aim, these interventions hope that altering the child's environment through the parents will bring change within the child. In this model, the work is exclusively undertaken with parents, either on their own or as a couple. Working through parents without seeing the child is not a new practice and can be found in the early history of the psychoanalytic treatment of children. Notably, Freud (1909)'s work with Little Hans' father, Winnicott (1977) with the Piggle's parents, and Furman (1981)'s work with bereaved families all testify of this practice. Despite not being new and having been used by imminent figures in the field, the current literature

on this type of intervention in child psychotherapy is rather scarce. It includes papers on a consultative service for parents, a few others on psychotherapy with parents, and one concerned with the parental couple relationship.

Parent Consultation

Jarvis (2005) and Trevatt (2005) describe a Parent Consultation Service (PCS) as part of Open Door, a charity dedicated to young people in London. Their service model is based on psychoanalysis, attachment theory, and child development. It offers six sessions followed by periodic reviews to parents of troubled adolescents. This model resembles the aforementioned parent guidance in parallel work; however, it is designed as a standalone practice rather than in the context of a child's therapy. It might, therefore, be helpful when adolescents are unwilling or unable to engage in therapy themselves. The PCS parent work is not psychotherapy with parents and does not aim to change their internal models. Parents are encouraged and supported to engage in their own therapy if needed. The intervention's objectives are clearly defined with the parents at the start and are kept in focus throughout. Therapists help parents to adjust to their child's transformation in adolescence and promote an authoritative parenting style. They 'work with the "glimpses" of the adolescent's communication that are reported to us by the parent and try to reach an understanding with the parent of what they may mean' (Trevatt, 2005, p.223). The mediating variables are laid out and based on the principle that when parents' anxiety is too high, they project inadequately into their adolescent child, their perception is screwed, and conflict ensues. Therefore, by providing a containing space where they can make sense of their child's behaviour, the parents' view of their adolescent and their unhelpful projections will be transformed, leading to better communication and an increase in the adolescent's sense of self and self-esteem.

Jarvis et al. (2004) collected data from parents and reported positive outcomes for the PCS on many parental measures. Although their small research was not a randomised controlled trial (RCT) nor included follow-up data or the adolescents' views, this represents a rare instance of the use of outcome measures for parent work and is therefore valuable.

Parent-centred psychotherapy

Whereas Sutton and Hughes (2005) insist on the 'parents-not-patients' notion in their psychotherapy of parenthood and that 'the central task of adult psychotherapy may be deemed "not our business"… such as marital difficulties' (p.179), others argue that when therapists work with parents, it is rather futile to attempt differentiating between their individuality and their parental role (e.g., Rustin, 2009). Thus, some child psychotherapists include individual psychotherapy with parents within their practice. The therapist's ultimate aim is still to help the child, but the patients in the room are the parents regardless of the child being in therapy. It can be used for parents of adolescents who refuse to engage in any treatment (Bailey, 2006) or when their disturbance impinges on the child in damaging ways (Rustin, 2009). This can be a standalone piece of work or a time of preparation where parents can be seen weekly for several months before allowing their child to attend therapy (Horne, 2000). This work addresses parental issues and defences as well as marital discordance to allow an environment for the child's therapy to start and be successful. Frick (2000) describes this type of work as suitable for parents with more entrenched deficits.

Similar to the PCS, the rationale here is that the relationship and the parental projections affect the child. Yet, in this instance, the therapist embraces the whole of the parents, as individuals with their past and present, as well as their marital and

close relationships. This way of working with parents helps them with conscious and unconscious obstacles to their 'original capacity for mature caring' (Frick, 2000, p.91). It addresses both the adult and infantile parts of the parents, exploring and attempting to make sense of the parent's internal conflicts to reduce the parents' projective identification with the child. By disentangling these unconscious dynamics often based on unresolved trauma from the parents' own childhood, the work aims to 'reorganize relational patterns through the deconstruction of some of the parental projections and anxieties that affect the child's self-representations' (Jacobs, 2006, p.237). In this approach, therapists can make explicit use of their transference and countertransference through interpretation offered to parents.

Thus, this intervention calls for the use of child psychotherapists' wide range of technical skills, yet their patients in the room are adults rather than children. This crucial difference could partly explain the scarcity of literature on this type of work and the divergence of opinions in the field. Some child psychotherapists might lack the confidence to conduct this treatment without specific training in working with adults.

Parental couple relationship

All the aforementioned interventions with parents focus on the child, parental functions, parent-child relationship, or parents as individuals. In this model, although the ultimate aim is still to improve the child's situation, the way to achieve this is by focusing on the parental couple. Whereas marital therapy can also focus on the parental couple, it 'often does not include much attention to the place of children in the family dynamics' (Rustin, 2009, p.216). The literature on this practice is close to non-existent, and Rustin (2009) acknowledges how challenging this is for child

psychotherapists to focus on the couple, with its marital and sexual aspects, yet she honestly acknowledges that it is sometimes necessary.

Only one paper outlining this way of 'working with the parental relationship as the identified patient in child psychotherapy' (Pantone, 2000, p.24) could be found. In this intervention, Pantone requires parents to commit to a period of couple treatment when referring their child for therapy and will not accept the referral if parents are unwilling to engage. Using the same rationale around projective dynamics as the aforementioned models, he also draws on principles of affect regulation, parent-infant psychotherapy, and attachment theory. The argument for his approach is that 'children internalize, in interaction with their parents, relational patterns that eventually become the bedrock of their interpersonal relatedness and character structure for many years, and that children are enacting these patterns with their parents and others on a daily basis' (p24). Unlike individual psychotherapy with parents, Pantone does not focus on the inner world or any of the parents; the parental couple relationship is his primary source of information and port of entry to address issues. The difficulties between the parents and the discrepancies in their view of their child are the mean 'to test the role that parental projections place on the child' (p.32). Pantone intends to make parents aware of their conscious and unconscious roles in the family dynamics by inviting them to 'discuss their differences and the impact that these discrepancies have on the family' (p.33). Thus, it aims to help parents change 'their participation in dysfunctional or psychopathogenic patterns with each other and with their children' (p.24), allowing the child to respond differently. Pantone also hopes this will provide a template for thinking about dynamics and each participant's responsibility rather than blaming one another.

This work highlights the possibilities of solely working with the parental couple and their intersubjectivity. However, it requires mindful and willing parents and might exclude many families. Similar to psychotherapy with parents, it also calls for confident therapists who have not been specifically trained to address the couple's relationship.

Perhaps driven by a lack of confidence and the fear of losing their core identity and impinging on adult or couple therapy, psychotherapists have written very little about working exclusively with parents.

Discussion

The literature shows that child psychoanalytic psychotherapists engage with parents in many ways. It is therefore important to highlight what these models and ways of working with parents have in common. Identifying their shared underlying psychoanalytic ideas can help better understand what makes the psychoanalytic approach distinct from others.

Commonalities

Child psychotherapists recognise the need to work with parents to allow a facilitating environment for the child (Winnicott, 1965) and the need to use 'reasoned flexibility' (Slade, 2008, p.227) when working with them. The rationale seems to be that parents require both therapeutic work to deal with their inner worlds and support with their parental realities and responsibilities. Parents might also often be seen as more resilient to a flexible framework. Yet, therapists still apply careful thinking while holding the parents' needs in mind.

Therapists also seem to agree that, more often than not, the lack of mentalization, reflective functioning (Slade, 2008), or insightfulness (Lieberman, 2018) impedes the parents' abilities to see their children as separate beings. Thus the dependent child

becomes the alienated or enmeshed recipient of the parents' projections, an extension of their own internal and unresolved conflicts. In turn, the child will be more vulnerable to receiving and acting out on these unconscious communications. For this reason, the literature emphasises the need for a safe and transitional space for parents to differentiate their adult from their infantile side, which will help them disentangle their subjectivity from the one of their children. The containing thinking space found in the setting and the therapist, models and enhances both maternal and paternal functions in parents. Indeed, similarly to maternal reverie (Bion, 1962), child therapists nurture and invite parents to be curious about their children by drawing on the adult part of themselves and their primary love for their children. This maternal function is encouraged in a safe and containing space with reliable and consistent boundaries that therapists enforce. The triangulation offered by the therapeutic space allows parents to take and internalise a 'third position' (Britton, 2004) vis-a-vis their children and broadly reflects a paternal function in enabling separation.

Therapists, therefore, model the role of the observer and actively aim at creating a reflective stance in their interaction with parents, as well as within parents. They act as a facilitator for a different experience, a new developmental object. The process empowers parents in their role as responsible carers and creates a model of a thinking third that they can internalise. In turn, this will be transmitted to the child and can be seen in the latter's new capacity for symbolic thinking and imaginative play (Slade, 2008), having himself acquire an internal space for it.

Thus, the lack of optimal parental functioning can be conceptualised as a result of a renewed 'missing link' situation (Britton, 1989, 2004). Whether it is conceptualised as a developmental phase or situation (Benedek, 1959), a transformative process (Piovano, 2004), or a 'process of progressive adaptation' (Parens, 1975, p165),

parenthood is a dramatic transition in one's life. As Offerman-Zuckerberg (1992) puts it, when becoming a parent, 'our unconscious gets recycled' (p.206). Intrapsychic conflicts re-emerge and transient regressions occur (Parens, 1975), and 'otherhood' (Shane & Shane, 1989) needs to be negotiated or re-negotiated. It introduces once again the challenge of psychic separateness within a dyadic unit like in the early oedipal situation.

Sadly, the literature on parent work lacks cross-referencing and explicit use of existing psychoanalytic ideas. For example, although child psychotherapists recognise the need for a reflective space for and within parents and to address their unresolved difficulties impeding the child, a crucial and uniquely psychoanalytic construct such as the oedipal situation is not used in the literature. Freud (1924) believed that the oedipal complex was the nuclear complex of all neurosis and that the oedipal situation persists as the fundamental organiser in one's mental life, although mostly unconsciously. With the expanded understanding and application of the oedipal complex (Britton, 1989; Young, 2001), this seems particularly relevant to parent work, yet it is absent.

Besides, the literature clearly emphasises the relational aspect in the development of the child's self. Still, Bowlby (1973)'s idea of internal working models is nowhere to be found, except in Lieberman (2018)'s writing on insightfulness. It is an essential psychoanalytic concept to describe how the child's internal world, his view of himself and the world around him is shaped within the context of his relationship with his parents. It is surprising that it would not be central in the literature on parent work.

Finally, although the literature demonstrates that powerful unconscious dynamics are at play in the family system, no psychoanalytic concepts seem to be systematically exploited in thinking about such dynamics. Bion (1961) has largely contributed to the

psychoanalytic understanding of group dynamics, yet, surprisingly, only Brady (2011)'s paper was found to use Bion's ideas 'to make interpretations that address the intricate functioning of the larger family group' (p.426).

Divergence

From the literature, one main evident variation in child psychotherapists' work with parents is whether to address the intersubjectivity of both parents and child by a sole therapist or separately with two therapists or to address them in their own right and separately to avoid contamination. Broadly, the British tradition, particularly with Kleinian roots, has remained primarily focused on the child's inner world, with a different therapist seeing parents concurrently for their parental capacities or, in rarer instances, in their own right. Although the increased importance given to parents in this tradition is demonstrated by the timid but growing literature and the inclusion of parent work in STPP, the confusing guidance around it might indicate a residual ambivalence around engaging with them and a fear of losing sight of their primary patient. On the other hand, again broadly, the American approach is more of a relational tradition in which the patient is more readily the parent-child relationship, and therapists developed simultaneous treatment models perhaps due to often working in private practice. Even though they have laid out more integrative dyadic models, most of these therapists admit that this approach is inapt for novice practitioners or very complex cases, with some wondering if realistic for a single therapist altogether (Altman, 2004).

In papers firmly embedded in the psychoanalytic stance, Altman (1994, 2000, 2002, 2004) attempts to integrate the two traditions (i.e., British and American). He offered that the 'focus is on the family system with a focus of the inner worlds of each member,

and the way these subjective worlds interact' (2000, p.37). This integration and use of the complex matrix of multidirectional unconscious communications which Altman offers feel like a sensible extension as opposed to a transformation of the tasks of child psychotherapists. However, in a very honest paper, Altman (2004) recognises that the dynamics at play are too much for one therapist to bear and to attend meaningfully. He also reflected that 'the emotional containing capacity of the therapeutic team is considerably greater than the containing capacity of an isolated child therapist' (p.204). Altman (2004) hoped for the two traditions to compensate for and complement each other to create a coherent formulation to help him in his practice with parents, which he struggles with through 'trials and errors' (p.204). On the other hand, Marks (2020) reports that she has found simultaneous work 'manageable' (p.24). Like Chazan (2006), Marks works simultaneously with parents and child or adolescent as part of a range of settings and advocates for a more flexible and responsive approach to the family based on needs rather than using a one-fit-all offer. She particularly argues for more ground work being done with parents in spite of the common 'pressure to start seeing the child as soon as possible' (2020, p.21). Overall, although she recognises that not all parents will agree to engage, Marks (2020) pleads for an 'emotionally richer' (p.21) type of work with them. She eloquently shares her positive experience of being a sole therapist engaging more intimately with parents, and of developing a common or metaphorical language with them which appears central to the therapeutic relationship. Marks also gives helpful examples of how to talk to parents about the rationale for working together prior or during the child's therapy. Marks' paper is a rare account of simultaneous work in the UK and might further encourage child psychotherapists from the British tradition to work more closely and simultaneously with parents. Yet, compared to Altman's papers, Marks' paper does not directly evoke

the psychoanalytic realm. Although she shares couple of case studies, Marks does not consider theoretical aspects and says little about the dynamics at play and how she manages them during simultaneous work.

Thus, therapists agree that disentangling what belongs to the parents and what is the child is commonly understood as the therapist's task as parents' unhealthy projection into or onto their child is often the presenting issue. The profession hopes that creating a safe and containing thinking space can be internalised by the parents and relayed to the child. If the ultimate aim when working with parents is to improve the situation of the child, questions around what shapes it can take, what is possible in different contexts and situations –e.g., private or public practice; severity of presentation, age, and how it can be done safely for all parties, remain in the absence of coherent psychoanalytic theoretical formulation and training to support this work.

Conclusion

The acceptance of the place of parents in the life of children has increased broadly in psychoanalysis due to neurodevelopmental and attachment research. Although this has led to a more explicit formulation for parent-infant psychotherapy, therapists have been left in the dark when working with parents of older children. With no common framework, therapists have developed their own ways largely based on their original psychoanalytic tradition and clinical setting.

The models or approaches found in the literature share common psychoanalytic foundations and concepts. Unfortunately, these are not often named or exploited with a shared language. Although new ideas like mentalization, parental reflective functioning, and insightfulness are helpful, relevant psychoanalytic concepts such as the oedipal situation, internal working models, and unconscious group dynamics are

not explicitly used. Besides, the lack of cross-referencing in the literature continues the fragmentation in this field.

Child psychotherapists are well placed to work with parents compared to any other professionals (Rustin, 2009). Their training allows for in-depth knowledge of child development and fine observational skills of unconscious communication between parents and children. Their personal analysis further helps them to differentiate between their own and the intersubjectivity of others. Yet, although they are well prepared to understand and interpret within the dyadic context, child psychotherapists are significantly less so within the larger family group (Brady, 2011). The lack of theoretical formulation around parent work could explain the inadequacy in their training. This deficiency might stem from child psychotherapists' fear of losing their original ties with adult psychoanalysis (Piovano, 2004; Novick and Novick, 2005). Moreover, the profession might need to reflect on their need for separation and individuation and remember that Freud (1898) thought it 'very probable that supplementary methods may be devised for treating children and the public who go for assistance to hospitals' (p.283). A coherent psychoanalytic formulation for parent work needs to address both the parent-child relationship and their respective inner world while keeping in mind their stage of development. This formulation and the integration of parent work in child psychotherapists' training would increase therapists' confidence to approach this work more flexibly based on the families' needs.

In the current cultural and economic context, where other modalities thrive on evidence-based data, the survival of child psychoanalytic psychotherapy is unsure. Having a clear psychoanalytic formulation would also allow the design and use of outcome measures reflecting the various work done with parents and its subsequent positive outcomes in children. From there, research can be achieved and evidence

collected. Ultimately, this would help therapists improve the child's situation in the best possible way.

References

Altman, N. (1994). A Perspective on Child Psychoanalysis 1994: The Recognition of Relational Theory and Technique in Child Treatment. *Psychoanalytic Psychology, 11*(3), 383-395.

Altman, N. (2000). Reconsidering Parent Involvement in Child Psychotherapy in the Light of Recent Developments in Attachment Theory: A Commentary on Papers by Warshaw, Pantone, and Aronson. *Journal of Infant, Child, and Adolescent Psychotherapy, 1*(1), 53-59.

Altman, N. (2002) Relational Horizons in Child Psychoanalysis, Journal of Infant, Child, and Adolescent Psychotherapy, 2(1), 29-38.

Altman, N. (2004) Child psychotherapy: Converging traditions, Journal of Child Psychotherapy, 30(2), 189-206.

Altman, N. (2004). Child psychotherapy: Converging traditions. *Journal of Child Psychotherapy, 30*(2), 189-206.

Bailey, T. (2006). There is no such thing as an adolescent. In M. Lanyado & A. Horne (Eds), *A Question of Technique: Independent Psychoanalytic Approaches with Children and Adolescents* (pp.180-199). Routledge.

Barth, D. (1998). About parallel work with latency children and their parents. *Psychoanalytic Psychotherapy, 12*(1), 29-45.

Baruch, G. (1997). The Impact Of Parental Interventions On The Analysis Of A 5-Year-Old Boy: A Clinical Account. *Int. J. Psycho-Anal., 78*, 913-926.

Benedek, T. (1959). Parenthood As A Developmental Phase: A Contribution to the Libido Theory. *Journal of the American Psychoanalytic Association*, *7*(3), 389–417.

Bion, W. R. (1961). Experiences in Groups. London: Tavistock.

Bion, W.R. (1962). Learning from Experience. London: Karnac.

Bowlby, J. (1973). *Attachment and Loss: Volume 2. Separation: Anxiety and Anger*. New York, Basic Books.

Brady, M.T. (2006). Book Review. Working with Parents Makes Therapy Work by Kerry Kelly Novick & Jack Novick, New York: Jason Aronson, 2005. *Fort Da*, *12*(2), 103-107.

Brady, M.T. (2011). The Individual in the Group. *Contemporary Psychoanalysis*, *47*(3), 420-437.

Britton, R. (1989). The missing link: parental sexuality in the Oedipus complex. In The Oedipus Complex Today, ed. J. Steiner. London: Karnac, pp. 83-101.

Britton, R. (2004). Subjectivity, Objectivity, and Triangular Space. *The Psychoanalytic Quarterly*, *73*(1), 47-61.

Chazan, S.E. (2003). Simultaneous Treatment of Parent and Child. London: Jessica Kingsley.

Chazan, S. E. (2006). Searching for Togetherness: The Simultaneous Treatment of a Mother and Her Early Adolescent Daughter. *Psychoanalytic Inquiry*, *26*(1), 70-91.

Cregeen, S., Hughes, C., Midgley, N., Rhode, M., & Rustin, M. (2016). Short-term psychoanalytic psychotherapy for adolescents with depression: A treatment manual. Karnac Books.

Dardas, L.A., van de Water, B., & Simmons, L.A., (2018). Parental involvement in adolescent depression interventions: A systematic review of randomized clinical trials. *International Journal of Mental Health Nursing*, *27*, 555–570.

Dowling, S., Lament, C., Novick, K.K., & Novick, J. (2013). Dialogue with the Novicks. *The Psychoanalytic Study of the Child*, *67*(1), 137-148.

Fonagy, P., & Target, M. (1996). 'Predictors of outcome in child psychoanalysis: a retrospective study of 763 cases at the Anna Freud Centre'. *Journal of the American Psychoanalytic Association, 44*, 27–77.

Freud, S. (1898). 'Sexual Aetiology of the Neuroses' in *The standard edition of the complete psychological work of Sigmund Freud, Vol.3 (1893-1899): Early Psycho-Analytic Publications* (pp261-285). London: The Hogarth Press and the Institute of Psycho-Analysis.

Freud, S. (1909). Analysis of a Phobia in a Five-Year-Old Boy. In J. Strachey, ed. (1953-66). The Standard Edition of the Complete Psychological Works of Sigmund Freud. Volume 10, 5-147.

Freud, S. (1924). 'The Dissolution of the Oedipus Complex' in The standard edition of the complete psychological work of Sigmund Freud, Vol. 19. (1923-1925): The ego and the id. Other works, London: The Hogarth Press and the Institute of Psycho-Analysis, pp172-179.

Frick, M. E. (2000). Parental therapy - in theory and practice. In J. Tsiantis, S. Boalt Boethious, B. Hallerfors, A. Horne & L. Tischer (Eds.), Work with parents: psychoanalytic psychotherapy with children and adolescents (pp. 65-92). London: Karnac.

Furman, E. (1981). Treatment–via–the parent: A case of bereavement. *Journal of Child Psychotherapy*, *7*(1), 89-101.

Furman, E. (1999). The impact of parental interventions. *The International Journal of Psycho-Analysis*, *80*(1), 172.

Goodman, S. (2017). The Balancing Act: Concurrent Parent-Child Work. *Journal of Infant, Child, and Adolescent Psychotherapy*, *16*(4), 252-257.

Goodyer, I. M., Reynolds, S., Barrett, B., Byford, S., Dubicka, B., Hill, J., & Senior, R. (2017). Cognitive behavioural therapy and short-term psychoanalytical psychotherapy versus a brief psychosocial intervention in adolescents with unipolar major depressive disorder (IMPACT): a multicentre, pragmatic, observer-blind, randomised controlled superiority trial. *The Lancet Psychiatry, 4*(2), 109-119.

Haine-Schlagel, R., & Walsh, N. E. (2015). A review of parent participation engagement in child and family mental health treatment. *Clinical Child and Family Psychology Review*, *18*(2), 133-150.

Horne, A. (2000). Keeping the child in mind: thoughts on work with parents of children in therapy. In J. Tsiantis, S. Boalt Boethious, B. Hallerfors, A. Horne & L. Tischer (Eds.), *Work with parents: psychoanalytic psychotherapy with children and adolescents* (pp. 47-63). London: Karnac.

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

Jacobs, L. (2015). Child Versus Parent-Focused Therapy: Will the Real Binary Please Stand Up Discussion of Laurel Silber's A View from the Margins: Children in Relational

Psychoanalysis. *Journal of Infant, Child, and Adolescent Psychotherapy, 14*(4), 373-379

Jacobs, L., & Wachs, C. (2002). Parent therapy: a relational alternative to working with children. New York: Aronson.

Jacobs, L., & Wachs, C. (2006). Parent-Focused Child Therapy: Attachment, Identification, and Reflective Function. Maryland: Aranson

Jarvis, C. (2005). Parenting problems: research and clinical perspectives on parenting adolescents: Problemi di genitorialità: prospettive cliniche e di ricerca sull'essere genitori di adolescent. *Journal of Child Psychotherapy*, *31*(2), 209-220.

Jarvis, C., Trevatt, D., & Drinkwater, D. (2004). Parenting Teenagers: Setting Up and Evaluating a Therapeutic Parent Consultation Service: Work in Progress. *Clinical Child Psychology and Psychiatry, 9*(2), 205–225.

Lieberman, A. (2018). Reflections on the theoretical contributions and clinical applications of parental insightfulness. *Attachment & Human Development*, *20*(3), 333-340.

Marks

, D. (2020). Fostering parental growth and enhancing the therapeutic alliance: key tasks for the child psychotherapist. *Journal of Child Psychotherapy*, *46*:(1), 20-34.

Nilsson, M. (2006). To be the sole therapist: children and parents in simultaneous psychotherapy. *Journal of Infant, Child, and Adolescent Psychotherapy*, *5*(2), 206-225.

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

Novick, K. & Novick, J. (2013). Concurrent Work with Parents of Adolescent Patients. *The Psychoanalytic Study of the Child, 67*(1), 103-136.

Offerman-Zuckerberg, J. (1992). The parenting process: a psychoanalytic perspective. *The Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry*, *20*, 205-214.

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

Parens, H. (1975). Parenthood as a Developmental Phase. *Journal of the American Psychoanalytic Association*, *23*(1), 154–165.

Piovano, B. (2004). Parenthood and parental functions as a result of the experience of parallel psychotherapy with children and parents. *International Forum of Psychoanalysis*, *13*(3), 187-200.

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

Ruberman, L. (2009). Working with Parents: Implications for Individual Psychotherapeutic Work with Children and Adolescents. *American Journal of Psychotherapy*, *63*(4), 345-362.

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

Rustin, M. (2000). Dialogue with parents. In J. Tsiantis, S. Boalt Boethious, B. Hallerfors, A. Horne & L. Tischer (Eds.), *Work with parents: psychoanalytic psychotherapy with children and adolescents* (pp. 65-92). London: Karnac.

Rustin, M. (2009). Work with parents. In M. Lanyado & A. Horne (Eds.), *The handbook of child and adolescent psychotherapy: psychoanalytic approaches* (pp. 206-218). London: Routledge.

Shane, M. & Shane, E. (1989). The struggle for otherhood: Implications for development in adulthood. *Psychoanalytic Inquiry*, *9*(3), 466-481.

Sielberg, L.M. (2015). Envisioning a home for child work within relational psychoanalysis: Response to Starr & Aron, Chazan, & Jacobs. *Journal of Infant, Child, and Adolescent Psychotherapy*, *14*(4), 380–384.

Sisk, D.A. (2020). Working with Parents In Psychodynamic Child Psychotherapy. (Publication No. 28022624). [Doctoral dissertation, The Institute for Clinical Social Work]. ProQuest LLC.

Siskind, D. (1997). Working with parents: Establishing the essential alliance in child psychotherapy and consultation. New York: Jason Aronson.

Slade, A. (2008). Working with parents in child psychotherapy: Engaging the reflective function. In F. N. Busch (Ed.), *Psychoanalytic Inquiry book series. Mentalization: Theoretical considerations, research findings, and clinical implications* (pp. 207-234). Mahwah, NJ, US: Analytic Press.

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

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

Trowell, J., Joffe, I., Campbell, J., Clemente, C., Almqvist, F., Soininen, M., Koskenranta-Aalto, U., Weintraub, S., Kolaitis G., Tomaras, V., Anastasopoulos, D., Grayson, K., Barnes, J., & Tsiantis, J. (2007). Childhood depression: a place for psychotherapy. *Eur Child Adolesc Psychiatry*, *16*, 157–167. https://doi.org/10.1007/s00787-006-0584-x

Tsiantis, J. (Ed.) (2000). Work with parents: psychoanalytic psychotherapy with children and adolescents. London: Routledge.

Warshaw, S. (2015). Mutative Factors in Child Psychoanalysis: A Comparison of Diverse Relational Perspectives, *Journal of Infant, Child, and Adolescent Psychotherapy*, *14*(4), 387-405.

Whitefield, C. & Midgley, N. (2015). 'And when you were a child?': how therapists working with parents alongside individual child psychotherapy bring the past into their work, *Journal of Child Psychotherapy*, *41*(3), 272-292. https://*doi*.org/*10.1080/0075417X.2015.1092678*

Winnicott, D. (1965). The maturational processes and the facilitating environment: studies in the theories of emotional development. London: Hogarth.

Winnicott, D.W. (1977). The piggle. Madison: International Universities Press.

Yanof, J. A. (2006). Book Review: Child Analysis: Working with Parents Makes Therapy Work by Kerry Kelly Novick and Jack Novick. New York: Jason Aronson, 2005. *Journal of the American Psychoanalytic Association*, *54*(4), 1437–1441.

Young, R.M. (2001). Ideas in Psychoanalysis: The Oedipus Complex. Cambridge: Icon Books.

Part 2: Empirical research

Parents' views and experience of parent work in Short-Term

Psychoanalytic Psychotherapy

Candidate Number: 952063

Word count: 8119

Abstract

Objective: Depression in young people is common, and their daily care management lies with their parents. Children and clinicians depend on parents for attendance and adherence to treatment. There is also growing evidence that parents' participation benefits their child's treatment outcomes. Still, research highlights the importance of the nature of parents' involvement and their perceived barriers to engagement as crucial factors for meaningful participation. Short-Term Psychoanalytic Psychotherapy (STPP) is a manualised and evidence-based treatment for adolescents with depression and offers up to seven sessions to parents. This study was conducted to explore the views and experiences of parent work by parents whose adolescents were referred to STTP to help clinicians improve parents' engagement and therefore improve the child's situation.

Method: This qualitative study used thematic analysis to analyse 19 semi-structured interviews with parents of adolescents at the end of their STPP treatment. The interviews were collected as part of the 'Improving Mood with Psychoanalytic and Cognitive Therapies' - My Experience' (IMPACT-ME; Midgley et al., 2014) study.

Results: Parents valued being involved in their child's treatment, but their perception of therapy, of being seen separately from their child, and of their initial contact with Child and Adolescent Mental Health Services seem to have influenced their engagement in parent work. When they attended sessions, their perception of the parent worker and of the therapeutic space facilitated or hindered their active participation. Parents' experience of the helpfulness of parent work seemed to have been associated with parents' ability to participate in their sessions meaningfully.

Participants used parent work in various ways, from "offloading" and asking questions to thinking about change and processing family dynamics.

Conclusion: This small study is a preliminary exploration, but it could help clinicians improve parents' participation by regularly assessing parents' perception of barriers to engagement and remaining attuned to their experience of the therapist and of the therapeutic space. Recommendations are drawn to help clinicians improve parents' meaningful engagement and outcomes. Understanding parents' experience of support in the context of their child's treatment for depression could improve therapeutic outcomes.

Impact Statement

This small-scale preliminary qualitative study examines parents' perceptions and experience of parent work offered to them in the context of their adolescent child receiving Short-Term Psychoanalytic Psychotherapy (STPP) for depression. STPP offers up to seven concurrent sessions to parents with a different therapist. It aims to support parents in various ways, such as containing parents' anxieties, encouraging them to be thoughtful about their child, and exploring the potential impact of the parents' state of mind on the child. This work is vital due to parents' crucial role in the lives and recovery of their depressed children. Depression in young people is common, and their daily care management lies with their parents. Clinicians depend on parents to treat children and need parents' collaboration and meaningful participation in intervention to improve the child's outcome. There is evidence that parents often feel vulnerable and undermined by children's mental health services. Hearing their experiences and perspectives is essential for services to be more successful in engaging parents and gaining collaboration in treating their suffering children. Furthermore, clinical and theoretical understanding of the use and benefit of parent work could be enriched by gaining parents' views on their sessions and their helpfulness. Thus, this study explores factors that facilitated or hindered parents' initial involvement and other variables impacting their meaningful participation in parent work sessions. It also describes how parents used their sessions and what they feel they gained from participating in parent work.

Findings suggest that clinicians should give more attention to and assess parents' views and vulnerabilities when their child is referred to mental health services. It highlights the need for clinicians to evaluate and address parents' perceived barriers to engagement and empathically respond to them from the time of initial contact.

Parent workers must remain attuned to parents' perceptions of their relationship throughout treatment.

Despite increasing evidence that parents' meaningful participation benefits their child's treatment outcome, this research highlights the neglected place given to parents in research and practice. This study hopes to bring attention to the need for further research on parents' role and experience in children's interventions for their mental health issues. In particular, these findings could inform research to develop assessment tools specifically for parents at the referral stage and to compare participation level and outcome at the end of the child's intervention.

In practice, mental health services working with children could use the findings to extend their knowledge of parents' perspectives and experiences of their services and better engage with them. Child psychotherapists and clinicians involved with parents might also obtain further insight into what might impact parents' collaboration and give them areas of exploration to increase the chance of meaningful participation.

In the future, this study might add to the evidence for the need and ways to include, assess and listen to parents when working with their children. Providing improved interventions wherein services and professionals are sensitive and attentive to the child's parents would ultimately benefit mental health care systems and young people in treatment.

Introduction

Depression is one of the leading causes of illness and disability among adolescents and is characterised by a high risk of suicide (Bernaras et al., 2019; WHO, 2021). In England, the last few years have seen a sharp rise in the prevalence of mental health difficulties in young people with one in five (20%) seven to 24-year-olds being identified as having a probable mental disorder in 2021 (NHS Digital, 2021). The Covid-19 pandemic contributed to this rise and it was estimated that nearly 406 000 young people will need support due to depression as a direct result of it (O'Shea, 2020). Although not fully understood, depression is thought to have both biological and environmental causes (WHO, 2021). Family environment is considered not only a strong predictor of depression onset in adolescence but also a protective or risk factor in its development (Dardas et al., 2018).

Parents are responsible for the daily care of young people and children with depression; therefore, clinicians depend on these parents to attend treatment (Nock & Ferriter, 2005). As Nock and Ferriter (2005) simply put it: "attendance and adherence to treatment are arguably the most basic necessities for effective treatment delivery" (p. 149). Researchers have therefore started to be interested in parents' experience of psychological treatment for their children, with the aim to increase their collaboration. So far, studies have mainly focused on parents' perceptions of the child's treatment (e.g., Nock et al., 2007; Stapley et al., 2015) or therapist (see Kazdin & Whitley, 2006) and on Child and Adolescent mental Health Services (CAMHS) (Bone et al., 2015; Evans, 2017). For example, both Bone et al. (2015) and Evans (2017) found that parents may feel fearful and apprehensive when engaging with CAMHS due to feeling out of their comfort zone and because of the lack of clear information provided by clinics. These family-centred findings provide valuable

information regarding factors that may facilitate or hinder parents' engagement and allow clinicians to adapt their practice accordingly to support children's treatment.

In fact, in their review on parent management of attendance and adherence in child and adolescent therapy, Nock and Ferriter (2005) found that parents' experience of barriers might be more influential on their engagement than other factors, such as their level of psychopathology, age of child, or modality of treatment. Kazdin et al., (1997) also found that parents' perceived barriers to treatment are significant predictors of participation in mental health intervention for children and adolescents. These barriers include practical ones, parents' perception of treatment and the relationship or alliance with clinicians. For example, parents' beliefs about their child's treatment, that is the credibility they attribute to the intervention and their expectancies of it, can predict their adherence to treatment (Nock et al., 2007). These 'barriers to treatment are best conceptualised as developing out of an interaction between the client and the treatment' (Nock & Ferriter, 2005, p. 153). These findings suggest that clinicians have an opportunity to improve engagement by addressing parents' perceptions and experiences of these barriers.

Research has also increasingly investigated and evidenced the benefit of involving parents in their child's treatment (e.g., Curtis et al., 2018; Dowell & Ogles, 2010; Midgley & Kennedy, 2011). In their literature review, Haine-Schlagel and Walsh (2015) examined 23 studies on parent participation engagement (PPE) in child and family mental health treatment. They highlight the difference between parents' physical attendance and their meaningful participation or PPE. They describe PPE as the 'parent's active, independent, and responsive contribution to treatment' (p.134) and include both parents' behaviour and attitudes in interactions with the child and the child's therapist. Across studies, they found that parents were only moderately

involved in their children's treatment; however, when PPE occurred, it was associated with many positive outcomes for their child. The authors recommend that clinicians focus on both attendance and PPE as they found that specific strategies can effectively improve them.

Dardas et al. (2018) conducted a systematic review of randomised clinical trials (RCT) of parental involvement in adolescent depression interventions. None of the 16 studies included in the review evaluated psychoanalytic interventions. Only three studies were loosely associated with psychoanalytic thinking, as they evaluated Attachment-Based-Family-Therapy (ABFT), in which attachment theory provides an overarching framework for the intervention. This treatment showed a significant differential impact when parents were involved and resulted in "significantly greater and more rapid reductions in suicidal ideation and depression, greater rates of recovery, and longer participant retention compared to an active usual care comparison group" (p. 565). Dardas and colleagues (2018) concluded that if parents' engagement is beneficial, the nature of the intervention with them is crucial for the outcome.

If parents have historically been marginalised in child psychotherapy (Rustin, 1998; Sisk, 2020), one recent manualised treatment for depressed adolescents, Short-Term Psychoanalytic Psychotherapy (STPP), exemplifies the increased recognition and inclusion of parents in child psychoanalytic psychotherapy. Following the large-scale RCT study 'Improving Mood with Psychoanalytic and Cognitive Therapies' (IMPACT; Goodyer et al., 2017), STPP is now an evidence-based treatment for adolescents with depression. It offers 28 sessions for the young person and up to seven sessions for their parents with another therapist. Whereas children are assessed for treatment, parents are not, and their sessions are non-mandatory. Furthermore, in reality, due to

limited resources, parent work is not always conducted by child psychotherapists in CAMHS, and practitioners with no psychoanalytic training might be seeing parents (Sutton & Hughes, 2005). Demonstrating the increased interest in psychotherapy research with parents and families, IMPACT-My Experience (IMPACT-ME; Midgley et al., 2014) qualitatively explored the perspectives of adolescents, parents and therapists in the STPP arm in the IMPACT trial.

While research with parents and families is relatively nascent, qualitative studies on clients' perspectives and experiences of therapy have long provided valuable insights for practitioners. Timulak and Keogh (2017) suggest that "therapists need to be attuned to their clients' perspectives on their relationship and therapy, recognising that what is important for one client may not be to another, or that what is important for one client may be important for another, but in a distinct or even contradictory way" (p. 1564). This calls attention to the incredible complexity of one's experience and the clinician's role, and to the question of what constitutes an experience. In their exhaustive review of the literature on the varieties of client experience in psychotherapy, Elliot and James (1989) define experience as "clients' sensations, perceptions, thoughts, and feelings during, and with reference to, therapy sessions" (p.444). They identified nine domains encompassed in clients' experience, five of which are intrinsic to patients' own psychological processes (intentions, feelings, style of self-relatedness, style of relating to therapist, and central concern). Two further factors refer to clients' experiences of their therapists (their actions and attributes). And finally, two domains are concerned with the patients' experience of change in therapy (impact and helpful aspects of therapy). Their subsequent recommendations and practical implications testify to the wealth of information therapists can learn from

qualitative research to improve practice, patients' engagement, and therapy outcomes.

Yet, to date and to our knowledge, no research has been conducted on parents' experience of their own sessions in the context of their child's psychoanalytic treatment. Consequently, this qualitative study aims to provide an initial exploration of parents' perceptions and experiences of parent work offered to them in the context of their adolescent's STPP treatment for depression. Specifically, this study hopes to explore what factors might have impacted parents' initial engagement and their further participation in parent work, how they used their sessions, and what they felt they gained from it.

Method

This research used material previously collected for the IMPACT (Goodyer et al., 2017) study, a large RCT conducted in 15 CAMHS across England. As part of this pragmatic superiority trial, 470 adolescents aged between 11 and 17 diagnosed with moderate to severe depression were randomly allocated to one of three manualised treatment interventions: Cognitive-Behavioural Therapy (CBT), STPP, or a brief psychosocial intervention (BPI). Alongside the main study, IMPACT-ME (IMPACT-My Experience; Midgley et al., 2014), a qualitative, longitudinal study aimed to explore the IMPACT participants' experiences. A sub-sample of families was invited to take part in semi-structured interviews before the start of treatment (Time 1; baseline). Families from the London sites were also interviewed at the end of the intervention (Time 2; 36 weeks after baseline) and again one year later (Time 3).

This current study focuses on the data from the IMPACT-ME interviews conducted at Time 2 with the parents whose children attended STPP and who were interviewed post-therapy in London.

Participants

In total, 53 sets of parents participated in the post-therapy interviews at Time 2. Out of these 53 sets of parents, 19 interviews were with parents whose adolescents were allocated to the STPP arm, and they constitute the sample of this study. The Time 2 interviews were selected for analysis as it was considered that these would provide a more vivid picture of parents' experience of the intervention rather than nearly two years after the start of treatment. All the interviewees -17 mothers and two parental couples- were the adolescents' biological parents. Their child had been referred to CAMHS for moderate to severe depression according to the *Diagnostic and Statistical Manual for Mental Disorders Fourth Edition* (American Psychiatric Association, 1994) and had been allocated to STPP with a child psychotherapist. Parents had been offered up to seven sessions with another clinician over the 28 weeks of their child's treatment and attended a post-therapy interview at the end. Some participants were seen by child and adolescent psychotherapists and some by other clinicians, such as psychiatrists. Table 1 shows the number of sessions attended by participating parents.

Table 1

Parents' attendance to parent work sessions

Number of sessions attended	0	1	2	3	4	5	7
Participants (n=19)	5	3	2	2	1	3	3

Given the study's aim to understand parents' views on parent work and factors that might have impacted their involvement, all interviews were included, regardless of parents' attendance and engagement.

Details of parents' marital, social and economic status, ethnicity, or the age of the adolescents were not fully available to the researcher. Although sometimes possible to deduce from the interviews, this aspect was not included in this initial exploration.

The IMPACT study was granted ethical approval by the Cambridgeshire 2 Research Ethics Committee (reference 09/H0308/137), local NHS trusts, and parents gave fully informed consent to take part in IMPACT-ME. Confidentiality and data protection was applied according to the local NHS Trust policies, University College of London, and the Anna Freud Centre. To further protect participants' confidentiality, any identifiable details given during interviews were anonymised in the transcripts, and potentially identifying information was changed in the extracts presented in the analysis.

Data collection

The interviews had previously been collected and transcribed by the IMPACT-ME (Midgley et al., 2014) team, and we are thankful to them for making this data available for this study. The interviews were conducted at home or in CAMHS clinics by

researchers who were blind to the families' treatment allocation. Researchers used 'The Experience of Therapy Interview' (Midgley et al., 2011), a semi-structured interview focusing on parents' overall experience, including their views on their adolescents' depression, CAMHS, their own involvement, the impact of treatment, etc. As interviews were semi-structured, parents could give their stories and views in their own way, while interviewers adapted their questions to gather relevant information. The interviews lasted between 30 and 103 minutes and were audio-recorded and later transcribed verbatim by the IMPACT-ME team.

Data Analysis

Thematic analysis (TA) was used for this study as this method allows the identification and analysis of specific patterns of both explicit and implicit meaning in the research material (Joffe, 2011). Furthermore, as parents' experience in child psychotherapy is understudied, TA seemed the most appropriate method in order to allow key meanings and issues to emerge. Indeed, TA "uses existing theoretical constructs to look at data while also allowing emerging themes to 'speak' by becoming the categories for analysis" (Joffe, 2011, p220). The novelty and specific context of this study ensured that the data firmly informed the findings; however, the researcher sought out some broad knowledge of psychotherapy research on adult patients' experiences to allow the TA's dual deductive-inductive approach.

According to Braun and Clarke (2006), conducting a thematic analysis involves six key phases: familiarising oneself with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report. The researcher followed these stages and familiarised herself with the whole data set, including recordings and transcripts. After extracting the data relevant to the study

within the 19 interviews, five were coded, and emerging patterns were found. For reliability, a graduate researcher also independently coded three of the first five interviews at the initial stage. The two researchers compared their initial codes and categories and had reflexive discussions on the findings' differences and emerging patterns. In line with the principles of Consensual Qualitative Research (Hill, 2012), once consensus was reached through discussion, the researcher proceeded to analyse the rest of the material. The initial categories were reviewed and checked against the extracts of the 14 remaining interviews. Additional categories were added, and themes were developed and refined as necessary. At this stage in the process, the two researchers jointly examined the emerging themes, and through reflective discussions they reached consensus on final themes and categories.

Findings

Key findings were grouped under three main themes. The first theme covers factors impacting *parents' initial engagement*. It includes three categories: parents' initial contact with CAMHS, their perception of psychotherapy, and their feelings about having a therapeutic space separate from their child. A second theme encompasses *parents' perception of the parent worker and the thinking space,* which they felt facilitated or hindered their ability to participate meaningfully in their sessions. The last theme describes the *parents' experience of their sessions*, including what they used them for and their view on their helpfulness.

Theme 1: Factors impacting parents' engagement

As parents reflected on their involvement in their adolescent's treatment, three main categories emerged as factors influencing their engagement in parent work. These were the parents' experiences of their early contacts at CAMHS (e.g., joint

assessment), their views on therapy, and their feelings about having a therapeutic space separate from their child.

Preliminary contacts with clinicians at CAMHS

Regardless of their views on therapy and subsequent engagement, the majority of participants reflected on how vulnerable they felt at the beginning of treatment - in the context of their adolescent's mental health difficulties- and how unhelpful their initial experience at CAMHS had been.

Parents felt fragile, powerless, and "out of their depth"; they were desperate for help and were voluntarily attending CAMHS for their children's sake. Yet, they described their initial contact with CAMHS clinicians as shocking and unsupportive, with clinicians' attitudes and responses being unthoughtful and dismissive. The many questions they were asked, the many forms they were requested to fill, and the change of professionals to whom they had to share their stories repeatedly were experienced as highly unhelpful. As illustrated in the extract below, parents felt "unprepared" and "thrown into" meetings with different clinicians without adequate explanation on what to expect or the rationale behind it.

> The most awkward time was when (.) me and my husband and (adolescent) went to meet the two psychologists as a-the only time we've ever all been together (…) right at the beginning (…) it was just so awkward (...) you know they'd be asking me really direct questions (…) that were a bit, a bit you know painful (.) and it was an hour of just (adolescent) feeling awkward, my husband feeling awkward and me just thinking oh please someone say something[1].

---

[1] Transcription notation: (.) denotes a brief pause; (…) denotes part of the text has been omitted.

During this initial phase, parents felt clinicians did not reach out to them to meet their needs, psychologically but also practically. For example, parents felt prevented from engaging as clinicians were inflexible and expected parents to fit into their schedule and location requirements.

> coz obviously I work during school hours (.) she only worked part-time (.) she wouldn't agree to the phone interviews like coz I said can I do it over the phone instead (…) she wouldn't do no appointment at all after half past 4 (.) I even said like in the mornings I would have been fine in the morning no she doesn't get there 'til like she couldn't do 9 o'clock I think (.) and I said I could do up 'til half 9 sort of latest coz I would need to get back into work erm but she just wasn't.

The intervention did not feel easily accessible to parents, and participants also reported a sense of confusion regarding what support was offered to them and the rationale for it. Most participants' initial meetings with CAMHS professionals were experienced as unsettling, leaving parents feeling uncomfortable, bewildered, and sometimes clearly undermined.

Views of therapy

When reflecting on being offered parent work in their child's treatment context, parents commented on their perceptions of talking therapy. Participants' backgrounds and experiences were varied, and their perceptions of therapy were mixed. Eight parents said little about it except that they initially did not know what to expect. Others shared that their thoughts on therapy informed their willingness or refusal to engage in parent work. Only one mother held a positive view on psychotherapy due to her previous experience, which she felt facilitated her engagement in parent work. As developed

further below, six parents were ambivalent about talking therapy, and four participants declined to attend sessions altogether due to their negative perception of it.

Six participants expressed their *ambivalence* about the value of therapy. Some justified their doubts by recalling unhelpful past experiences of therapy for themselves. Others with no previous therapy experience were sceptical they could be helped by talking, especially about things they felt could not change, such as the past, their genes, or the way they are "wired". Some parents seemed torn between attending for their child's sake and their helplessness in the face of unchangeable aspects of themselves. This was the case of a mother who was "in two minds whether, to think whether therapy actually even helps me to be honest (.) you can't really change the past (.) there's nothing I can do about that (.) you know I'm not in control of my genetics."

Therapy was also sometimes perceived as potentially judgmental; as illustrated in the extract below by one mother, some commented on their ambivalence due to their apprehension of being blamed by clinicians who might not help but rather echo their sense of shame and "failure" as a parent.

> I thought it was a bit daunting you know going in there (...) it quite embarrassing you know sitting there and telling them you know admitting that you can't cope with your child (.) cause you think to yourself 'oh God what are they gonna think about me are they gonna think I'm a bad mum'.

These six parents who shared their ambivalence attended less than three sessions.

Other participants (n=4) shared that therapy was *inappropriate* for them either because it was unnecessary or because it felt incompatible with themselves and their belief system. These parents found parent work unnecessary, as they did not have

issues themselves and had other resources to draw on. For instance, one parent felt she did not need a therapist's input as she already had family and friends to give her "reality checks". Another parent who perceived talking therapy negatively placed her views in the context of her religious faith, as shown in the extract below.

> To be honest when I was offered I said I wasn't going. Cause I don't know how to deal, I don't like it to be honest. Just sitting there talking, I don't really like it. (…) I feel very uncomfortable (…) It doesn't appeal to me one bit (…) I don't wanna become reliant on that! I'm a Christian, I believe, I pray for my son you understand? I have faith that he will get better, things will get better, and that's what I do! I don't have to go to this sort of things.

Furthermore, the modality of therapy, i.e. psychoanalytic approach, was described by some parents as provoking and somehow aloof. Talking to a stranger about personal matters or using "Freudian nonsense" felt incongruous, unnecessary, and perhaps threatening. For example, one mother reported feeling threatened by the lack of control over what could be said and come from the exchange with a therapist. These four parents did not engage in parent work and clearly established that the clash between their perception of therapy and their self-construct constituted a too great obstacle.

Separation from adolescent

Another common factor influencing parents' engagement in parent work seems to be their reaction to being seen without their child. Even when valuing having their own space to think with a clinician, most parents commented on the separateness from their child and the need to have joint or family sessions. Many felt frustrated not to be seen with their child, not knowing what was said in their child's therapy, and not

receiving enough feedback. The mother cited below did not engage in parent work and would have been interested in participating if seen with her child by the same therapist.

> **I: I wondered whether you would've wanted to be involved with the therapy at all.** P: (…) yeah I would've done. I would've like a little bit, yeah to be able to (.) of have had (.) yah s-some kind of feedback (.) there was no opportunity for that. Cause she would literally, come down the stairs, put her head round the door, (adolescent) would follow her up the stairs and she would, no contact with me at all (.) Or at least every sort of three weeks to have maybe have a session with me present.

Parents felt excluded from their child's care, yet, as in the extract below, some reflected on this difficulty, acknowledging the need to accept and support their adolescent's separation and individuation.

> I think not being (.) not being part of (adolescent)'s therapy is actually quite hard as a mother because you (...) Well you spend your whole life being totally involved in everything that goes on with them (…) and obviously now she's 17 (.) I need – you know (.) I am withdrawing from her life (.) but it's quite hard (.) that she goes off and I know nothing about that hour.

Some parents could reflect on this individuation struggle and attend parent work, while others felt unable to engage due to the absence of joint sessions with their child.

Participants' negative experience of their initial contact with CAMHS, which left the vast majority of them bewildered, was the first vital barrier to engaging positively. In addition, parents' perceptions of therapy, of the intervention's format and modality appear to have further influenced parents' ability to engage in parent work.

Theme 2: Facilitating and hindering factors affecting participation in sessions

When thinking about their experience of engaging in parent work, participants primarily talked about their feelings toward the parent worker and their response to the thinking space provided by the clinician. Participants experienced these variables as facilitating or hindering their active participation in parent work. While some participants associated their enjoyable and meaningful engagement in sessions with the containing qualities[2] they attributed to the parent worker, others felt alienated by the perceived differences between themselves and the parent worker. Finally, some participants felt too threatened by the parent worker to attend many sessions or participate meaningfully.

Parent workers' containing qualities

Seven parents talked about their ability to participate meaningfully in their sessions due to their feeling of containment evoked by the parent worker. They explained this feeling stemming from the perceived parent worker's attributes and actions. They often described the clinician as interested, non-judgmental and understanding, insightful and helpful. They also perceived the clinician's style and general approach, such as being calm yet engaging and talkative, as promoting their participation in sessions. Although they may have experienced some of the parent worker's actions as challenging at times (e.g., questioning how the adolescent might have felt about a specific parental behaviour or response), they experienced the clinician's interest, questioning, and interpretations as facilitating positive outcomes. These feelings seem to have grown over time for many, as shown in the extract below. A parent explicitly

---

[2] Containment is a psychoanalytic concept developed by Bion (1962). In very simple terms, it refers to the process by which a mother modifies her baby's communication to make its emotional aspect more manageable before returning it to the baby. It is now widely used in the context of the therapeutic relationship with the therapist providing emotional containment to their patient.

described how her view of the parent worker changed between the initial meetings at CAMHS and the more intimate context of the therapeutic relationship.

> I think the first time we met (parent worker) (…) I was not convinced (…) I was a little bit (.) unsure initially (…) and of course she didn't do that when we then met with her later on I don't think but anyway I think I- I thought it was a good relationship and I enjoyed working with her coz I found her (.) yeah I liked her style in the sense that she-she had a sense of humour as well (.) and we used to get going on things and she was very good I think at just trying to help us bring us around to see things sometimes without-without making us feel dreadful but just trying to work it through in a calm way and so she gave us some good strategies I think I'm not saying we're perfect but we're not but erm but no she brought a good calm focus to it I think so I enjoyed I think I enjoyed working with (parent worker) I thought she was very good (.) very understanding you know.

Parents enjoyed going to their sessions and engaged well as they felt valued, understood, not judged, and put at ease to talk and think about their difficulties. They greatly valued the thinking space which they experienced as "necessary" and "crucial" to support them. The therapeutic space was described as a safe and containing environment where they could say anything without the fear of upsetting the parent worker described as a professional and neutral "stranger". They also expressed their disappointment in losing this precious space and not having follow-ups.

Alienating differences with parent worker

When parents perceived the parent worker as too different from them, particularly in terms of background (e.g., education, social and economic) and professional

approach, participants felt unable to participate in their sessions meaningfully. In these instances, like for the mother below, participants felt alienated and unable to connect with the clinician.

> I have a certain way of being, and I think that for her (parent worker) maybe she didn't, she didn't erm, like that, I, I don't know, I gave her a book on the wages for housework campaign, cos I thought that'd be interesting to her (…) not actually getting wages for housework but the concept of valuing domestic work and unpaid work (.) just to kind of give her an understanding of where I was coming from a little bit (.) I thought that might be, I, how can I say it, erm, I don't think she understood how things were in our family, we're fairly unusual in some respects.

In several cases, parents experienced the clinician as disconnected and unable to relate to them, making them feel misunderstood and unable to use the therapeutic space. Furthermore, like with the parent cited below, parent workers' actions (e.g., questioning, paraphrasing, interpreting) were experienced as distorting or lost on them.

> It was almost like her interpretation (.) of what I was saying rather than (.) what I was saying (.) and it was do you think that it's this that you mean and I went actually no I mean this (.) you know I'm pretty articulate and (.) this is what I'm saying to you.

These parents attended some sessions and still stated that it was "absolutely right" to involve them in their adolescent's treatment. Yet, they attributed their inability to participate meaningfully in their sessions to the perceived mismatch between

themselves and the parent worker's attributes and approach. Thus, the parent worker and the therapeutic space were experienced as inadequate.

Threatened by the parent worker's thinking

Finally, four participants expressed having felt threatened by what the clinician had to offer. They experienced the clinician's thinking as too overwhelming and challenging, posing a threat to their own mental state. Some reported feeling criticised not because of the clinician's attributes or actions but because of their own sense of responsibility and "failure" as a parent. Like the mother quoted below, these parents described the parent worker positively but found it too difficult to engage thoughtfully and meaningfully with them in these sessions.

> I didn't wanna do it go there (laughs) anymore and her open my eyes to anything and upset me so I didn't see her anymore (…) she was fine you know she was a really nice lady you know she didn't make me feel uncomfortable or anything I think it was just the fact that (...) I suppose I knew what I was doing but I didn't want it to be real kind of thing you know because I suppose I was just seeing it as though (.) I'm just protecting them kind of thing but then she just made me realise that I've gotta let 'em grow up (…) but yeah I didn't have any problems with her I think she was you know she was quite nice enough.

When feeling threatened by thinking with the parent worker, parents were ambivalent about attending sessions or declined further participation. Overall, they could not create a therapeutic relationship as even when attending, they worried about and struggled to engage meaningfully with the parent worker's thinking.

Overall, how parents perceived the parent worker's attributes and actions seem to have facilitated or hindered parents' meaningful participation in parent work sessions.

Theme 3: Use and helpfulness of parent work

Regardless of how they felt about the clinician and the thinking space, when asked how they used their sessions and how these may have been helpful, all attending parents reported not remembering much about the sessions, and many found it hard to explain. Whereas some parents found parent work unhelpful, others described how they used their sessions and what they gained from them.

No use and unhelpful

Participants struggling to engage in parent work or to relate to clinicians reported little use of their sessions and their lack of impact on them. Although they attended, some parents could not use their sessions meaningfully. For example, a mother shared: "I used to go and I'd sit there for an hour and not say a word".

These parents reported not having gained anything valuable or adequate to alleviate their difficulties or helplessness. Specific issues and advice might have been discussed in sessions, but parents felt that it was not sufficient or relevant for them to apply. A mother exemplifies this as she thought she did not gain "anything from it (…) apart from she (parent worker) said to me oh praise him up. I do remember her saying that and I just, you know, I do try but (.) it's very difficult".

Thus, parents who attended some sessions but felt unable to engage meaningfully with clinicians did not make much use of their sessions and experienced the intervention as overall unhelpful.

Answers and reassurance

Some participants experienced parent work as helpful in answering their many questions and easing their anxieties about parenting their depressed adolescents. They described using their sessions to "offload" their struggle brought about by their child's mental health difficulties and to seek reassurance by asking questions about it. One father reported that they used to ask the therapist "a lot of questions", perhaps often "asking the therapist questions that we already knew" but that they "just wanted (…) a bit of reassurance."

As with the father cited below, parents' questioning sometimes aimed to disentangle ordinary difficulties in adolescent development from depression.

> part of the difficulty was sorting out the-the what might be called the impact of-of just being a teenager… and separating that from the depression… so, you know we had those discussions on a number of occasions with the counsellor as well, erm you know what-what can you attribute to… growing up and teenage behaviour and… what is-what is the illness of depression.

Parents felt relieved, comforted, contained, and sometimes empowered through talking to and getting encouragement from a professional with experience of young people with depression. Parent work was also reported to have provided a renewed sense of hope regarding their adolescent and the future.

Behavioural advice

Parents also used and found their sessions helpful to gain advice and guidance regarding strategies to manage and interact with their adolescents. They described bringing specific examples or aspects of their child's behaviour with which they were struggling. These instances allowed parents and clinicians to discuss what might be helpful or unhelpful in these moments. They would further think and co-create other

strategic behavioural ways of responding, such as when the adolescent is angry, as seen in the following extract:

> If she comes out and I just I can tell by the body language and the and the way she comes down the stairs and if she's still in the same mood she gets sent straight back up. If she's ok and she comes down calm, then she's fine. I just don't drag it on with her. **Interviewer: And you said that that was from the conversation, conversations that you'd had with (.)** P: Yeah.

Parents used sessions to help them think about difficult interactions and felt the intervention helped them change their response to some of their child's behaviour.

Recognising some (of their own) difficulties

Participants talked about specific personal difficulties being acknowledged through talking to the parent worker and becoming more self-aware. Sharing their experience with the clinician helped them recognise that some of their unmet needs or difficulties might impact the adolescent's development. As a result, like the parent below, they modified a specific aspect of their parenting which they linked to their own difficulties.

> I suppose it sort of opened my eyes thinking maybe that is contributing to how she feels because (…) having this meeting and this woman saying 'oh why don't you let her duh-duh' and (.) Thinking oh God do you know what maybe (...) it is the way I'm treating her is having an impact and making her like this as well maybe it is something to do with me (.) things got a bit better you know.

As a result, this mother allowed her daughter to do some specific things which were age-appropriate. Another outcome of parent work was that some parents who became aware of some of their difficulties shared their intention to seek further support for themselves.

Processing family dynamics

Parents also used their sessions to discuss how they related to their adolescent and think about family dynamics, including within the parental couple, with the adolescent and other children. They found it valuable to examine these interactions to understand better their unconscious motivation, possible meaning, and their impact on each other. Participants felt it helped them think about their child as a separate mind and mentalise their experiences. This resulted in an internalised thinking space within the parent, which showed through parents' new ways of communicating and interacting as a family. Like the example below, parents reported a new ability to interpret their adolescent's behaviour as a means of communication rather than an attack on themselves.

> it helps… me to pull back a little bit (.) and hear more of what she's got to say (…) when she says something and then… maybe if that hurts or touches a nerve and then you-you answer back (laughs) in a way that (…) is about the pain that I'm feeling not about what she's said (…) so to be able to step back and say she's not really attacking me… it's just… how she's feeling at that moment and… let's look at why she's feeling… like that (…) and then you start to talk about it… and then she'll say - well I didn't really mean that anyway (laughs) (.) it's just a reaction (.) because I was feeling rubbish about myself and I said that.

All attending parents expressed their views on the usefulness of their parent work sessions and have engaged and used their sessions in different ways. From feeling contained and empowered to acquiring advice and processing family dynamics, parents gained new perspectives about their relationship with their adolescents and

themselves. Yet, some parents thought it was not helpful or adequate to alleviate their difficulties.

Discussion

To our knowledge, this is the first study exploring parents' perception and experience of parent work in child psychoanalytic psychotherapy. We aimed to shed some light on parents' perceptions of parent work, what they felt facilitated and hindered their engagement and use of sessions, and how they benefitted from it. Participants gave a vivid account of their experience of being offered separate sessions as part of their adolescent's STPP treatment.

Initial contacts with CAMHS clinicians were generally experienced negatively, with parents left feeling unsupported and confused, and these preliminary experiences might have impacted some parents' ability to engage in parent work. These findings support the aforementioned studies on parents' poor experience of initial engagement (Bone et al., 2015; Evans, 2017) and add to the evidence of their overall feelings of being undermined by CAMHS (Association for Young People's Health, 2016; Hagell & Kenrick, 2021). Our findings indicate that, besides the content of overt communication, the relational aspect of initial meetings is crucial for parents. The mismatch between parents' vulnerable state of mind and the clinicians' attitudes and approaches contributed negatively to parents' experience. Therefore, these early contacts represented missed opportunities to create a positive start for a good rapport and a chance to evaluate parents' vulnerabilities, their views, and any perceived barriers to engagement.

Another finding was that parents valued being involved in their child's treatment and having their own 'thinking space'. However, they also experienced a sense of

separation and exclusion from their adolescent's treatment, with majority of parents wanting some joint work. Whereas some reflected on the format of separate sessions as challenging to bear but necessary in the context of their child growing up, others perceived this separation as an obstacle to engaging in parent work. This finding indicates a need for clinicians to allow an opportunity to explain the format's rationale clearly and explore parents' views and concerns. Adding joint or family sessions or reviews at specific times in the treatment could be considered if parents' feeling of exclusion impeded their willingness to engage.

Furthermore, parents' perception of the type of intervention offered, that is parent work in the context of their child's psychoanalytic psychotherapy, was also found to impact some parents' engagement. Participants' views on parent work were grounded on their perception of talking therapy based on previous knowledge, experiences, and beliefs. Only one mother held a positive view of psychotherapy, which she associated with her ability and willingness to engage in parent work. On the other hand, parents who were sceptical about aspects of therapy, such as the experience being shameful or useless to change the past or their genetics, were ambivalent towards parent work and did not attend many sessions. Perhaps a more unexpected finding was some parents' strong negative perception of psychoanalytic psychotherapy as a factor preventing them from engaging in parent work. The RCT context meant that, although they agreed to participate, parents had no choice in the type of intervention they received, which could have impacted their experience and willingness to engage. Nevertheless, these non-engaging parents who perceived therapy and/or the psychoanalytic approach as incongruous with their belief system and self-representation made it clear that this mismatch prevented them from participating in their child's treatment.

If this echoes previous findings on the importance of parents' beliefs about the intervention offered for future adherence and their participation in their child's treatment (Kazdin et al., 1997; Nock et al., 2007), there are some differences. In these previous studies, the cognitive-behavioural intervention offered to parents mirrored the sessions offered to their children. Both were highly manualised and focused on strategies to manage the child's challenging externalised behaviour. In this current study, if adolescents were receiving STPP, participants were offered parent work and not individual psychoanalytic psychotherapy. Interestingly, some parents called their clinician "therapist" or "counsellor". In contrast, others did not, referring to "the lady at CAMHS", "she" or by the clinician's first name or job title (e.g., psychiatrist). Therefore, parents who rejected parent work based on their perception of psychoanalytic psychotherapy might highlight a general confusion -also found in other parents' experience from initial contacts- about what they were offered, by whom, and the nature of it and its purpose. This confusion might well stem from the lack of clarity and formulation around parent work within psychoanalytic child psychotherapy (Sielberg, 2015; Slade, 2008), with psychotherapists still wondering about these 'parents-not-patients' (Sutton & Hughes, 2005, p179). Besides, although it reflects reality in CAMHS, this ambiguity could have been aggravated by clinicians other than child psychotherapists taking the role of parent worker in this study.

In line with previous findings from psychotherapy research with adults, when they engaged in parent work, participants' experience seemed influenced by parents' perceived attributes and actions of the clinician (Elliot & James, 1989). When parents felt there were alienating differences between themselves and the clinician (e.g., socio-economic status), or when they felt threatened to have their "eyes opened" through thinking with the clinician, they were unable to use their sessions meaningfully

and reported little gain from it. On the other hand, positive qualities attributed to the parent worker facilitated a positive therapeutic relationship and parents' active engagement in and use of the sessions. When they felt valued, understood, and not judged, parents appreciated the sessions and experienced them as safe, supportive, and as providing a 'thinking space' which they were disappointed to lose. For participating parents, talking to a professional was a source of containment, reassurance, and advice about parenting their depressed child. Through their sessions, parents recognised some difficulties in themselves and some decided to take steps to act on them. Participants who thought about family dynamics in their sessions felt they gained increased self-awareness and new ways of relating to their adolescents. These findings broadly confirm the importance of the therapeutic alliance on the outcome of parent work (see Elliott & James, 1989; Lambert & Barley, 2001) and are a valuable addition to what child psychotherapists consider the aims of parent work to be (Holmes, 2018).

Research has shown that the nature of parents' involvement in their children's treatment is key to the outcome of psychological therapy with children and adolescents (Dardas et al., 2018). With the importance of family environment and relationships in adolescents' depression, it is perhaps not surprising that more relational-based therapies addressing family dynamics could be helpful. However, as seen in this study, parents come with various perceptions, beliefs, experiences about treatment, services and clinicians which impact their ability and willingness to engage (Kazdin et al., 1997; Nock et al., 2005). This confirms the crucial need to empathically assess and remain attuned to parents' concerns about engaging throughout the intervention (Timulak and Keogh, 2017). Regularly monitoring and addressing parents' perceptions of talking therapy, the offered modality, their views on the clinician and their anxieties about

being seen separately from their adolescents are potential ways of counteracting parents' perceived barriers to engagement. Overall, adopting a more collaborative, partnership-based approach, offering clear and adapted explanations for the suggested treatment could also help parents to feel heard and valued and could contribute to modifying perceived barriers.

Limitations and further research: This post-hoc analysis was conducted on data collected from the IMPACT-ME study; thus, findings derive from an interview that was not specifically designed for the purposes of this study and a small convenience sample. Parents chose to take part in the interviews, and the sample is, therefore, limited to those parents willing to share their overall experience and views on parent work. Furthermore, interviews were collected at the end of STPP, and bias can stem from initial unmet expectations of treatment and/or memory distortion. Future research could explore parents' perspectives on parent work before and after treatment and develop tools to capture parents' views, expectations and potential perceived barriers to engagement at the referral stage. It would also be helpful to create interviews specifically designed to understand the many layers of parents' experiences using Elliot and James' (1989) domains. Further research on the impact of parents' religious beliefs and sociodemographic backgrounds on their level of engagement and participation might also be worth exploring. More research is also needed to investigate the correlation between parents' participation and satisfaction with parent work and the impact on the child's outcome (including dropout).

Conclusion

Parents' experience of parent work offered as part of their adolescent's therapy is complex and influenced by multiple factors. Findings from this preliminary small study

support Nock and Ferriter (2005)'s idea that parents' perception of barriers to engagement might be more influential than other factors and that it is partly borne out of interaction with treatment and can, therefore, be influenced. Thus, CAMHS clinicians need to give more attention to and assess parents' needs and vulnerabilities and their perceived barriers to engagement to address and empathically respond to them. Furthermore, they need to remain attuned to parents' perceptions of their relationship throughout treatment. Due to their unique training, child psychoanalytic psychotherapists are well-placed to conduct this work with parents (Rustin, 2000). They are indeed well-equipped to be alert and attuned to these changes and to parents' unconscious communication. However, despite their ability to draw from and apply their psychoanalytic competence, child psychotherapists would benefit from a clearer framework when working with parents (Holmes, 2018; Slade, 2008). This would give therapists the confidence to approach parents with a clear offer and rationale for integrating them in their child's treatment. Moreover, a united and coherent message recognising the place and importance of parents in children's interventions within CAMHS –which name is sadly reinforcing the focus on the child- would normalise and encourage parents' participation. Besides, to create a useful therapeutic relationship, clinicians need to meet parents where they are and thus adopt a more responsive and flexible approach driven by families' needs rather than being clinic-led. As Marks (2020) puts it: 'more intimate engagement with parents will provide a more solid foundation for treatment' (p33). Ultimately, more effective interventions for young people with depression would benefit them.

References

American Psychiatric Association. (1994). Diagnostic and Statistical Manual for Mental Disorders. (4th Ed.). Washington, DC: Author.

Association for Young People's Health (2016). Supporting young people with mental health problems: results of a survey of parents. London: AYPH.

Bernaras, E., Jaureguizar, J., & Garaigordobil, M., (2019). Child and Adolescent Depression: A Review of Theories, Evaluation Instruments, Prevention Programs, and Treatments. *Frontiers in Psychology, 10,* 543. DOI: 10.3389/fpsyg.2019.00543.

Bion, W. (1962). *Learning from experience*. London: Heinemann.

Braun, V., & Clarke, V., (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101.

Bone, C., O'reilly, M., Karim, K., & Vostanis, P. (2015). 'They're not witches…'Young children and their parents' perceptions and experiences of Child and Adolescent Mental Health Services. *Child: care, health and development*, *41*(3), 450-458.

Curtis, S., Thorn, P., McRoberts, A., Hetrick, S., Rice, S., & Robinson, J. (2018). Caring for Young People Who Self-Harm: A Review of Perspectives from Families and Young People. *International journal of environmental research and public health*, *15*(5), 950. https://doi.org/10.3390/ijerph15050950

Dardas, L.A., van de Water, B., & Simmons, L.A., (2018). Parental involvement in adolescent depression interventions: A systematic review of randomised clinical trials. *International Journal of Mental Health Nursing*, *27*, 555–570.

Dowell, K.A. & Ogles, B.M. (2010). The Effects of Parent Participation on Child Psychotherapy Outcome: A Meta-Analytic Review. *Journal of Clinical Child & Adolescent Psychology*, *39*(2), 151-162.

Elliot, R., & James, E. (1989). Varieties of client experience in psychotherapy: An analysis of the literature. *Clinical Psychology Review*, *9*(4), 443-467.

Evans, N. (2017). Experiences of a child and adolescent mental health service. *Nursing Children and Young People*, *29*(5), 41-45.

Goodyer, I. M., Reynolds, S., Barrett, B., Byford, S., Dubicka, B., Hill, J., & Senior, R. (2017). Cognitive behavioural therapy and short-term psychoanalytical psychotherapy versus a brief psychosocial intervention in adolescents with unipolar major depressive disorder (IMPACT): a multicentre, pragmatic, observer-blind, randomised controlled superiority trial. *The Lancet Psychiatry*, *4*(2), 109-119.

Hagell A., Kenrick J. (2021). Rethinking how we support the parents and carers of young people with mental health problems: policy and practice issues and emerging solutions. London: AYPH

Haine-Schlagel, R., & Walsh, N. E. (2015). A review of parent participation engagement in child and family mental health treatment. *Clinical Child and Family Psychology Review*, *18*(2), 133-150.

Hill, C. E. (2012). *Consensual qualitative research: a practical resource for investigating social science phenomena*. The American Psychological Association.

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

Joffe, H. (2011). Thematic Analysis. In D. Harper, & A. R. Thompson (Eds.), *Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners* (pp. 209-223). John Wiley & Sons, Ltd.

Kazdin, A.E, Holland, L., Crowley, M., Breton, S. (1997). Barriers to Treatment Participation Scale: evaluation and validation in the context of child outpatient treatment. *J Child Psychol Psychiatry*, *38*(8), 1051-62.

Kazdin, A.E. & Whitley, M.K. (2006). Pretreatment Social Relations, Therapeutic Alliance, and Improvements in Parenting Practices in Parent Management Training. *Journal of Consulting and Clinical Psychology, 74* (2), 346-355.

Lambert, M.J. & Barley, D.E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy: Theory/Research/Practice/Training, 38*(4), 357-361.

Marks, D. (2020). Fostering parental growth and enhancing the therapeutic alliance: key tasks for the child psychotherapist. *Journal of Child Psychotherapy, 46*:(1), 20-34.

Midgley, N., & Kennedy, E. (2011). Psychodynamic psychotherapy for children and adolescents: a critical review of the evidence base. *Journal of Child Psychotherapy, 37*(3), 232-260.

Midgley, N., Ansaldo, F., Parkinson, S., Holmes, J., Stapley, E., & Target, M. (2011). Experience of therapy interview (Young Person, Parent and Therapist Versions). Unpublished manuscript, Anna Freud Centre, London.

Midgley, N., Ansaldo, F., & Target, M. (2014). The meaningful assessment of therapy outcomes: Incorporating a qualitative study into a randomised controlled trial evaluating the treatment of adolescent depression. *Psychotherapy, 51*(1), 128–37.

NHS Digital. (2021). Mental Health of Children and Young People in England, 2022 - wave 3 follow up to the 2017 survey. Retrieved on 321/05/23 from: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2022-follow-up-to-the-2017-survey/part-1---mental-health.

Nock, M. K., & Ferriter, C. (2005). Parent management of attendance and adherence in child and adolescent therapy: A conceptual and empirical review. *Clinical Child and Family Psychology Review*, *8*, 149–166.

Nock, M.K., Ferriter, C. & Holmberg, E. (2007). Parent Beliefs about Treatment Credibility and Effectiveness: Assessment and Relation to Subsequent Treatment Participation. *Journal of Child and Family Studies, 16*, 27–38.

O'Shea, N. (2020). Covid-19 and the nation's mental health Forecasting needs and risks in the UK: October 2020. Retrieved on 31/05/23, from: https://www.centreformentalhealth.org.uk/publications/covid-19-and-nations-mental-health-october-2020

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

Rustin, M. (2000). Dialogue with parents. In Tsiantis, J., Boalt Boethious, S., Hallerfors, B., Horne, A. and Tischer, L. (Eds.), *Work with parents: psychoanalytic psychotherapy with children and adolescents* (pp. 65-92). Karnac.

Sielberg, L.M. (2015). Envisioning a home for child work within relational psychoanalysis: Response to Starr & Aron, Chazan, & Jacobs. *Journal of Infant, Child, and Adolescent Psychotherapy*, *14*(4), 380–384.

Sisk, D.A. (2020). Working with Parents In Psychodynamic Child Psychotherapy. (Publication No. 28022624). [Doctoral dissertation, The Institute for Clinical Social Work]. ProQuest LLC.

Slade, A. (2008). Working with parents in child psychotherapy: Engaging the reflective function. In F. N. Busch (Ed.), *Psychoanalytic Inquiry book series. Mentalisation:*

Theoretical considerations, research findings, and clinical implications (pp. 207-234). Analytic Press.

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

Stapley, E., Midgley, N., & Target, M. (2015). The Experience of Being the Parent of an Adolescent with a Diagnosis of Depression. *Journal of Child and Family Studies*, *25*(2), 618-630.

Timulak, L., & Keogh, D. (2017). The client's perspective on (experiences of) psychotherapy: A practice friendly review. *Journal of clinical psychology*, *73*(11), 1556-1567.

WHO. World Health Organisation. (2021). Fact sheets: Adolescents: health risks and solutions. Retrieved on 03/01/21, from: http://www.who.int/mediacentre/factsheets/fs345/en/

Part 3: Reflective Commentary

Word Count: 4004

Candidate number: 952063

When embarking on the child and adolescent psychoanalytic psychotherapy training, I was aware of the research component which had become woven into it rather than being a mere optional element. I understood this change as a necessary step within the cultural context of our healthcare system and country to provide evidence of the benefit of our professional stance and work. Thus, research mostly felt like an essential tool to protect the future of child psychotherapy more than something from which I could learn much as a clinician. Through this paper, I hope to convey how my thinking has evolved with time through conducting research during my training. To understand this journey, starting with the background of my application for the doctorate is necessary.

When I arrived in this country many years ago, I undertook a Bachelor's degree in psychology. Research and statistics weighted heavily in the curriculum, and this felt like yet another language to learn. My seminar leader understood my questioning as a mark of eager interest in the realm of statistics. In reality, I was merely figuring out how to employ and apply these words, which were all new to me. Although I would not remember how to use statistical tools today, aspects of the language stayed with me. I had learned a great deal from papers and classic experiments and developed a critical, if not suspicious, mind regarding research. While studying, I took on multiple volunteer positions, including with a charity supporting people suffering from traumatic brain injury (TBI) and another with struggling families with children under 3. In my final year, I chose to conduct a literature review on the neurodevelopmental impact of children witnessing domestic violence informed by attachment theory and a qualitative research on the experience of family carers of TBI victims. Both areas were painfully heavy, but I experienced research as a rather intellectual and 'scientific' exercise allowing one to remain emotionally safe. In hindsight, my interest in wearing a

researcher's hat might have well served as a defence against the more painful aspects of relational work and introspection. Through these two research projects, I was impressed by one finding: the significance of professionals' and carers' attitudes and states of mind in the recovery of the sufferers. Trauma from a brain injury or witnessing violence as a child impacted the brain, but so were the minds of others in overcoming it. Although it seemed clear to me that it was the case, especially while listening to my study participants, I could not prove it in a 'scientific' manner. Thus, although I learned a lot, I felt frustrated not to be able to appropriately translate what I found the most striking, the profound impact of the relational and psychological aspects on the recovery process.

After my Bachelor's, I enrolled in a course on child development research at the Tavistock and volunteered as a research assistant at the Anna Freud Centre (AFC). Later, I applied for a master's in psychoanalytic neurodevelopmental science but was unsuccessful. At the time, I discussed my application with a psychoanalyst and child psychotherapist from my country of origin. This therapist inspired and encouraged my career in this field and is someone I hold in great esteem. His reaction was to question the why of the matter. What could I ever learn from the brain that would help me help children in my consulting room? Point taken. Probably nothing. I was left wondering if I had lost my native culture and the way towards my initial purpose -psychotherapy- while learning all these new 'scientific' words. The researcher's hat had perhaps felt emotionally safer, but it was time to go back to my true interest, psychotherapy, so I applied for the doctorate. To summarise, my perspective was that beyond the many inevitable biases, research could easily be and is commonly manipulated, rendering findings rarely surprising and sometimes suspicious. Research allowed people to share or prove their point and get approval through 'evidence' and funding. However,

it was irrelevant to clinical work due to its limitation in translating complex human phenomena.

With this in mind, I welcomed the woven research element in the child and adolescent psychoanalytic psychotherapist (CAPP) training as, in this evidence-based culture, it felt necessary for the survival of the profession I hoped to join at the end of it. On reflection, proving to the world that child psychotherapists' work was worthwhile and incredibly beneficial in helping individuals and their development was my sole interest in research. I just had to master and become fluent in the research language to add to the scarce evidence for it. Starting the training with research seminars in the first year was helpful to return to this language. The first piece of research we had to undertake was an audit. Although perhaps not very exciting to many, I was intrigued as it sounded potentially helpful. Being the first trainee in my small Child and Adolescent Mental Health Service (CAMHS) clinic and due to the limited presence of my service supervisor –the only child psychotherapist there- my colleagues had very little knowledge of psychoanalytic work. Their interest in it was sometimes overwhelmed by a feeling of envy for the protection and care I received to fulfil the requirements of my CAPP training. Offering open-ended treatment, seeing a child multiple times a week or receiving supervision weekly felt like a dreamy luxury to my overstretched colleagues. Thus, I felt the audit would provide an opportunity to do something relevant to my clinic, show a different aspect of my role, and perhaps alleviate the stereotype of the 'precious' psychoanalytic therapist. In the first few weeks of my placement, I was shocked to not see many children in the building, and as 'DNAs' (Did Not Attend) were often mentioned in team meetings, I chose to look into this for my audit. Researching for it was tedious but somewhat enjoyable work. It often allowed me to dive into patients' records to understand the context of their DNAs. After all, being

fascinated and curious about people's stories and making sense of their behaviour is what brought me to be a psychotherapist. Being in front of a screen, I appreciated having time to explore what could lie behind families labelled as being 'difficult to engage' when 'just not turning up'. It was an opportunity to investigate and advocate for patients' care, ultimately hoping for improvement for the child. Although it was different from being a therapist, it felt relevant and was aligned with my motivation and aim to be one. Interestingly, the findings showed that the number of appointments not attended by clinicians was as many if not more than patients' DNAs. It revealed little coherence around definition, recording, and DNA policies. It also exposed how clinicians were often relieved when their patients did not appear for appointments. These findings gave me a picture of the service at the time: a fragmented service with overwhelmed clinicians and many families feeling let down. The audit results were shared and provoked a few conversations in the team. Equipped with my fiery disposition and valuable findings, I was enthusiastic about advocating for improvements. Management invited me to participate in other discussions and meetings for a broader audit in the Trust. Sadly, nothing came out of it due to strategic people leaving their posts and the overall problematic state of the Trust, and I had little time to pursue the matter further while training.

This experience contributed to my then-emerging perspective on being a clinician in CAMHS. The audit not resulting in any improvement left me feeling disappointed with management and a bit helpless and hopeless. It raised many questions for me. How can one do meaningful therapeutic work in such a large, depleted, if not broken, organisation such as the NHS? I was also disappointed with myself as, primarily due to time, pursuing the matter for improvement had not made it to my priority list, mainly consisting of surviving the training. Even after graduation, I still find managing the

boundaries of my work challenging. Part of me wants to concentrate, consolidate and nurture my psychoanalytic work, and this part would happily ignore the unhealthy organisational dynamics around my practice. Another part of me wants to 'fix' this broader system for the sake of clinicians and families. This inclination is partly an enlargement of my therapist's heart, which aims to help children. Through the audit, I realised that the wider system within which my psychoanalytic practice sits also needed attention to improve my work. I had learnt that a chaotic family does not allow much change for a suffering child. Similarly, a dysfunctional CAMHS clinic is not a setting where a therapist can thrive on working well, which is ultimately detrimental to children. The system needs to be thought about, worked with, and shifted to give clinicians and families a better chance. Despite this experience still feeling like a lost opportunity, I value having learned and conducted an audit and the chance it gave me to be both a clinician and a potential contributor to service development. Until then, I had little sense that research could be exploratory and a genuinely useful tool to improve clinics and thus help clinicians in their practice.

When it came to the empirical research from the second year of training, the choice felt easy. The training school offered our year group to use the material from the adolescents or parents who participated in the qualitative study 'Improving Mood with Psychoanalytic And Cognitive Therapies - My Experience' (IMPACT-Me; see Midgley et al., 2014). I was instantly attracted to research parents' views on the support offered to them in the context of their child receiving Short-Term Psychoanalytic Psychotherapy (STPP). We were learning a lot about adolescents, and I was already working with them, but I had not heard about parents in my training yet and had very little to do with them in my clinic. I chose to research the material from interviews with parents at the end of the treatment of their depressed adolescent. This choice of

hearing parents talking about their experiences was undoubtedly motivated by a desire to ease my apprehension about having to work with them, which was a training requirement. Thus, this was an opportunity to use research in a clinically relevant way which would be very valuable to my novice practice. When asked what I would like to research about parents, I stated: 'their experience of parent work'. There was no other research on the topic, but this seemed straightforward enough, and the ease with which I produced my research proposal mirrored this view. Approaching the task with the confidence that 'obviously' parent work would have been helpful to these parents, this research was therefore going to be my first contribution to evidence psychoanalytic work. Besides, a qualitative study would capture some of the real benefits that quantitative ones do not due to the lack of relevant outcome measures for this type of work. Easy. And naïve or foolish, of course. If one intuitively understands what 'experience' means, intuition has no place in a research paper, and 'experience' needs to be defined by research standards. Besides, familiarising myself with the data quickly shattered my splendid agenda of evidencing the great work of child psychotherapists with parents. I was grateful not to have to carry out a study from scratch and collect any data myself. This 'shortcut' was such a precious time saver. Yet, this meant that I had to work with non-specifically designed material for my study, which would limit the depth of my investigation. Furthermore, many parents had refused or could not attend the sessions offered to them. Many were not seen by child psychotherapists but by psychiatrists or other clinicians. A few hated Freud and the psychoanalytic stance. Needless to say that my grand agenda was rapidly humbled.

In parallel, we were asked to create a separate literature review linked to the empirical research. This task was also a bit of a hurdle. The project ambitiously started in my mind as a literature review on the various theoretical aspects of the therapeutic

process with parents, how it works and why. The literature was, however, not cooperative with my initial plan. The psychoanalytic literature on parent work was so scarce that it was not a possibility, even with a mix of theoretical and case studies papers. There again, my underlying plan of sharing the inner working of what child psychotherapists do so others could understand and fully appreciate the depth and benefit of their work was disturbed. Was I ever able to evidence the wonderful work I wanted to do? After the shock and disappointment had passed and with the support of my supervisor, the choice of review eventually emerged quite organically. Before being able to advocate for child psychotherapists' work with parents, there was a need to know what this work is or what it looks like. Thus, gathering the fragmented literature on the various work with parents offered by child psychoanalytic psychotherapists in one review seemed necessary. Through the early process of devising my literature review, I read extensively. These excellent and in-depth papers were not research papers but clinical accounts and psychoanalytic psychotherapists' thoughts. I admire authors who can clearly and coherently translate their ideas on complex phenomena within the mind's realm. My favourite papers are written with clarity, assertiveness and authority without ever losing sight of further wondering at the end. This 'speaks' to me. This is the 'language' of thinking and reflecting which I understand, value and informs my being and practice. In contrast, I find research papers often too tentative and nearly apologetic of the psychoanalytic stance, with authors being prevented from making links, making sense and wondering. These belong to the realm of psychotherapy, not research papers. I had to re-think what I wanted or could do many times to conform to these rules and work through the frustration of letting go of ideas and links. It was painful. I had to learn to accept that my empirical research was taking its own course away from my initial plan, and I had to let the data and the research protocol lead me

rather than the other way around. Thankfully, my supervisor showed great patience towards my exasperated mind, gently guiding me towards what constitutes 'good' research. I also came across a paper by counselling psychologists Timulak and Keogh (2017), entitled 'The client's perspective on (experiences of) psychotherapy: A practice friendly review'. I became inspired by the idea of producing 'practice friendly' papers. Another influential paper was 'Aims in parent work: a brief qualitative survey' by Holmes (2018). These studies and a few others helped me see what research could offer to therapists because they evidenced the possibility of a pertinent link between research and practice. Thus, if I could not add to the scarce evidence for their work, I could at least aim to devise my papers to be helpful for child psychotherapists. This worthwhile aim sustained my enthusiasm and helped me find my voice through the difficulty of adhering to the research framework requirements during the write-up process. Still, despite being incredibly interested in my research and literature review topics, I found structuring and writing the papers very laborious. I wanted to sum up in my words my understanding of the data, which felt more compelling and thought-provoking than conforming to the rigid and restricting framework of research articles. Putting my findings into an appropriate form for others to understand instead of stating my ideas was something I was also learning at work in writing notes, case studies or reports. In my practice and research papers, I had to learn to shape my findings and 'translate' them appropriately. At the end of my last year of training, I presented my literature review during an AFC research workshop. I felt heartened by how well-received it was and was encouraged by others' interest in learning from it. This little experience somewhat showed me what 'mastering' the research language could look like and achieve. Research could actually be useful for psychotherapists to help one another and learn things about our practice.

Conducting research also gave me an experience of the discrepancy between the core task of our psychotherapy work and the possibility afforded by today's science. Research tools and outcome measures do not appropriately capture psychoanalytic concepts or human beings' complexity. How could we operationalise or measure one's mind, containment, regression, resistance, the core complex or the paranoid-schizoid position? How can we reflect the benefit of child psychotherapy in a child's development? Interestingly, I find in my work that some parents cannot link their child's improvement to the work we did together. When the parent worker or care coordinator asks, they can't think of what brought these changes, 'it sort of just happened'. These parents often want to know what is happening in sessions and are frustrated I do not give advice, strategies or 'do' something with their child. There are surely many reasons for this, but I wonder if, in their mind, merely talking with a psychotherapist could not possibly 'fix' their child, who they often saw as very damaged. In the absence of a concrete input which they can clearly define and quantify, it seems difficult, if not impossible, to recognise any changes resulting from it. Of course, some do despite not understanding and are very grateful for the difference they see in their child's development. These parents perhaps do understand that absence of evidence of what is happening in therapy does not mean evidence of absence of anything happening. And certainly, we don't know all of what happens either, but for the little we know or believe is happening, how could we operationalise it? How could we measure what is happening in and between the psyche of both therapist and child in the room and outside while still conducting therapy? It seems impossible and perhaps even unnecessary, but somehow our culture is attempting to do just that, maybe to ease the anxiety and reassure not parents directly but commissioners and politicians.

Sadly, I think this quest to measure and prove has also led to misusing research and has negatively impacted clinics, therapists and many families. The systematisation of research and the evidence-based culture found in clinics do not allow for much understanding and trust in clinicians. In my second year of placement, I vividly remember the words of the family therapist facilitating a meeting in which we discussed cases to decide on their care plan. Pointing to a big blue folder containing all the guidelines and pathways in front of her, she genuinely asked: 'do we go with that, or do we use our good old common sense?' This experienced therapist was unsure if her abilities and expertise could supersede recommendations from the 'scientific' evidence obtained by some research at our disposal. This instance stayed with me. Later, our CAMHS management asked clinicians to use an outcome measure after each appointment. I don't believe this was offered as a choice, but I chose not to. Asking a child at the end of our session to fill in a form would not only interfere with our work but also make no sense to whoever was interested in monitoring how my young patient felt after each session. I aim to facilitate a therapeutic space wherein children and adolescents can safely express their negative feelings and feel angry with me to give them a new developmental experience. Therefore, if given a questionnaire after each session, they would be unlikely to tick the smiley face often or 'totally agree' with the statement that the clinician made them feel better today on the form. This data would not be surprising and would only tell me something I already know: something is being worked through. So how could that data benefit anyone? Research tools must be just that, not interfering with therapy and not deskilling clinicians. Research should be used to support and enrich clinicians' expertise, i.e., be practice-friendly, not to diminish it.

For that reason, perhaps no one is better placed than clinicians to conduct research. However, the question is: where do you start and stop your job as a psychotherapist? How does one balance and integrate these different aspects of the work? How can I find a comfortable place to practice in the NHS with these additional tasks? I think this constant friction between attending therapy work and managing the broader organisational system represents the most challenging aspect of being a contemporary child psychotherapist in CAMHS. During the training, the geographical and time division between the psychoanalytic and research aspects of the training reflected a similar conundrum. Similarly to children adapting to a life with separated parents, finding a way to manage a sort of integration in the middle of this split was taxing. Indeed, the two institutions we relied on and needed to attend felt like a divorced parental couple. The motherly British Psychotherapy Foundation (BPF) felt more nurturing with its nourishing feed, its wondering thinking space –its reverie- and represented a safe base where my initial attachment lay, the therapeutic and psychoanalytic stance. On the other hand, the Anna Freud Centre, particularly after its relocation to its slick purpose-built, was somewhat more structured and demanding, representing more of a paternal function. Travelling between the two, mentally and physically, often left me feeling like I needed to cut myself in two to please both. One of the paternal functions in children's development is to help the separation process between child and mother. The training's research aspect has sometimes felt like a pull away from my primary task or allegiance, psychotherapy. It took a lot of thinking space and kept me from seeing the children on the lengthy waiting lists during my clinical hours. Like a child who wants his parents to talk and be united, seminars on the need to conduct research as psychotherapists would have been helpful for me to appreciate the link between the two better.

Similarly to the historical evolution of child psychoanalytic psychotherapy, my initial preoccupation as a therapist was mainly directed at the child's inner world. Still, it became increasingly evident that the family system around him/her needed attention to allow the child to progress. During my training, I learned that the environment around my practice also needed to be addressed, and research is one tool to do so. Research can indeed be exploratory and lead to clinical improvement. It can also help child psychotherapists gather fragmented information related to our practice and allow us to understand better the families with whom we work. However, research has limitations, as seen in the gap between the psychoanalytic realm and today's 'science'. Research can also be limiting when privileging this inexact science over clinicians' thinking. Referring to the increased integration of parents in child psychotherapists' work, Rustin talked of 'a shift in professional identity' (1998, p.233). We are perhaps seeing another change with child psychotherapists having to conduct research and integrate more managerial aspects in their work. As with the former shift, this new dimension needs to be considered and defined. Regarding parent work, my research told me two things. Firstly, as reflected in the fragmented literature and field, there is still no coherent theoretical or clinical framework for this work. Secondly, child psychotherapists feel unprepared and left to find their own way in the 'complex maze of working with parents' (Slade, 2008, p.211). Conducting research in the training might perhaps better prepare child psychotherapists for the current shift in their professional identity. However, my experience tells me that if we want to avoid the puzzlement of yet another maze, we need to explicitly address the rationale for this change and think about the new boundaries of our work. Besides, if research is to be an integral part of psychotherapists' role, adapted tools must be developed to fit their

needs. Yet, advocating for the need to accept that everything about being human and relationships can't be measured also seems essential.

References

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

Midgley, N., Ansaldo, F., & Target, M. (2014). The meaningful assessment of therapy outcomes: Incorporating a qualitative study into a randomised controlled trial evaluating the treatment of adolescent depression. *Psychotherapy*, *51*(1), 128–37.

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

Slade, A. (2008). Working with parents in child psychotherapy: Engaging the reflective function. In F. N. Busch (Ed.), *Psychoanalytic Inquiry book series. Mentalization: Theoretical considerations, research findings, and clinical implications* (pp. 207-234). Mahwah, NJ, US: Analytic Press.

Timulak, L., & Keogh, D. (2017). The client's perspective on (experiences of) psychotherapy: A practice friendly review. *Journal of clinical psychology*, *73*(11), 1556-1567.