My Child and Me:

A Qualitative Exploration of the Experiences of Parents Who Have Had a Child or Children Receive Psychological Therapy

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THE FOLLOWING PARTS OF THIS THESIS HAVE BEEN REDACTED FOR DATA PROTECTION REASONS:

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<u>Acknowledgements</u>

City University Declaration

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Section A: Preface

In this section I will give a brief introduction to each of the sections of my portfolio. The over-arching theme of this portfolio is the impact that mental health can have not just on the individuals who experience it, but on the people around them and their families as well. Research has shown that when someone receives psychological therapy, it has a reciprocal impact upon other people in their lives, including their families and significant others (Bedics, Henry and Atkins, 2005; Pereira, Lock and Oggins, 2006; Murray, 2007; Smerud and Rosenfarb, 2011). For me, it has been important to acknowledge the systemic effect that mental health difficulties have, and I felt this has been particularly poignant within children's mental health.

Section B of my portfolio presents an original piece of qualitative research that I conducted, which aimed to explore the experiences of parents who have had a child or children receive psychological therapy. A literature review had shown that there was a lack of research in this area that had been conducted in England, and I was keen to address this gap by conducting this research. Possible reasons for a lack of related research could be due to the negative attitudes that continue to be present within the UK towards mental health and psychological therapy (Scholsberg, 1993; Bailey, 1998), which are explored within this research and which may adversely affect the willingness of people to openly share their personal experiences.

I interviewed eight parents of children who had received a variety of different types of psychological therapy for a variety of different mental health difficulties. The children were all under sixteen years of age at the time they had received their therapy, and the parents who took part were all the primary care givers to the children at the time of their interviews. Interestingly, all of the parents who generously came forward to take part in this research and to share their stories were all mothers, and therefore I will refer to them as mothers and not parents. I used Interpretative Phenomenological Analysis to analyse my data (see Smith,

Flowers, and Larkin, 2009), and the aim of the research was to explore the individual experiences of these mothers to find out how they made sense of having a child receive psychological therapy. I also wanted to see if there were any shared elements of their experiences.

It emerged that there were four master themes present in the experiences of the mothers: The Augmentation of Closeness, Exploring What it Means to Have a Child with Mental Health Difficulties, The Journey of Therapy, and Negotiating the Role of Parenthood. Overall, it appeared that there were many shared elements to the experiences of the mothers. The mothers experienced an increased closeness with their child as a result of their experience, they outlined the perception of stigma that is present around mental health and psychological therapy and the impacts that having a child with mental health difficulties had on their own lives. The mothers also commented on the process and outcomes of their child's therapy, and how this experience had made them reflect on what it means to be a parent. I have discussed the results of this research in relation to previous research and theory, and also outlined the limitations of this research. I have outlined the implications for practice, and ideas for future research.

Section C of my portfolio presents a publishable paper that focuses on the themes of stigma and self-blame that were apparent in the experiences of the mothers who took part in my research. I chose to write a paper that focussed on these themes, as I felt they were a very significant part of the mothers' experiences, and held many shared elements between the mothers. Previous literature had shown the negative effects that the stigma around mental health can have on people, including reducing the likelihood that people would seek help, and having even more negative effects on people than the symptoms of the mental health problem they are suffering from (Feldman and Crandall, 2007). Previous literature also showed how parents, particularly the mother, is held responsible for their child's development and well-being, and that when children develop mental health problems, it is

often the mother that is blamed (van Mens-Verhulst, 1995; Sheppard, 2000) and the mother

often internalises this blame and engages in a process of self-blame (Furman, 1995;

Sheppard, 2000; Corrigan and Miller, 2004; Jackson and Mannix, 2004). Some of the

experiences outlined in the literature were present for the mothers who took part in my

research, and the paper focuses on these themes. I conclude the paper by giving a brief

outline of the implications, and of ideas for future research.

I felt that an exploration of the themes of stigma and self-blame highlighted the impact that

children's mental health had upon the mothers and tied in to the over-arching thread of my

portfolio. I chose to write the publishable paper for inclusion in a journal focussing on stigma

and its impacts, rather than for inclusion in a parent or child and adolescent journal, as

stigma and self-blame were the main themes explored. These themes highlighted an

extremely salient part of the parents' experiences, and I felt that this paper could offer a

unique and fundamental contribution within such a journal compared to how the impacts of

stigma have been previously explored within research and literature. The majority of

literature exploring the impacts of stigma focus on stigma from society against those who are

suffering from mental health difficulties, and less literature exists focuses on parents'

experiences of stigma with relation to having a child with mental health difficulties.

Section D of my portfolio includes a client study that I have chosen to present, which outlines

my work with a child whom I saw when I was in my second year of training as a Counselling

Psychologist. I used Psychodynamic Play Therapy with Rosie[1] to enable her to explore her

experiences of domestic abuse. I chose to present this client study as the therapeutic work

had a powerful effect on me, and enabled me to learn the importance of both supervision

and personal therapy throughout my clinical work. The relationship I developed with Rosie

and the transference and counter-transference I experienced whilst working with her fitted

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[1] I have referred to this client as "Rosie". However, this is a pseudonym, and all other names and identifying details in this client study have been changed to ensure anonymity and to protect client confidentiality.

well with the thread of this portfolio, as it made me reflect upon the impact that she, as well as her difficulties, had upon me both personally and as a therapist. I wanted to highlight this impact, and how it contributed to my development as a Counselling Psychologist. The effect that past events in the family environment and the subsequent difficulties Rosie was experiencing had had upon not just Rosie, but her mother and siblings as well, and how these had affected the relationship between Rosie and her mother, highlighted the systemic impact that mental health can have; effecting the individuals who experience it but also the people around them, their families, and the professionals supporting them, thus connecting with the thread of this portfolio.

The journey of my training on the Professional Doctorate in Counselling Psychology and the creation of this research has been long and emotional, one which has been marked by many positive and negative moments which have both interfered with the process of conducting the research and writing the portfolio, and also added to the essence of the process and helped to shaped my ideas, beliefs, and passion. There have been many occurrences throughout this journey that have shaped my identity both personally and professionally.

My interest in conducting this research has sparked from experiences that I have had during the clinical placements that I have completed as part of my training, as well as personal experiences that I have had throughout my own life. I feel very passionately about mental health and the impacts of mental health, and in particular the areas of children, parents, and families. I have worked in different areas using different therapeutic approaches with different client groups, but have found the work that I have done with children and their parents to be the most inspiring and to have influenced and shaped my epistemological standpoint. As I have outlined in more detail within the Methodology chapter, my epistemological standpoint lies within a version of the social-constructionist approach. I come from the view that meanings tend to be socially constructed via many different factors in society, including our culture and stories that have developed within our own family and

personal experiences (Hedges, 2005), which I feel to be of importance to consider when working with children and parents, and within mental health in general.

The over-arching thread of this portfolio of the impacts of mental health resonate deeply within myself and my own personal experiences with my loved ones. I feel honoured that I have had the opportunity to conduct a piece of research that explores the experiences of parents who have had children receive psychological therapy, and that I have been able to write a paper on the themes of stigma and self-blame that are experienced as a result of mental health difficulties. The process of writing a client study that explored a journey for both myself and my client has in itself also been a valuable experience. My journey, though thoroughly rewarding and life changing, has been difficult and challenging and I have reflected throughout this portfolio on the challenges that I have faced and how I have attempted to overcome them.

This portfolio aims to contribute to the theory and practice of Counselling Psychology by providing a deeper insight for practitioners who work with parents, children, and families into the impacts that child mental health can have, not just upon children but also upon parents and practitioners themselves. As discussed in Section B of this portfolio within the Introduction chapter, Applied Psychologists, including Counselling Psychologists, are increasing getting involved in the delivery of psychological therapies to children and their families. The piece of original qualitative research presented in Section B, along with the paper for publication in Section C, explore the experiences of mothers and highlight the prevalence of self-blame and stigma around child mental health difficulties. Along with my own reflections as a Trainee Counselling Psychologist on the impacts that my work with Rosie had upon me, this portfolio provides rich qualitative insights which can be considered by Counselling Psychologists within their work with children and families, and can contribute to practitioners' therapeutic and reflective practice.

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Section B: Doctoral Research

My Child and Me:

A Qualitative Exploration of the Experiences of Parents Who Have Had a Child or Children Receive Psychological Therapy

Supervised by Professor Carla Willig

Abstract

Previous research has examined general attitudes towards mental health. These attitudes have tended to be stigmatised, which results in a negative impact upon the individuals who suffer from mental health difficulties. When parents have a child who suffers from a mental health difficulty, they are also affected by these stigmatising views, and there appears to be a culture of blame placed upon parents, particularly mothers. When a child needs psychological therapy, the effects that parents can have upon their child's therapy have been well researched, but the effects that children's mental health and the receipt of psychological therapy has upon the parents has been less researched, and there is a significant lack of research conducted around this area in the UK. This piece of research aimed to address this gap and to explore parents' experiences of having had a child or children receive psychological therapy. Eight mothers were interviewed all of whom had a child or children under the age of sixteen years receive psychological therapy. A semi-structured interview schedule was used, and the data was analysed using Interpretative Phenomenological Analysis. Four master themes emerged from the analysis which highlighted how the mothers made sense of having a child receive psychological therapy; the enhancement of relationships, exploring the meaning of having a child with mental health difficulties, the journey of therapy, and negotiating the role of parenthood. These themes are further discussed, and links are made to relevant previous research and literature. The challenges of conducting this research are discussed, along with the strengths and limitations of the study and the implications for the field of Counselling Psychology and practice. Ideas for future research are also presented.

Keywords: parents, children, mental health, psychological therapy, IPA

Chapter One: Introduction

Within this introduction I aim to present a context for this research by examining previous literature and research that has been conducted in related and relevant areas. The wealth of literature that could be explored in relation to this research is vast, and I acknowledge that for the scope of this study I have presented just some of the existing literature that I found to be interesting and relevant, in order to provide the rationale for conducting this piece of research. I have chosen to present literature that is relevant in setting the context for this research, and have tried where possible to present both core and key research as well as the most recent literature available. In parts, some of the literature presented appears dated but still relevant to the key concepts and topics, and highlights important concepts which I felt essential to include. In places where multiple studies yielded similar results, I have grouped together citations to minimise repetition and duplication of concepts.

 I have presented the facts and figures for the prevalence of mental health problems among adults and children, and have examined the general attitudes towards mental health, including the concepts and effects of stigma and blame. The English dictionary defines the term "stigma" as a "mark of social disgrace", and the term "stigmatising" as to "mark as being shameful" (Stigma, 2013). I have therefore used these terms within these contexts. I have looked into literature related to the relationship between parent and child, and have further divided this into the areas of the mother-child relationship and the father-child relationship, as well as looking at the parent-child relationship as a whole. The mother-child relationship is more widely investigated than the father-child relationship. However, due to the complexity and versatility of modern day family systems, and the change of the traditional nuclear family with a mother and father set-up, I felt it important to acknowledge the roles that both mothers and fathers play with regards their children. This is why I chose to invite parents of both genders to take part in this research.

I have also looked at literature relating to how parents feel about their child's therapy, their expectations, and also how the parent can impact upon their child's therapy. I have finished this section by exploring previous research that has looked at the impact of children's mental health upon parents, and outlined a brief rationale for conducting this research. Although the area of literature to explore was vast, I chose to narrow it down into the areas outlined above as these areas provided the most relevant context and most significant background upon which my research was built and connected.

Attitudes towards mental health

Mental health is thought to comprise, among other things, subjective well-being, perceived self-efficacy, autonomy, competence, intergenerational dependence, and the self-actualization of one's intellectual and emotional potential. Mental health can be seen as paramount in affecting many other areas of one's life, and highlights the holistic importance of good mental and emotional wellbeing (World Health Organisation, 2001).

It is reported that despite the importance of mental and emotional wellbeing, and it being as important to people's overall wellbeing and functioning as physical health, mental health is not in most countries treated in the same standing as physical health. It is thought that less than one per cent of the total health expenditure in most countries around the world goes on mental health, despite mental and behavioural disorders making up approximately twelve per cent of the global burden of disease (World Health Organisation, 2001).

Among the most common health conditions are mental health problems, which are thought to affect, in any one year, approximately one quarter of the population (Mental Health Foundation, 2007). In 2000, The Office for National Statistics Psychiatric Morbidity Report suggested that approximately 450 million people in the world had a mental health problem (Singleton, Bumpstead, O'Brien, Lee, and Meltzer, 2001), and that of this number, only a small minority are thought to have received treatment. It has been further suggested that one

in four British adults have experienced at least one mental disorder, with one in six experiencing a mental disorder at any given time, and that it was likely that one in four families would have at least one member experiencing a mental health problem or behavioural disorder (Mario, 2005; The World Health Organisation, 2001).

Thompson (2012) suggested that one in ten children and young people aged between five and sixteen years of age have suffered from an emotional or behavioural problem that had a sufficient enough impact upon their wellbeing to cause either themselves or others to worry. Of these children and young people, it appeared only one in five would have been seen in specialist services such as Child and Adolescent Mental Health Services (CAMHS).

Westerhof and Keyes (2009) explored the concepts of mental health and mental illness, and proposed a two continua model. This model proposes that both of these concepts are separate and yet related, with one continuum denoting the presence or absence of mental illness and the other continuum denoting the presence or absence of mental health. It also needs to be further considered where mental health problems lie in relation to mental health and mental illness. Mental health problems or difficulties do not appear to be as chronic or severe as a mental illness, but do denote difficulties within mental and emotional wellbeing. Keyes (2002) described two states of subjective well-being and psychological and social well-being; a high level of both which is termed flourishing, and a low level of both which is termed languishing. A mental health problem would perhaps be akin to languishing, and experiencing a low level of subjective, psychological, and social well-being, and may be more easily addressed and alleviated than a more chronic mental illness.

There are unfortunately many negative attitudes towards mental health and those who need professional help for mental health problems and illnesses, and much stigma is still attached. It has been found that there is stigma and discrimination which originates not just from the general public around mental health, but also from professionals and practitioners who work

within the general and mental health systems (Scholsberg, 1993; Bailey, 1998). It is thought that while literature does exist into the existence and the impact of stigma in different countries (Fabrega, 1991; Wahl, 1999; Crisp, Gelder, Rix, Meltzer, and Rowlands, 2000; Stuart and Arboleda-Flórez, 2001), this literature is still in its adolescence (Pescosolido, Olafsdottir, Martin, and Long, 2013). Studies into mental health have called for more research to be done into the area of stigma across different social and cultural communities, in order to better understand where such stigma originates from, what the meanings of stigma are, and what the impacts are (Slu, 1989; Ng, 1997; Hopper and Wanderling, 2000; Caracci and Mezzich, 2001; Rutz, 2001).

The response to a community survey that looked at people's attitudes towards the presence of a local community mental health service suggested that there is still a great degree of stigma in existence (Huxley, 1993). The respondents to the survey were asked about their knowledge of mental health services, as well as their own personal attitudes towards mental health difficulties. In those respondents who actually knew someone who was suffering from a mental illness and receiving help, there was a lesser sense of embarrassment around stigma and mental health difficulties, although for many other respondents, despite there being a more open attitude towards mental health difficulties among them, stigma was still present.

A study was undertaken that examined the nature and extent of stigma against people who sought therapy for depression (Ben-Porath, 2002). Case vignettes were presented to undergraduates that were identical except for the last paragraph which outlined either seeking help or not seeking help, and depression or back pain. The undergraduates then rated the individual in the vignette on various personality dimensions. It was found that the people in the vignettes that suffered from depression were seen to be more emotionally unstable than those who suffered with back pain, and the depressed individuals who sought help for their depression were seen as especially emotionally unstable. These results

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highlight concerns that mental health difficulties may go untreated due to stigma against those who suffer with them, and the stigma against those that seek help.

A related study by Jorm and Wright (2008) in Australia aimed to look at stigma within the attitudes of young people and their parents towards mentally ill peers. A large scale telephone survey was carried out to assess stigmatised attitudes, also using vignettes which depicted depression, depression with alcohol misuse, social phobia, and psychosis. The prevalence of stigma was found in the forms of perceiving mentally ill people as being distant socially, being dangerous or unpredictable, being weak and not ill, perceiving stigma from other people, and a reluctance to disclose. The attitudes of the young people correlated with the attitudes of their parents, which suggests that children and young people's belief systems are strongly influenced by those of their parents. Therefore, accessing the beliefs of parents and working with parents around issues of stigma could potentially have a positive generational effect in the overall reduction of stigma.

It has been suggested that a possibility that such stigma around mental health still exists could be due to the way that the media portrays mental illness, in such a way that makes the public believe someone who has mental health problems will behave unpredictably, violently, or be dangerous. It may also be because, according to Arboleda-Flórez (2008), when someone walks down a busy street in a large city for example, they may come into contact with someone who is stereotypically mentally ill, leading them to believe that the existence of mental health problems can only have negative consequences and will inevitably lead to someone's demise. It is beliefs and portrayals such as this that create and perpetuate stigma around mental health.

Link and Phelan (2001) outlined the importance of addressing stigma by saying that it can affect an individual's ability to cope with their mental illness, produces stress, and could potentially leave them more vulnerable. It is also suggested that the effects of stigma upon

the individual can lead them to feel devalued and inadequate, can mark them as tainted and deprive them of their humanity, and can also cause their identity to be called into question (Crocker, Major, and Steele, 1998; Candall, 2000; Dovidio, Major, and Crocker, 2000; Pescosolido, Olafsdottir, Martin, and Long, 2013). The effects of stigma are thought to be so damaging that it may interfere with the process of recovery (Wahl, 1999; Markowitz, 2001), and is thought to be as harmful as the symptoms of the mental illness itself (Feldman and Crandall, 2007).

Verhaeghe, Bracke, and Bruynooghe (2008) suggested that stigmatisation against the mentally ill could negatively affect their self-esteem and their quality of life. They conducted a quantitative study using questionnaires completed by clients of rehabilitation centres, which examined whether peer support could buffer the negative association between self-esteem and stigmatisation. A negative association was found between stigmatisation and self-esteem, and a positive association between peer support and self-esteem. However, despite the finding that peer support could to some degree neutralise the negative effect upon self-esteem that came from stigmatisation, this only happened when little stigma had been experienced. For clients who had experienced many stigmatising experiences, the positive effects of peer support were not present to the same degree. The negative effects of the experienced stigmatisation were thought to have hindered any positive effects that peer relationships may have had for these clients. This further highlights the negative impacts that stigma can have upon people who suffer with mental health difficulties, and the need to address this within society.

It has also been suggested that there is a high correlation between self-stigma and feelings of shame regarding mental health difficulties. Self-stigma and shame were found to be more prevalent within men and younger adults, those with lower rating of mental health, and those who had not previously received psychological support (Reynders, Kerkhof, Molenberghs, and Van Audenhove, 2014). Self-stigma has also been found to reduce willingness to seek

help (Schomerus, Matschinger, and Angermeyer, 2009). Self-stigma could therefore potentially act as a barrier to accessing treatment, and the groups of people that are thought to be most vulnerable to suffering self-stigma and therefore to not accessing treatment would include young males. This would give a good indication of who mental health awareness and service promotion could be targeted towards in communities.

Not only is general stigma in existence against those who suffer with mental health problems, but there is also much stigma against parents whose children suffer from mental health problems. In society the parents, particularly the mothers, are all too often blamed for the causation and the development of problems within their children (van Mens-Verhulst, 1995; Sheppard, 2000). This could be due to the importance that psychoanalytic theory and attachment theory place upon the relationship between a mother and her children (Freud, 1933; Klein, 1952; Winnicott, 1962; Bowlby; 1969).

Parents, particularly mothers, are thought to feel increasingly guilty when their children suffer from mental health problems, and there is thought to be a common element of self-blame within mothers (Furman, 1995). The presence of stigma and the tendency for the mother to be blamed could possibly result in a process of the mother internalising the blame coming from society (Sheppard, 2000; Corrigan and Miller, 2004; Jackson and Mannix, 2004). The effects of having a child with mental health problems upon parents are outlined in more detail later in this chapter.

The relationship between parent and child

The relationship between parent and child has been one of the most researched relationships. Child development research has outlined the existence of a parent-child connection, which is seen as an active ongoing, dynamic, bidirectional relationship between parents and their children, emphasising the quality of the emotional bond and how this bond

is maintained over time (Maccoby, 1983; Kuczynski, 2003; Lezin, Rolleri, Bean, and Taylor, 2004).

Attachment theory suggests that there is a deep and enduring emotional bond connecting two people across time and space, specifically between a parent and child, and the first experience of attachment that an infant has will determine how that infant will develop (Bowlby, 1969; Ainsworth, 1973). Four main attachment styles have been outlined which consist of secure, insecure-avoidant, insecure-resistant, and insecure-disorganised (Ainsworth, Blehar, Walters, and Wally, 1978). These different styles of attachment between parent and child are thought to affect the psychological and emotional adjustment of the child (Bretherton, 1985; Hazan and Shaver, 1990; Carlson and Sroufe, 1995; Colin, 1996).

A wealth of literature also exists into parenting styles. Lezin, Rolleri, Bean, and Taylor (2004) suggested that there are different styles of parenting, the main ones being permissive parenting, authoritarian parenting, and authoritative parenting. Permissive parenting exhibits either high or low warmth and low levels of control, authoritarian parenting exhibits high levels of control, and authoritative parenting exhibits high levels of warmth with a moderate level of control. These different parenting styles, as with the different attachment styles, are also thought to affect children's wellbeing and their emotional and intellectual development. The authoritative style of parenting is thought to be most effective in promoting well-adjusted children who achieve the best outcomes, and is most beneficial to children's intellectual and emotional development (Lezin, Rolleri, Bean, and Taylor, 2004; Layard and Dunn, 2009; Field, 2010). This parenting style is often measured by combining the scales of warmth and responsiveness with control and demandingness (Baumrind 1971; Maccoby 1983).

Considering the effects that attachments styles and parenting styles can have on children, the parent-child relationship becomes thought of as a fundamental cause of both healthy and unhealthy development, and therefore leaves parents open to blame when their child

suffers mentally, emotionally, or developmentally. Most early research which tends to focus on the bond between parent and child tends to focus more on the maternal bond. Perhaps this is due to the pressure that women feel to enter motherhood, which could be associated with motherhood being a life choice that is presented as a historical social norm for women (Johnson, 2003).

In a paper examining the nature of a child's tie to his or her mother, Bowlby (1958) referred to object relations theory, which is the process of developing a psyche in relation to others in the environment during childhood. Bowlby discussed how a child's personality can be shaped by their experience of their first object relations. This tends to be the mother, and normally by twelve months of age infants have developed a significant bond to their mother. The nature of this bond was explained through the existence of four factors; the Secondary Drive, the theory of Primary Object Sucking, the theory of Primary Object Clinging, and the theory of Primary Return-to-Womb Craving. These theories are thought to be drawn from natural instinctive behaviour, through which a bond with the mother is formed due to her proximity to the child and her ability as a mother and as a female to provide the above factors. However, Bowlby (1969) acknowledged that the bond between mother and child could be created by any mother type figure, by anyone who mothered the child and was able to facilitate the necessary four factors, meaning the mother-child bond is not exclusive to the natural mother.

The mother-child relationship has been closely examined through the exploration of the effects of maternal deprivation, and how disruption in the mother-child relationship could have negative consequences (Bowlby, 1944; Rutter, Tizard, and Whitmore, 1970; Ainsworth, Blehar, Walters, and Wally, 1978). Such disruption in this fundamental relationship is also thought to cause difficulties with mental health, development, and attachment patterns (Freud, 1933; Winnicott, 1962; Bowlby, 1969; Klein, 1952; Beatie, 1988; Fonagy, Leigh Kennedy, Mattoon and Target, 1995; Schore, 1997). A child's motivation, attention,

academic achievement, and behaviour at school are also all thought to be affected by the mother-child relationship (Feldman and Wentzel, 1990; Harrist, Zaia, Bates, Dodge, and Pettit, 1997; Jacobson and Hoffmann, 1997; Pianta, Nimetz, and Bennett, 1997; Noom, Dekovic, and Meeus, 1999; Moss and St-Laurent, 2001; Morrison, Rimm-Kauffman and Pianta, 2003).

A study which looked at the quality of the mother-child relationship in relation to cognitive performance found that children's mental ability by the age of four years was significantly and positively correlated with an affective, close mother-child relationship (Estrada, Arsenio, Hess, and Holloway, 1987). It was also found that the quality of this relationship was correlated with the readiness of the children for school at age five to six, and the children's school achievement at the age of twelve years. Although this study highlights the complex nature of the mother-child relationship and the effects it can have on a child's mental development, it was conducted a relatively long time ago and the results may not necessarily be applicable to modern day school achievement and school practices.

Music (2011) outlined that despite the debate around nature versus nurture, it is now thought that neither nature nor nurture are more dominant than the other. However, certain patterns are in existence within children who have experienced a rupture in their early parental attachments. For example, Music suggested that children raised in orphanages that do not provide regular quality human interaction and contact will develop impairments in a range of developmental areas such as their language development and skills, their attachments to adults, and their ability to comprehend the psyche and emotions of other individuals. Music outlined the concepts of experience dependence and experience expectance. Experience dependence refers to the theory that an individual's brain will develop differently in relation to the types of early experiences they encounter. Experience expectance refers to the basic things that we as humans are naturally prepared to receive, such as the meeting of our basic physiological needs, that we require in order to flourish and develop.

The theory of mentalization has been described by Fonagy, Gergely, Jurist, and Target (2002) and Bateman and Fonagy (2004) as being the process by which our experience of the world is facilitated through a mental process of interpreting our own actions and the actions of others as meaningful, based on purposeful mental states including personal desires, beliefs, feelings, and needs. The development of mentalization is thought to be affected by early attachment, and children whose early attachments were poor or disrupted and who suffered abuse tend to have difficulties developing the ability to engage in the process of mentalization.

As the mother is often expected to be the primary caregiver to an infant possibly, as outlined previously due to her proximity to the child and ability as a female to meet certain physiological needs of the infant (Bowlby 1969), much emphasis is placed upon her to provide an adequate environment to the infant. She is expected to provide the necessary experience expectant inputs, as Music (2011) suggests, to enable her child to prosper and to develop the capacity for mentalization. It is suggested also that children can be protected from experiencing psychosocial and interpersonal difficulties through early experiences of mentalization from the primary caregivers, namely the mother (Bateman and Fonagy, 2004).

Literature also exists which examines the importance of the bond between father and child. Within classical Freudian psychoanalytic theory, the theories of the Oepidus and Electra complexes acknowledge the primary roles that both mothers and fathers play in the psychosexual development of sons and daughters. The Oedipus Complex and the Female Oedipus were developed by Freud (1924; 1949; 1956), and the Electra Complex developed by Jung (1970) as a manifestation of the Oedipus complex in girls. These complexes outline the psychological experiences that manifest within young boys and girls within their relations to their fathers and mothers, which are obligatory in order for them to develop a mature

sexual role and identity as they grow up. It is thought that the outcome of these complexes occurs when the young boy or girl reaches identification with the parent of the same sex.

More recently, the important role that fathers play in children's development has been examined. The interest in this area could be seen as relatively new due to the fact that in modern society, many mothers are now in full-time employment, and fathers are expected to take a greater role in taking care of children (Hochschild, 1989; Thornton, 1989).

The closeness of young adults with their fathers is thought to contribute to happiness, satisfaction in life, and lower levels of psychological distress, highlighting the importance of this relationship and the significance of the father figure (Amato, 1994). Paquette (2004) suggested that fathers make a unique contribution within the parent child bond, which has been termed the "father-child activation relationship". This relationship is thought to be founded upon the basis of physical play between the father and child, and is comparable to the calming mother-child attachment relationship, which in contrast provides the child with comfort and safety when the child is experiencing stress. Fathers are thought to help their children develop an openness to the world, and encourage them to take risks whilst in parallel being a figure of security. This enables the child to develop courage, confidence, and obedience through the emotional bond with their father.

Bronte-Tinkew, Moore, and Carrano (2006) conducted a study into the father-child relationship, and how this relationship and the parenting styles used by fathers affected the likelihood of adolescent risk behaviours. It was found that a positive father-child relationship reduced the likelihood that adolescents would engage in risky or delinquent behaviours. While the risk of adolescents engaging in such behaviours increased when the fathers executed an authoritarian parenting style, this negative effect was reduced depending on the strength of the relationship between father and child. The negative effects of a permissive parenting style were also reduced when the father-child relationship was positive. While this

research is suggestive of the positive and protective effects that a strong father-child relationship has on adolescents, the effects were found to be more prevalent within father-son relationships over father-daughter relationships. This suggests that there is a possible gender bias within the positive effects of father-child relationships.

It was interesting that much of the literature on the mother-child relationship focussed upon the importance of this relationship with regards to the negative effects and consequences a disrupted or ineffective relationship would have on children. In contrast, much literature that looked at the father-child relationship appeared to focus on the benefits of this relationship and how it contributed in unique ways to a child's wellbeing. Perhaps this highlights how central the mother-child relationship is, and how the mother is often put in a position of blame over the father when children develop difficulties.

Alldred (1998) suggested that gender specific terms such as "mother" or "father" tend to be used less frequently in recent literature than the overarching term of "parents". Even with less use of specific terms, these concepts are still thought to be laden with a gender bias, and gendered concepts are often used more frequently when there is a negative reference to parents, such as a judgement about being a lone mother or an absent father.

Raemakers and Suissa (2012) outlined how the concept of a nuclear family is much less prevalent than it once traditionally was, and that the shift to the use of the term parents as a plural, rather than a specific reference to mother or father, can be seen to be a result of the breakdown of the traditional family system involving one mother and one father and the gender imbalance within this system. They suggest that in a modern day era, the concept of raising children has become not just a role for a mother and father, but a role that expands out away from traditional biological relations to something which people of any gender, mix of genders, or any sexuality in any set up of relationship can take on. Perhaps this is why much of the literature and research examines concepts to do with parents, rather than

separating out specific gendered roles, despite the majority of studies having only mothers as participants.

Children's Therapy

It is increasingly being recognised how important therapy is for children experiencing psychological difficulties and mild, moderate, and complex problems, as outlined below by Wilkinson (2009). Regardless of the type of therapy offered to a child, the reasons for offering it will undoubtedly be the same; to reduce the problematic symptoms the child experiences, and to promote psychological wellbeing.

Emma Wilkinson, a health reporter for BBC News, reported in 2009 that Lord Layard, who was responsible for developing the Improving Access to Psychological Therapies (IAPT) service, had called for an increase in the training of child specialists. This call came under the justification that treating individuals' difficulties during childhood would reduce mental health problems experienced later in life (Wilkinson, 2009). Lord Layard also further suggested that access for children to evidence-based psychological interventions should be drastically improved, and this initiative was supported by The British Psychological Society (2009a).

Dr Jenny Taylor, the Chair of The British Psychological Society's Division of Clinical Psychology, sent a letter to Ed Balls, the Secretary of State for Children, Schools and Families. In this letter, Dr Taylor outlined that when working with children and adolescents with complex problems, applied psychologists are best placed to carry out not only the clinical work, but also to undertake training and supervision within this area. She suggested that applied psychologists possess a high level of research skills which are often underused, and that training for new therapists working in this area should aim to equip them to deliver a range of evidence-based approaches (The British Psychology Society, 2009a).

The service developments aimed at increasing access for children to evidence-based psychological interventions come after what was seen to be an increase in mental health difficulties in children in the UK between 1974 and 1999 (Collishaw, Maughan, Goodman, and Pickles, 2004). By delivering treatment through the use of evidence-based psychological interventions, the cause of these mental health problems and the contributing problems within society fail to be addressed, such as social disadvantage. It is thought that children who live in the poorest households are three times more likely to develop mental health difficulties than those from more affluent homes (Green, McGinnity, Meltzer, Ford, & Goodman, 2004), and that an individual's environment can contribute to the activation of underlying genetic vulnerabilities (Murphy and Fonagy, 2012). Cromby, Harper, and Reavey (2013) further acknowledge the complex relationships between social, psychological, and biological factors that underpin mental health problems.

Delivering treatment in a clinical manner and in clinical settings also fails to utilize other important areas in the lives of children and young people, such as community centres and schools, that could offer poignant opportunities and locations for further intervention (Schmied and Tully, 2009). Murphy and Fonagy (2012) also suggested that social media be utilised in the development of effective treatment delivery, which is ever more relevant in modern day society where the use of social media is prevalent. Even though the increased use of social media can be argued to have negative effects on individuals, Campbell, Cumming, and Hughes (2006) suggested that it is valuable in providing individuals with a social network and increasing people's social abilities, support, and even their self-confidence. Social media could therefore be utilised to increase young people's access to treatment and support outside of the clinic room.

Less emphasis within service development initiatives is placed upon those difficulties that are persistent within children and young people, such as autism spectrum disorders, and treatment instead focuses on more short-term interventions (Goodman, Ford, and Meltzer,

2002). There are also questions about the reliability of some of the research conducted to inform the current evidence base for psychological interventions, including methodological flaws, which make it difficult to generalise outcomes from the research setting out into clinical practice (Murphy and Fonagy, 2012).

There are many different types of psychological therapy which could be offered to children who are experiencing psychological difficulties, and different types of therapy are suggested for different presenting problems. A meta-analysis conducted by Weisz, Weiss, Han, Granger, and Morton (1995), looked at studies which used a variety of different types of therapies for children and adolescents. The main categories of therapy included in the meta-analysis were behavioural such as Cognitive Behavioural Therapy, non-behavioural such as Client-Centred, social skills, respondent, and modelling therapies. Psychoanalysis is suggested to be the longest and most established model of therapeutic work that has been used with children, although other approaches such Cognitive Behavioural Therapy (CBT) and Person-Centred approaches have utilized many of the core principles that have derived from Psychoanalysis (Daniels and Jenkins, 2010).

The National Institute for Health and Clinical Excellence (NICE) published guidelines regarding the types of therapy that should be offered to children. For example, for children suffering from depression, the NICE guidelines (The National Institute for Health and Clinical Excellence, 2005a) suggested that therapy should be offered in the form of cognitive behavioural therapy (CBT), interpersonal therapy, or short-term family therapy, and should be offered for a minimum of three months. The NICE guidelines for the management of post-traumatic stress disorder (PTSD) in children in primary and secondary care (The National Institute for Health and Clinical Excellence, 2005b), focussed upon the deliverance of Cognitive–Behavioural Therapy (CBT), eye movement desensitisation and reprocessing (EMDR), and supportive therapy in treating the psychological symptoms. Various research and case studies have been published showing the effects of the different types of therapies

(Axline, 1964; Cohen, Mannario, Berlinger, and Deblinger, 2000; Jaberghaderi, Greenwald, Rubin, OliaeeZand, and Dolatabadi, 2004; Adler-Nevo and Manassis, 2005; Morrison, 2009).

It is suggested that within their work with children, therapists need to address empowerment. This is due to the importance of children needing to be treated as individuals, children needing to develop certain skills in order for them to cope with problems in their lives and to help them to develop as individuals, and the essence of autonomy for children in allowing them to develop their sense of self and build their self-esteem (Daniels and Jenkins, 2010).

As later discussed in this literature review, importance is placed upon parental participation in some capacity in children's therapy for various reasons, and can be seen as being important in predicting the success of the therapy for the child (Delaney and Engles-Scianna, 1996). However, parental involvement is sometimes debated, especially within Psychoanalytic approaches, which suggest that the child should be the client and that the involvement of parents may restrict the child's ability to speak freely and to disclose personal or sensitive material, out of fear of the consequences of disclosure of this material to their parents (Daniels and Jenkins, 2010). This may have implications when family therapy is the choice of treatment, as during family therapy, children and parents are both included as active participants. Systemic Family Therapy is defined as "an approach to helping people with psychological difficulties which is radically different from other therapies. It does not see its work as being to cure mental illnesses that reside within individuals, but to help people to mobilise the strengths of their relationships so as to make disturbing symptoms unnecessary or less problematic." (Stratton, 2011, p.5). Possible implications are further discussed in the following section of the Introduction.

Parents and their child's therapy; feelings, expectations, and impacts
The NICE guidelines for depression in children and young people (The National Institute for Health and Clinical Excellence, 2005a) outlined that the treatment of children and young

people who suffer from depression should acknowledge the child or young person's wishes and needs, as well as those of the parents and carers, and that parents and carers should ideally be in involved in the process of making any decisions regarding the child or young person's care and treatment. It has further been outlined that parents and carers must give their consent in order for their child to have therapy (The British Psychological Society, 2009b).

Parents and care givers are a fundamental part of a child's therapy, especially for younger children. In a lot of cases, it is the parent who makes the decision that their child should be referred for therapy (Rosenbaum, 1994), and parents are often asked or expected to be actively involved in their child's therapy (Kazdin, Bass, Ayers, & Rodgers, 1990). It is also suggested that parents are essential for the continuation of their child's treatment, and of the improvements gained from the treatment after it has finished, and that parents can also have an effect upon the symptoms of their child (Nevas and Farber, 2001).

Bowen (1976; 1978) outlined eight connecting notions within the family system, which are thought to be a developmental sequence; Triangles, which refers to a relationship system consisting of three parties, where the third acts as a balance between the other two when they are in conflict, resulting in two sides being harmonious whilst one side is in discord; Differentiation of self, which refers to the difference in the extent to which individuals are able to separate their emotional and intellectual states and be autonomous, or to depend on other people for recognition and become highly fused; Nuclear family emotional system, which refers to patterns that circumscribe where problems may develop within one generation of a family; Family projection process which entails the diffusion of emotional problems onto a child from a parent; Multigenerational transmission process, which describes how a child's problems are intensified over numerous generations; Emotional cutoff, referring to how unresolved emotional issues are dealt with by cutting off the emotional contact with certain family members; Sibling position, the position of each sibling within the family and how

certain siblings may be targeted for triangulation; and societal emotional process, which ascertains that triangles are extended outside of the family system into everyday society.

Bowen's (1976) theory of family systems fed into the development of the existing notion of family therapy, and highlighted the importance of involving parents and children, along with other family members, within the course of therapy. Bowen was suggesting that individuals can only be understood as part of the family unit rather than in isolation, as all members of a family are interconnected and mutually dependent. This theory links with the function of family therapy, and the focus within this mode of therapy that presents a shift from an individual being the cause of a problem to an exploration of the family and dysfunction within this system (Foley, 1984).

Stith, Rosen, McCollum, Coleman, and Herman (1996) suggest that during family therapy, therapists do not always consider the wishes of the children regarding whether they want to be involved or not, or the children's thoughts and feelings about family therapy. They conducted research into children's views on their experience of receiving family therapy. Sixteen children aged between five and thirteen years were interviewed, and it was found that these children did want to be involved and to have a significant role in the family therapy, even during sessions in which they may not have been the primary focus. Whilst this appears positive, a dilemma may still be presented for therapists who are working with parents and children together in a family therapy setup with regards to confidentiality. The therapist must attempt to elicit trust from each member of the family by not colluding with or being covert about the secrets of one particular member, through almost becoming a part of the system in a process Minuchin (1991) referred to as "joining".

The parents of children who received therapy often have strong feelings about the therapy and the process, and it is important that the parent cooperates with and supports the child's therapy in order for it to be successful (Nevas and Farber, 2001). Parents' beliefs about the

therapy their child will receive can play an important role in whether the parent engages with the therapy, and with younger children it is usually the parents that are responsible for consenting to the therapy, possibly initiating the therapy, bringing the child to their therapy, and paying for the therapy if a fee is involved (Nock and Ferriter, 2005; Nock, Ferriter, and Holmberg, 2007).

Vogel, Michaels, and Gruss (2009) suggested that parental attitudes in general do influence children, from their childhood right through until adulthood. They further suggested that an individual's attitude towards therapy, and the process, is the main factor which will determine that individual's intention to seek the therapy. As parents' attitudes are suggested to have an influence on children, it is therefore further suggested that a parent's attitudes towards therapy could influence a child's willingness to seek it.

Chazan (2003) has a specific interest in simultaneous parent-child treatment, and outlines in her book that the dynamics of relationships within families will undoubtedly have an impact upon the child's therapy, and that successful change for a child cannot be achieved if the family dynamics do not allow it and are not supportive of it, no matter what the therapy entails. Chazan explains that this is paradoxical as the parent will bring the child for therapy in the hope that the therapy will help the child to achieve desired changes, but then as is the case sometimes, the parent may then disengage from the process leading the therapy to fail.

Nevas and Farber (2001) wanted to look at parents' attitudes towards their child's therapist and therapy. In order to do this, they conducted a small-scale quantitative study using 51 parents or carers, who had children aged between five and eleven years old. They distributed questionnaires which asked the participants to rate their agreement on a scale, to pre-given negative and positive statements across four measures, which regarded attitudes towards their child's therapy and therapist. They found that parents' attitudes were consistently positive, and that the parents felt their child's therapy was working. They

discovered mostly positive feelings towards the child's therapist, and positive feelings consistent across a range of variables. It was also found by Gerkensmeyer, Austin and Miller (2006) that parents' expectations about services were generally met, and they tended to report high satisfaction.

Nevas and Farber (2001) did suggest that the positive findings from their study may have been attributed to the fact that the parents who participated in the study all had children who had completed their course of therapy, and therefore saw the resulting benefits that the therapy had, which could have influenced their positive attitudes. It would be difficult to generalise the results to parents whose child had discontinued therapy mid-treatment. Another possible limitation of this study is its quantitative design. I have referred to the limitations of quantitative designs later in this section.

Kazdin, Holland, and Crowley (1997) suggested that premature drop-out rates for families who began treatment were between forty and sixty per cent, and they discussed the impacts premature termination of therapy can have. They further suggested that there was not one single factor which could determine whether or not a family would drop out of treatment, but a range of different factors. They conducted a quantitative study which focussed on premature termination from child therapy in outpatient services, and suggested that perceived barriers to participation in outpatient child therapy appeared to have a large effect on drop-out rates. They found that the main perceived barriers which increased the likelihood of premature drop-out included difficulties in coming to treatment, perceptions that the treatment is not relevant, and a poor relationship between parent and the child's therapist.

Another study measuring the impact of parental expectations on children's therapy found that parental expectations for their child's therapy which were not met resulted in a negative influence upon the continuation of treatment (Elliott, 1995). With regards to their

expectations, it was found that expectations around the characteristics of the child's therapist that were not met, for example if the therapist was perceived as less caring and involved than the parent had anticipated, resulted in a higher drop-out rate, along with unmet expectations around the needs for the therapy and the resulting benefits. It was found that expectations around the parent's involvement and support that were not met did not create a higher drop-out rate, suggesting that there was a combination of unmet expectations around the characteristics of the therapist, that worked together with unmet expectations around the impacts of the therapy, that affected the early termination of children's treatment by parents.

This study suggested that when children are referred for therapy, it is important to work with the parents to identify their expectations for the therapy in order to ensure the parents feel their expectations are being met, and if they feel they are not being met, this can be addressed appropriately by the therapist, to reduce the likelihood of early termination of the therapy by the parent. These findings correlate with the findings of Kazdin, Holland, and Crowley (1997), suggesting that there are common factors which predict whether parents will terminate their child's therapy. It has further been suggested that parents' beliefs about the effects that certain treatments and therapies can have for their child will affect whether the parent and the child attend and engage with the treatment (Nock and Ferriter, 2005).

Nock, Ferriter, and Holmberg (2007) conducted quantitative research looking at parents' beliefs about treatment credibility and effectiveness, and how this affected their participation in their child's treatment. Seventy-six parents completed a credibility/expectations questionnaire before their child commenced treatment, which measured the parents' beliefs about how convincing and necessary certain treatments were for their child, and the parents' beliefs about the improvements and benefits that would be achieved for their child through engagement with certain treatments. The focus upon treatment credibility and effectiveness in this study was due to the suggestion that most of the changes that are elicited from psychological treatments are often correlated with these factors (Kazdin and Wilcoxon, 1976;

Kirsch, 1990; Frank and Frank, 1991). This study found that parental beliefs about treatment credibility and effectiveness were significantly related to the parents' motivation for treatment for their child. These factors also significantly predicted whether the parents stuck to the treatment, affecting adherence even into the seventh and eighth week of treatment. This suggested that the early beliefs of parents have an effect upon not only if they engage with the treatment, but also on the treatment outcomes as well, highlighting a possible relationship between adherence and outcomes.

Many other studies have examined the effect of parental expectations on their child's therapy. For example, Schuman and Shapiro (2002) used two different interventions, aimed to further inform parents about the process of children's' therapy, and examined the effectiveness on the parents' expectations for the child's treatment, and the attendance rates. They found that a combination of showing parents a video-tape, plus giving them a brochure, increased the accuracy of their expectations, which in turn lead to higher attendance to the therapy, than of those parents' with less realistic expectations.

Morrissey-Kane and Prinz (1999) looked at the engagement of parents throughout the process of their child's therapy. They suggested that engagement was affected by parental beliefs about the cause of the child's difficulties, their perception of their ability to handle these difficulties themselves, and their expectations of how much therapy could help their child. It was predicted that parental expectations would influence attributions and engagement. It was found that expectations were not directly related to the engagement in the child's treatment. However, they also found that parental expectations seemed to be a mediating variable between the amount of sessions the parent brought the child to, and their attributions. The study provided support for an attributional framework in understanding some of the possible causes of engagement, and could be applied to services where families have been identified as being at risk from disengaging.

Similar studies have examined the effect of parental expectations and hopes for therapy outcomes with regards to different types of therapies, such as occupational therapy, rather than psychological therapy. Cohn, Miller, and Tickle-Degnen (2000) found that parents, from their child's occupational therapy, hoped for an increase in the child's social participation, that the child would learn strategies to help them cope with and self-regulate their behaviour, and for the child to feel more confident and competent. They also hoped to learn strategies that they could use in order to help their children, and to gain some validation from the professionals by feeling that the professionals understand the challenges that the parents faced. These hoped-for outcomes bear similarities to the hoped-for outcomes and expectations of the parents whose children were receiving psychological therapy. This could highlight the importance of managing parental hopes and expectations for any type of therapeutic input for children.

The previous research done into parental expectations and feelings about their child's therapy, and the impact and influence that can parents can have, shows that there are measurable factors that can predict whether the parent will initially engage and continue to engage with their child's treatment and lessen the impact of parents choosing to withdraw their children from therapy. Daniels and Jenkins (2010) suggest it is more helpful to engage parents in their child's therapy from the onset, in order to ensure the parents are supporting of the therapy. They also describe how unfortunate it is that some children never get the chance to access therapy due to parental barriers.

The majority of the outlined previous research used quantitative methodologies and collected data using surveys and questionnaires. While this makes collecting data from large samples of parents ideal, and enables statistical tests to be run to show significance (Pistrang and Barker, 2012), quantitative methods of analysis do not allow for the capturing of individual experiences. While these studies are therefore highly generalizable to large populations of parents, the true essence of the individual experiences of each of the parents

with regards to their feelings and expectations about their child's therapy are lost. Using questionnaires can be a reductionist method of data collection, and can be said to be an artificial creation by the researcher which only collects information within a limited range, and results in the researcher imposing their own meaning of what is and is not important when developing the questions (Popper, 1959; Ackroyd and Hughes, 1981). Therefore, the question would need to be raised as to how prevalent some of the measured aspects in the quantitative studies would have been within the parents' experiences of their child's therapy if they had not already been outlined as pre-set variables.

The Impact of Children's Mental Health and Therapy on Parents

Nevas and Farber (2001) suggested that there is much published literature which examines how the child has experienced their own therapy, such as that by Frailberg (1951), Freud (1974), and Tyson (1978). However, Nevas and Farber acknowledged the substantial lack of attention paid to the parents' experiences of this process. When a child suffers from mental health problems, the impact often extends beyond the child to the parents. This correlates with research that suggests that when an individual receives psychological therapy, it can have a reciprocal impact upon their significant others (Bedics, Henry & Atkins, 2005; Pereira, Lock and Oggins, 2006; Murray, 2007; Smerud and Rosenfarb, 2011).

There have been a few studies which have examined the experiences of parents who have had children suffer with mental health problems, suicidal behaviour, and developmental disorders such as autism and learning disabilities. Literature shows that these experiences are likely to cause an increase in stress for the parents and for the family system (McKinney and Peterson, 1987; Koegel et al., 1992; Dunn, Burbine, Bowers, and Tantleff-Dunn, 2001; Hauser-Cram, Warfield, Shonkoff, and Krauss, 2001). Most of the following studies were conducted in Sweden, one in Canada, and only two in the UK; one in England and one in Northern Ireland. This highlights a gap in UK based qualitative literature around this topic area.

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Daly (2005) conducted a phenomenological study looking at the effect of adolescent suicidal behaviour upon mothers, which was conducted in Canada. Daly used unstructured interviews with six mothers who all had an adolescent child who was exhibiting suicidal behaviours, and analysed the data using thematic analysis. The main themes that were found were failure as a good mother, the ultimate rejection, feeling alone in the struggle, helplessness and powerlessness in the struggle, cautious parenting, and keeping an emotional distance. Daly suggested that there was a profound feeling of multiple loss and unresolved grief within the mothers, highlighting how much of an impact their child's suicidal behaviours were having on them, and showing how important it is for professionals to consider the experience of mothers.

A study by McLaughlin, McGowan, O'Neill, and Kernohan (2014) in Northern Ireland further explored the lived experiences of suicidal behaviour on family members who were the primary carers. This study also used thematic analysis on the transcripts of eighteen participants, and found that there was one master theme of hard work for the family, and four subthemes of family burden, competing pressures, secrecy and shame, and helplessness and guilt. This study showed that the impact of caring for a suicidal person upon their family members was difficult and spread to other areas of the carers' lives, affecting both their everyday tasks and also their own emotional wellbeing.

Benderix, Nordström, and Sivberg (2007) conducted a study in Sweden which looked at the experiences of ten parents from five families who had children aged between ten and eleven years of age who suffered from autism and learning disabilities, who went to live in a group care home. This study highlighted that whilst the children were still living at home, the parents experienced negative emotions including sorrow and grief at their child's problems, and a heavy impact upon themselves and their families, including a feeling of being unable to control their child's behaviours and negative effects upon the siblings of the child and the

other family members. After the children had gone to live in the group homes, parents reported feeling a tension between being relieved at the care that the child was receiving, and also guilty that they had handed their child over into someone else's care. This study took into consideration the experiences of both genders of parents.

Pejlert (2001) explored the meaning of parental care-giving when there was a son or daughter in the family who suffered from a severe mental health problem, and lived within a care setting. The phenomenological and hermeneutic perspective of this study, which was also conducted in Sweden, highlighted the themes of living with sorrow, anguish and constant worry, living with guilt and shame, the comfort and hardships of care, coming to terms with the difficulties, and hoping for a better life for their child. There were mixed emotions that came out of this study, including both a feeling of comfort that the child was receiving good care, and also a cultural conflict between the system providing the care and the family, which was interpreted as a threat to the parental role. Within the process of trying to come to terms with the mental illness that their child was suffering from, the parents attempted to make sure they took care of themselves, and maintained a hope for their child's future. The parents also reported experiencing an element of stigma through the way that their child's mental health problem was labelled, and feelings of shame in their relations with both the public and the professionals involved in their child's care.

A further Swedish study by Lindgren, Åström, and Graneheim (2010) looked at the lived experiences of parents of the professional care given to their adult children who self-harmed, and also followed a phenomenological hermeneutic approach. It was found that within their experiences, the parents positioned themselves as being in a limit situation, which the researchers interpreted as being similar to being held to ransom in a hostage situation, and being in an unbearable situation that had to be resolved. Themes emerged around feeling trapped, lost, and searching for hope. The parents also felt that they were blamed for their child's self-harm, resulting in confusion, and the only feelings of respite that the parents had

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were thought to evolve from the moments in which there was some peace or a clear resolution to the problem, which gave them hope for their child's recovery. What these situations of moments of peace or of clear resolutions to the problems involved were not explicitly outlined within this research.

A further qualitative study was also conducted by Johansson, Anderzen-Carlsson, Ahlin, and Andershed (2010), also in Sweden, which looked at the experiences of mothers who had an adult child who suffered from a chronic mental illness. The mothers in this study reported that they were constantly thinking about their child, and that managing their child's mental health problems had become a long-term responsibility for them, resulting in the experience of situations which were full of uncertainty and sorrow for the mothers. It was also found that, similar to the above study, the mothers did report moments of feeling hopeful, and that understanding more about their children's difficulties led to an increase in their confidence in their own abilities to manage certain situations involving their children.

A recent qualitative study using IPA with nine mothers who had had an adult daughter in therapy was conducted by Kemp (2013) in England, who aimed to explore how this experience affected the mother-daughter relationship. The results suggested that the mothers were supportive of their daughter's therapy, and felt that they had seen benefits as a result of their daughter receiving therapy. The mothers reported that there were negative effects on the mother-daughter relationship, including an increase in the anger and criticism that their daughters displayed towards them, but that there were also positive changes such an increase in closeness within the relationship, and increased communication. The mothers appeared to spend time questioning what had caused their daughters' difficulties, which led them to feel emotions such as guilt, anxiety, and confusion. The results of this study highlighted similar experiences as the above studies that looked at the experiences of parents who had had both a child and adult child receive therapy.

The studies by Pejlert (2001), Lindgren, Åström, and Graneheim (2010), Johansson et al. (2010), and Kemp (2013) looked at the lived experiences of parents who had an adult child with a mental illness, although many of the experiences are comparable to those from the studies of parents who had a child or adolescent with mental health problems. The main findings that came out of all of the studies, regardless of whether the child was an adult child, adolescent, or younger child, were a variety of negative emotions for the parents including helplessness, powerlessness, grief, guilt, worry, stigma and blame. These similarities could suggest that the parental role and the pressures and impacts of having a child with mental health problems transcend the child's age and maturity, and continue to affect parents regardless of the child's age. According to Raina et al. (2004), being a carer for a child with a mental or physical disability is a role that will extend the course of the child's lifespan.

The qualitative methodologies of these studies provide rich and interesting insights into the impacts that having a child with mental health difficulties has upon parents. However, as previously outlined, there appears to be a lack of comparable studies of this nature carried out in the UK.

Rationale for the Research

The wealth of literature that exists around this topic, as suggested by Nevas and Farber (2001), examines how children have experienced their own therapy. There is less literature that concentrates on how the parent experiences having had their child in therapy. The majority of literature that does focus upon this area appears to include research that has been conducted in America, Canada, Australia, or Sweden. Whilst some relevant research conducted in the UK is in existence, there is a significant lack, which highlights a gap in the field of knowledge that I aim to contribute towards by conducting this research.

Furthermore, much of the previous research seems to focus upon certain aspects of a parent's experience. For example, many of the quantitative studies aimed to examine certain specific variables. Many of the qualitative studies focussed on a specific client group, such as parents of autistic children or children who displayed suicidal behaviours, or focussed upon certain aspects of the parents' experience, such as the impact upon the mother-daughter relationship. The present research aimed to widen out the client group and to explore the experiences of parents who had had a child or children receive a range of psychological therapies for a range of different mental health and developmental difficulties.

Counselling Psychologists are increasing getting involved in the delivery of psychological therapies to children, and are also encouraged to be involved in the supervising and training of others who deliver these services. As has been previously outlined in the literature review, The British Psychological Society (2009) showed its support for an increase in applied psychologists delivering evidence-based psychological therapies to children, and suggested that they had to desired tools and skills to implement this work most effectively. This therefore means that there is a strong relevance for this piece of research for the field of Counselling Psychology. I hope that this research will provide an interesting insight with which to aid their knowledge and practice, along with all other professionals who work in related areas.

By researching the experiences of parents who have had a child or children receive psychological therapy, it will give a greater understanding to all professionals who work in children's' services and with parents, and allow them to be more aware, more mindful, more considerate, and more knowledgeable of the experience for the parents throughout the whole process. The increased awareness and information that this research will provide to professionals will undoubtedly be beneficial in a variety of ways, whether it helps to identify common difficult experiences and highlight areas in which services could improve or change,

or whether it offers a greater understanding and appreciation of parents and how they make

sense of having a child suffer with mental health difficulties and receive therapy.

Chapter Two: Methodology

This chapter will aim to further discuss qualitative research and Interpretative Phenomenological Analysis (IPA), and my epistemological standpoint in relation to the choice of methodology used. I will outline the practical details and procedures executed within this research.

Research Aim and Design

This study aimed to investigate the research question "What are parents' experiences of having a child receive psychological therapy?" It does not aim to use the data collected to discover a theory about parents' experiences, and does not suggest that there may not be a range of different experiences, of which different factors may be of influence. Rather, the aim is to gain insight into the quality and texture of parents' experiences on the basis of close phenomenological reading of their accounts. A qualitative research design was used to investigate the question, and data was collected from a small sample of participants using a semi-structured interview schedule. This data was then analysed using an Interpretive Phenomenological Analysis framework (IPA) (Smith, Flowers, & Larkin, 2009).

Rationale for Choice of Research Methodology

In order to justify why IPA was the most appropriate form of analysis to use for this research, it is necessary to look at what IPA aims to do. IPA was developed by Professor Jonathon Smith, who is a Professor of Psychology at Birkbeck University in London (Birkbeck University of London, 2011). It has strong foundations in phenomenology, which is the study of experience, hermeneutics, which is the theory of interpretation, and idiography, which looks at the particular and the individual. IPA aims to examine the lived experience of individuals, and attempts to allow that experience to be defined in its own terms. It looks at each set of data in individual detail, before proposing any general claims (Smith, Flowers, and Larkin, 2009).

IPA primarily focuses on the lived experience, and any event or occurrence becomes an experience when it is important to the individual (Smith and Shinebourne, 2012). Smith and Osborn (2008) suggested that IPA is concerned with looking at an individual's experience of an event, situation, or occurrence, and aims to discover their individual meaning of this experience. Smith, Flowers, and Larkin (2009, p.202) similarly suggested that research using IPA could "offer a more detailed and nuanced analysis of the lived experience of a small number of participants with an emphasis on the convergence and divergence between participants."

Considering these factors, IPA was the most appropriate methodology to use for this piece of research. As this research was concerned with the parents' individual experience of having had a child or children in therapy, the exploration of the meaning of these experiences, how the parent makes sense of their personal meaning, and to discover if there were any shared meaning across these experiences, IPA offered appropriate analysis to fit with the main aim of the research. Any type of quantitative design would have been inappropriate and insufficient for capturing and reflecting aspects of individual experience. This is because not only does quantitative research aim to analyse data collected from large samples of participants, but it aims to look at data from a more statistical and numerical viewpoint, and enables a numerical summary of the data to be given in order to make comparisons (Pistrang and Barker, 2012). Quantitative approaches are also useful for manipulating variables and making generalisations about data (Yardley, 2000).

It could have been possible to analyse data around this idea using Grounded Theory, and Smith et al. (2009) suggested that Grounded Theory is in fact the main alternative method that researchers adopt when considering whether to use IPA. Charmaz (2001, as cited in Charmaz, 2008) stated that Grounded Theory involved a set of guidelines for gathering, synthesizing, analysing, and conceptualising date that has been collected qualitatively, in

order to build a new theory. She further suggested that Psychologists often use Grounded Theory to study individual processes, and that Grounded Theory can also be used to study psychological topics including personal experience and emotions. However, Glaser and Strauss (1967) outlined that Grounded Theory aims to discover theory from data, and that this theory cannot usually be replaced by a different theory. Smith, Flowers, and Larkin (2009) also outlined that Grounded Theory often uses a much larger amount of data, and usually aims to create a conceptual-level explanation of theory of a certain phenomenon.

This aim of this research was to examine the individual experiences of parents who have had a child or children in therapy, and aimed to interpret these experiences. It did not aim to use the data collected to discover a theory about parents' experiences, and did not suggest that there may not be a range of different experiences, of which different factors may be of influence, as discussed further in the problem statement and sampling considerations. In addition, IPA allows for the phenomenology that lets the researcher be reflexive within the process, and allowed me to explore my own place and position in relation to the research. Even though Charmaz (2001, as cited in Charmaz, 2008) argued that this was possible within her constructionist version of Grounded Theory, due to the time restraints associated with this research project, I felt that Grounded Theory would have been not have been an appropriate methodology to use and that IPA was a much more appropriate methodology.

Furthermore, it may have been possible to analyse the data for this research using Thematic Analysis. Thematic Analysis is used to look at patterns of meaning across a set of themes, which allows the researcher to explore shared meanings and experiences, and to find out what is common in the way that a certain area or topic is discussed, spoken about, or written about, and then goes on to make sense of those similarities (Braun and Clarke, 2012). However, IPA is more suited to not just looking at a pattern of meaning across a set of themes or a group of participants, but it also focuses upon the unique characteristics of the individual participants, and their individual meaning of their experience. As outlined above by

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Smith, Flowers, and Larkin (2009) IPA aims to look at data in individual detail before proposing any general claims and looking at common themes across participants' experiences. Furthermore, and perhaps most importantly, Braun and Clarke (2012) emphasise that Thematic Analysis is not necessarily an approach that would be used to conduct qualitative research, and that it is only a method of analysing data rather than a methodology. This is perhaps due to the fact that decisions about how to interpret the themes that are identified through a Thematic Analysis would still need to be taken.

Other methods of analysis including Discourse Analysis and Narrative Analysis would also not have been appropriate methods to use to conduct this research and to analyse the data. Discourse Analysis primarily focuses on the function of language; the way people use language to do things, and to construct versions of the social world (Potter and Wetherell, 1987). This method of analysis takes verbal reports from participants and regards them as "behaviours in their own right which should be the focus of functional analysis" (Smith, Flowers and Osborn, 1997, p.70). This research, whilst looking at linguistic details within the transcripts as part of the analysis process, did not aim to primarily focus on the function of the language in the data, nor the way that language was used to construct the social world of the participants. The linguistic considerations within the analysis only focussed upon how language was used to help the participants make sense of and apply meaning to their experience.

Narrative Analysis is an approach that looks at how humans use narratives and stories and to interpret and make sense of the world. It takes a social interactional approach to narratives, which includes focusing upon interaction on a local level, emphasising the contextualising power of narratives, and a commitment to social theoretical concerns (De Fina and Georgakopoulou, 2015). This analytic approach looks at how participants position themselves within their narratives, and what they do with their narratives. De Fina and Georgakopoulou (2015, p.3) suggest Narrative Analysis should be shaped by "ideologies,

social relations, and social agendas in different communities, times, and spaces" and takes a social constructionist view to identity. This approach would not have captured how the participants made sense of their personal meaning regarding the experience of having had a child or children in therapy, nor the shared meaning across the participants in the way that IPA allows.

Epistemology of IPA

Phenomenology

Phenomenology can be defined as a philosophical approach which is concerned with lived experience (Smith, Flowers, and Larkin, 2009) and the way things appear to individuals through the experiences they have with things or others in the world (Eatough and Smith, 2008). As discussed by Giorgi and Giorgi (2008), Snygg (1904-1967) came up with the movement of grass-roots phenomenology and coined the term "phenomenological". Snygg (1941) characterised this as "the world of the naïve, immediate experience in which each individual lives, the everyday situation of self and surroundings which the unsophisticated person takes to be real" (p.415).

Influential philosophers who shaped phenomenology included Husserl (1927), Heidegger (1927/1962), Merleau-Ponty (1962), and Sartre (1943/1956). Husserl (1927) was a philosopher whom founded the school of phenomenology, and for him this involved looking at human experience and the essence of experience. Heidegger (1927), a student of Husserl, continued to develop ideas around phenomenology and instead of focussing on individual psychological processes, Heidegger focussed on the question of existence itself (Smith, Flowers, and Larkin, 2009). Merleau-Ponty (1945), similar to Heidegger, came from the stance that our knowledge about the world holds an interpretative quality, but he went on to describe a more embodied nature of the relationships of individuals with our world. Sarte (1943), like Merleau-Ponty, was interested in a more interpretative and existential standpoint

with regards to the position of humans in the lived world, and moved away from descriptive and empiricist views.

Hermeneutics

Hermeneutics is the theory of interpretation. IPA does not take a purely descriptive stance to research and is heavily influenced by hermeneutics. Smith and Shinebourne (2012) outline that a level of interpretation needs to be applied to researching individuals' experiences and the meaning of their experiences. They state that hermeneutics first began by offering a guide for the interpretation of religious and biblical texts. Hans-Georg Gadamer (1990/1960) first discussed the philosophical meaning of hermeneutics in his work Truth and Method. For him, the theory of interpretation and understanding meaning involved both interpretation and application (Schmidt, 2006). Gadamer (1990/1960) built upon both Schleiermacher and Heidegger's views of interpretation. Schleiermacher offered a holistic view of interpretation by suggesting that there were two types: grammatical and psychological. Grammatical interpretation aimed to look at the exact and literal meanings of texts, while psychological interpretation is concerned with the individuality of the person who created the text (Smith, Flowers, and Larkin, 2009).

Heidegger (1927/1962), as described previously, proposed the concept of "Dasein", which translated means "being in the world", or "being there". Heidegger also used the term to refer to "perceiving the measure of other objects", and acknowledged that the way in which the world is made meaningful is through the use of interpretation (Spinelli, 1989, p.108). Heidegger therefore linked phenomenology with hermeneutics, as described by Moran (2000, p.229); "Phenomenology is seeking after a meaning which is perhaps hidden by the entity's mode of appearing. In that case the proper model for seeking meaning is the interpretation of a text and for this reason Heidegger links phenomenology with hermeneutics."

Smith and Osborn (2003) further described the idea of a double hermeneutic, which occurs when using IPA. The double hermeneutic involves a participant trying to make sense of an experience, followed by the researcher trying to make sense of the participant trying to make sense of the experience. This means the researcher relies on the participant's personal account of their lived experience, therefore making the researcher's process of sense-making a second order process (Smith, Flowers, and Larkin, 2009).

Smith, Flowers, and Larkin (2009) go on to describe the theory of the hermeneutic circle, which consists of the process of looking to the whole in order to understand any individual part, and then looking to the individual parts in order to understand the whole. This creates a dynamic and circular relationship within the process of interpretation, and provides an iterative relationship with data when conducting IPA research.

Idiography

Most other psychological methods, such as quantitative and psychometric methods of investigation, can be described as being 'nomothetic' and concerned with making claims about a large group of people and creating general assumptions about human behaviour. However, IPA is different in this respect as it aims to look at the particular, and uses smaller selective samples. IPA examines the particular by using a thorough systematic approach to data in order to capture a sense of detail, and also to examine how a particular lived experience is made sense of by certain people in certain contexts, in order to give a general sense of this experience as phenomena (Smith, Flowers, and Larkin, 2009).

IPA is well known for utilizing small selective samples of participants, via a process of moving from a single case to more general phenomena (Smith, Flowers, and Larkin, 2009). Single case-studies have also been used within IPA (see Smith, 1991; Smith, Michie, Allanson and Elwy, 2000; Bramley and Eatough, 2005; Eatough and Smith, 2006; Shinebourne and Smith, 2009).

Epistemological Standpoint

As outlined by Willig (2013), when we conduct research it is essential that we are clear about the goals and aims of our research and what it is possible for us to gain knowledge about. This is our epistemological position, and in this section I will address the epistemological standpoint I took throughout conducting this research.

There exists a continuum of epistemological positions, ranging from realist to relativist. A realist position adopts the view that our data should provide a truth about the world, while a relativist position concedes that there is no one truth, and that research should aim to explore the ways in which different versions of an experience are created. Positions in between include that of a critical realist, and of a phenomenological standpoint (Willig, 2013). It was hard to bracket myself into one such category, and I felt in agreement with Willig (2013) whom discussed how researchers can become too consumed by labels, and that it is more important to be clear with oneself what knowledge we seek and how we will conduct research in order to generate this knowledge.

However, I have to acknowledge how epistemology and ontology, which is concerned with the nature of the world and assumes that one will always make some assumptions, have influenced me throughout this process. The phenomenological epistemological standpoint resonated with me the most, with a viewpoint that experience is not fixed but rather constructed through interpretation (Willig, 2013).

What fits for the me most is perhaps a version of social-constructionist approach. Social constructionism takes the standpoint that meanings are socially constructed; "…feelings, emotions, the self and all aspects of our social worlds are culturally and historically constructed. We share some meanings with others of our gender and culture, but there may be other more relevant 'local' meanings/stories that have developed within our particular family or personal experiences." (Hedges, 2005, p. 28). Social-constructionism questioned

the positivistic approach, and research conducted from a social-constructionist approach aims to explore how different social realities are constructed (Willig, 2013). Research by Harré (1986), Potter and Wetherell (1987), and Parker, Georgaca, Harper, McLaughlin, and Stowell-Smith (1995) looking at various genres such as emotion, prejudice, and psychopathology highlight this approach. Smith, Flowers, and Larkin (2009) also highlighted that IPA aligns with a social constructionist approach, but takes a less stringent view of social constructionism than other forms of analysis, such as Discourse Analysis.

I had to acknowledge that I came into this process with underlying assumptions of my own, and already had at least some expectations about what the experiences of parents who had had a child or children in therapy might be, based on my own experiences working within children's services. Despite having some expectations about what this experience may be like, I took a more relative ontological standpoint and felt that there would be many interpretations that could be applied to the knowledge that would be generated through this research. I acknowledged that I was a "person-in-context" and had preconceptions (Larkin, Watts, and Clifton, 2006, p.108) but did not impose any preconceptions upon my data. I took a Heideggerian-like stance, and was prepared to change and adjust my preconceptions according to what emerged from the analysis of my data. I adopted the view that this piece of research would be a "co-production" between myself and my participants, and acknowledged that my part in the research may inherently play a part in the interpretation and the results (Burr, 2003, p.152). This is further described in the following reflexivity section.

<u>Reflexivity</u>

When considering reflexivity and how the researcher influences the process of the research and how meaning is structured, it is important to consider both personal reflexivity and epistemological reflexivity. Epistemological reflexivity involves the researcher thinking about the personal assumptions they have made throughout the research process, and how these

assumptions have impacted upon the research and the findings. Personal reflexivity involves the researcher reflecting upon how the research has impacted upon them as an individual, and also how their own personal beliefs, values and experiences have impacted upon the research and the research process (Willig, 2013).

Epistemological Reflexivity

I found it a struggle to balance out description and interpretation throughout this research, and felt at times I did not know if I was getting the balance right. When thinking about the positions of description vs. interpretation, Larkin, Watts, and Clifton (2006) suggested that they exist as two points on a continuum, upon which there are many different levels of interpretation. Therefore, I felt that there were times where I moved back and forth along this continuum. The descriptive stage felt safe for me, as I could stay close to my data, and although eager to interpret, initially I met moving into the interpretation stage with a little trepidation. I found Smith's (2004) description of IPA involving researchers basing their theoretical framework upon the participants' individual descriptions and perceptions, but also being allowed to move beyond and transcend this, as reassuring when stepping into the position of interpretation. Coming from a largely social-constructionist standpoint, I was eager to interpret my participants' conceptualisations, but was also cautious to remain true to their experiences. As outlined by Smith, Flowers, and Larkin (2009, p.37), IPA invites the researcher to engage in a combination of both phenomenology and hermeneutics; **"**without the phenomenology, there would be nothing to interpret, without the hermeneutics, the phenomenon would not be seen."

As mentioned within my reflections upon my epistemological standpoint, I remained aware of my own preconceptions when conducting this research. I adopted the view that this piece of research would be a "co-production" between myself and my participants, and acknowledged that my part in the research may inherently play a part in the interpretation and the results (Burr, 2003, p.152). Smith (2004, p.45) described a "biographical presence"

of the researcher, and suggested that the researcher's own experiences and personal resources are needed in order to make sense of what is present in the data. Whilst conducting the research and analysing my data, I remained aware of this and used my own preconceived ideas and standpoints as a source of insight, whilst attempting to also remain explicit about how these may shape my interpretations of my data, and my perspective upon my analysis. This process is discussed by Finlay (2008).

Personal Reflexivity

I experienced a sense of ambivalence when embarking upon this research. I am not a parent myself and I worried that people might question my motivation for wanting to explore the experience of parents. Although I am not yet a parent myself, I had different motivations for wanted to conduct research in this area, which were based upon previous clinical experience during placements and my own experiences during childhood. As a child, I had not felt listened to by my parents and had found this frustrating and hurtful, and felt that it affected my relationship with my parents. I had wanted to be listened to and understood by my parents, but as I grew older I found myself wondering what it had been like for them raising me, and the struggles they may have faced as parents. I had felt a sense of anger at them not attempting to connect with me and understand me, particularly as a teenager, which was balanced by feelings of guilt at knowing that they too must have struggled and perhaps not known how to reach out and connect with me. I also hope to be a parent myself one day, and by researching experiences of parents I hope to be able to better understand my own parents' experiences and also gain some insight in preparation for when I become a mother.

When I first started my training as a Counselling Psychologist, I knew my interest lay in the area of children, parents, and families, and my first and subsequent placements were a reflection upon this. I always knew that I wanted my research to lie within this area, but it took a lot of thinking and reflection to decide which area specifically I felt I wanted to research, that would also address a gap in previous research and therefore give a voice to

perhaps an underrepresented participant group. It was during my very first placement that

my research question began to take shape. I undertook a placement in a service which

provided Psychodynamic Play Therapy to children who had been witnesses or victims of

domestic abuse. This involved a high number of referrals from Social Services. Whilst

working within this service I had limited contact with the parents of the children, and this was

deliberate on the part of the service in an attempt to protect the relationship between the

therapist and the child. Two experiences struck me throughout the eighteen months I was on

placement; the high drop-out rates and the lack of engagement of the parents with the

service. This initially sparked my interest in why this was happening. Why were the parents

pulling their children out of therapy? Why were the parents not supportive of the therapy?

What was the experience of having a child be referred for psychological therapy really like

for the parents? I felt these questions to be essential to my belief that parents' attitudes can

affect the attitudes, beliefs, and feelings of their children, as has been discussed in the

literature review.

As also previously discussed in the literature review section of this research, much of the

research that was around at the time I was formulating my idea aimed to look at the

experience of the children who were receiving the therapy, the experiences within a family

therapy setting, or parent's experiences from a quantitative viewpoint and measured different

pre-set variables. The majority of literature that did focus upon this area appeared to include

research that has been conducted in other countries, or looked at the experiences of parents

with an adult child, which highlighted a gap in the field of knowledge.

A great part of formulating my research question came from a personal stance, reflecting

upon my own experiences as a child and what it had been like growing up with my parents,

and also a professional stance and wanting to understand the experiences of parents in

order to improve children's services. Due to my experiences within my placement and my

own personal familial experiences, I acknowledged I was coming into the research with

preconceived ideas that for the parent, the experience of having their child in therapy would be a difficult experience, one with which they may not have been completely amenable. When I initially started recruiting, I had wanted to explore the experiences of parents who had had a forced referral of their child for therapy. However, recruitment was a difficult process and I slowly began to realise that this group of parents did not want to speak about their experiences, and the participants that were coming forward to take part had a different view of their child's therapy and had come into the process from a different perspective. This is itself was an interesting and unexpected finding for me, and perhaps one that I could relate to more due to my own personal views on the benefits of therapy for children.

I found stepping out of the role of the therapist and stepping into the role of being the researcher throughout my research very difficult. Although I acknowledged that my counselling skills would in some ways be of benefit to the interview process, in the way that I would be able to attempt to build a trusting relationship with my participants and express enough empathy and curiosity to make them feel at ease when sharing such a personal experience, I also acknowledged that at times this wouldn't and wasn't always beneficial. There were times during the interviews that I felt, especially when listening back to my audio recordings, that I should have been more directive with questions or phrased my questions in a different way to address my research question, instead of being empathic and risking the relationship turning into a client/therapist relationship rather than a participant/researcher relationship. But there were also times in which I felt like my skills as a Trainee Counselling Psychologist enhanced my relationship with some of the participants, and allowed them to open up about painful parts of their experience that they may not have otherwise felt able to share.

This appeared to be struggle that as a researcher and Trainee Counselling Psychologist, I was not alone with. Dickson-Swift, James, Kippen, and Liamputtong (2006) conducted a study that found that it was common for qualitative researchers to find it difficult to manage

the boundaries between being a researcher and being a counsellor. The results of this study appeared to mirror my concerns about the therapeutic role within research interviews. Rizq (2008) also reflected upon how both the research interview and counselling required similar skills, such as empathy, rapport-building, and active listening. She commented upon the "protected space" (p.3) that is present in both a counselling environment between counsellor and client, and within the research environment between researcher and participant, during which someone discloses their personal and difficult experiences with someone whose role is to actively listen. Overall the researcher/therapist was a difficult balance for me to maintain, and throughout the whole research process I felt I have stepped back and forth and back and forth again into both of the roles of research and of therapist. What I felt was important was that I was aware of my feelings about this and was conscious of when I was stepping in and out of each role.

My own personal therapy provided a huge support to me throughout the research process, as it helped me to understand myself and my own beliefs and preconceptions and their origins. I was able to reflect more upon why this area of research was so important to me, and this understanding helped me to bracket off my own beliefs and experiences from the experiences of the participants, and to own them. I also found it helpful to keep a research diary through the process of my research in which I could log my feelings and struggles and reflect upon them.

Validity, Reliability, and Generalizability

The area of validity is often discussed within quantitative research, along with reliability and generalizability/representativeness. However, when conducting qualitative research, these areas cannot be so straightforwardly measured and applied (Finlay, 2006).

Validity is defined by Willig (2013, p.24) as "the extent to which our research describes, measures or explains what it aims to describe, measure or explain." Willig suggested that

qualitative can address validity in three different ways; qualitative research methods allow the participant to question and correct the researcher's construction of the meanings of what's being researched; qualitative research methods most often collect data from real-life settings, ensuring there is high ecological validity; throughout the research process the researcher is involved in a process of reflexivity, enabling there to be a continuous effort on the part of the research to evaluate their role within the research. All of these factors increase validity within qualitative research.

I also found it useful to approach the issue of validity within my research by reflecting upon the guidelines of Yardley (2000), who suggested qualitative research methods acknowledge that elements of subjectivity will come into play. Yardley's guidelines included paying close attention to the areas of sensitivity of context, commitment and rigour, coherence and transparency, and impact and importance.

Reliability refers to whether or not the same conclusion would be drawn from a set of data or a specific measurement on different occasions (Willig, 2013). Qualitative research, particularly IPA, is less concerned with reliability due to the fact that the aim is to explore a lived experience that could be unique. This is true of my research, which did not aim to discover a theory about parents' experiences or to suggest that there may not be a range of different experiences of which different factors may be of influence.

The generalizability of qualitative research is more of a questionable subject. My research did not attempt to make large sample generalisations about the data collected, or to present my findings as a universal truth, as would be the aim of a quantitative method. However, the aim of conducting this research was to understand what the experience of having a child or children receive psychological therapy was like for parents, and therefore to make a contribution towards the implications of this experience and how the findings could be usefully transferred. My justification for using a qualitative methodology may be explained by

Haug's (1987, p.44) suggestion that "if a given experience is possible, it is also subject to universalisation." The findings and meanings of my research may not be generalizable or representative in a statistical sense as would be required through a quantitative method, but are transferrable when applied to other situations, contexts, or people (Finlay, 2006).

Methodological Procedures

Sampling and Participants

This research aimed to recruit parents who had previously had a child, or children, receive therapy. As outlined in the research strategy, eight parents were recruited, including a parent who was initially recruited to take part in the pilot interview. The parents that took part in the research were recruited from a variety of sources, which are outlined in the recruitment methods section of the Methodology chapter.

The parents who were invited to participate in this research had to have had at least one child who had previously received therapy. The age of the child at the time of therapy would need to have been less than sixteen years of age. According to the HM Revenue and Customs "Decision Maker's Guide", the age of majority in England and Wales is age eighteen, but in Scotland is age sixteen. The age of majority, according to the Age of Majority Act (Canadian Legal Information Institute, 2000), is when an individual ceases to be a minor. The individual would then be granted the full legal rights and responsibilities available to an adult. As no nationality of participants was to be excluded, parents whose child was under the age of sixteen at the time they received psychological therapy, and therefore classed as a minor, were eligible to participate.

The child's therapy had to have already been participated in within the last five years at the time of recruitment, and not currently be ongoing. Five years was chosen as a benchmark by myself as I wanted therapy to have been completed fairly recently to minimise the impact of discussing a past, remembered event, but was also mindful that it may be difficult to recruit

parents who had had a child or children receive psychological therapy. Parents may not have wanted to openly speak about and share this experience, particularly if the referral for their child for the therapy had been a forced referral by the Local Authority, and so I had not wanted to make the timescale of the therapy participation too narrow for fear of not being be able to recruit enough parents.

Parents whose child or children were still currently in therapy were not eligible to participate in this research. This was in order to increase the validity of the study, and to encourage the participants to be honest about their experiences of having had their child in therapy. If therapy had still have been ongoing, there may have been a risk that participants may not have, despite the confidentiality of the interviews, been completely honest about their experience particularly if the experience was negative, due to a fear of the implications this may cause, especially if Social Services were involved in the referral for the child's therapy (Gerkensmeyer et al., 2006). However, I acknowledge that there could have been implications for using parents' accounts of a remembered event. The importance that is placed upon memory and the verbal reconstructions of memories and past events has been outlined in psychoanalytic theory (Heineman, 1998). Additionally, interviewing parents after their child's therapy had ended allowed them to reflect upon the experience as a whole, and to consider the effects of the experience both during the therapy and afterwards, which enriched the analysis of their lived experience of this event. Inclusion was not affected by whether the child had completed their course of therapy, or whether therapy was terminated prematurely for whatever reason.

The reason why the child was in therapy did not feature in the inclusion or exclusion criteria, although when conducting the interviews, and analysing the data, I remained mindful that the reason for the child being given therapy may have affected in some way the parents' experience of the process. Similarly, the type of therapy the child received was not included

in the inclusion nor exclusion criteria, although once again, it was important for me to bear in mind that this may have affected the experience for the parent.

The title of the research stated that it aimed to explore *parents'* experiences of having had a child or children in therapy. Therefore, both female and male parents were eligible to participate. The main selection criteria were that the parent who participated needed to have been the primary caregiver to the child who received therapy. Although it is possible that gender may have affected the experience of the parent, gender was not part of the selection criteria. This was due to the importance outlined in the literature of both the mother-child and father-child relationships, and also that in recent times the concept of raising children has become not just a role for a mother and father, but a role that expands out away from traditional biological relations to something which people of any gender, mix of genders, or any sexuality in any set up of relationship can take on (Raemakers and Suissa, 2012).

Flowers and Larkin (2009) suggested that it is advisable to find a homogenous group of participants, so that the psychological variability within that group can be explored and analysed. Although the gender of the participant may have possibility resulted in differences, homogeneity of the sample aimed to be achieved through each participant being the primary caregiver to the child who received therapy, and therefore all being in the same position whilst sharing this experience. However, interestingly so, only mothers came forward to participate in this research meaning that the sample used for the research achieved homogeneity through all the parents being mothers as well as being the primary caregiver to the child who had received psychological therapy.

Ethnicity and nationality were not exclusive, and I considered the practicalities and ethics of hiring an interpreter if the participant required one, and if the participant was unable to fluently and satisfactorily express their experiences in English. However, as all of the parents

who participated in this study spoke English and were either British or American in nationality, an interpreter was not required.

Recruitment Methods

Recruitment methods included contacting a range of private or charitable services that offered therapy for children (a letter to services is displayed in Appendix A). Services were located by recommendation through word of mouth, and also by searching for various services using internet search engines. One charity which offered emotional support to children, young people, and parents offered to advertise my research in their monthly newsletter. Although NHS services such as Child and Adolescent Mental Health Services (CAMHS) would have been ideal to provide a relevant sample of participants, they were not contacted for participant recruitment due to the requirement of NHS ethical approval. The time constraints of this research project would have made it difficult to apply for NHS ethical approval, and so this was avoided. This did not mean that some of the participants who took part in this research had not accessed NHS services and came forward to participate via an alternative recruitment method.

Some services offered to display a poster that I created (displayed in Appendix B) in the buildings where the psychological services were located, advertising my research and requesting participants. However, there was a possibility that this recruitment method could have only reached parents whose child was currently receiving therapy and not previous clients who would perhaps not still be visiting the building after their child's therapy had finished. I still used this method of recruitment as there was a chance that the poster may have been seen by parents whose children were coming to end of their therapy, and an interview could have been arranged for a date commencing the end of the child's therapy.

Other services were happy to spread the word of my research and to direct any potentially interested participants towards my poster, or a website that I had set up

(http://parentexperience.yolasite.com). I also asked people and professionals I knew to spread the word, and used internet sites to advertise for participants (www.facebook.com, www.twitter.com, www.mumsnet.com). An example of an advert used on such internet sites can be found in Appendix C. The majority of mothers that were interviewed had seen the advert for my research in a charity's monthly newsletter and contacted me to participate, and the remaining mothers had seen my research advertised on the internet and social media sites.

Recruitment of the eight mothers that participated in this research resulted in seven out of the eight having either a personal or professional background within mental health. This was interesting in itself and had not been intentional. It led me to reflect upon why it was that this group of people were more willing to speak about their experiences of having had a child receive psychological therapy, than those who did not possess a background in mental health. I have included discussion around my reflections within the Discussion chapter, and the possible implications that the recruitment of this group of mothers had upon the findings.

Semi-structured Interview Schedule

The research included in-depth semi-structured individual interviews with parents who have had a child or children receive psychological therapy, and were tape recorded. Interviews were used to collect data, which gave the participants a chance to tell their own story using their own language and words, as suggested by Smith, Flowers, and Larkin (2009). The main interview questions which drove the research are displayed in Appendix D.

The questions that were included in the research schedule were used to explore what life was like for the parents before, during, and after their child had received therapy, and to invite them to explore how this made them feel, and the impact the whole experience had upon them. Drawing from the findings in previous literature, I was keen to explore parents' experiences of how the whole process had affected them and their own lives as well as the

lives of their children, their experiences of the service and the therapist that had worked with their child, and their views upon the positives and negatives of the whole experience. It would have been interesting to have explored in more depth the parents' roles as professionals working within the field of mental health, and how they felt this may have impacted upon their experience. However, when designing my original interview questions, I had not anticipated that the majority of parents who would come forward to participate in the research would have had a background in mental health. Perhaps such questions could have been added into my interview schedule as my research progressed and my participant group became more defined. On reflection, it may also have been interesting to have collected more demographic information about my participants. I had chosen not to do this during recruitment, in an attempt to protect participant confidentiality and ensure anonymity.

Smith and Osborn (2008) suggested that when collecting and analysing data using IPA, it is most suitable to collect the data through semi-structured interviews, as this allows both the researcher and the participants to explore in more depth any areas of interest that come up during the interview, and to also have a certain amount of freedom to modify questions based on the participant's answers to the previous questions. They further suggested that conducting semi-structured interviews, rather than structured interviews, or other forms of collecting data such as asking the participant to keep a personal diary, allows rapport to be built with the participants, and to be guided by the interview schedule rather than dictated by it, therefore allowing the freedom to follow the direction in which each participant is taking their narrative, in order to attempt to enter the world of the participant.

The reason that the interviews were audio tape recorded was, as also suggested by Smith and Osborn (2008), that to conduct the type of interviews that are needed in order to analyse data using IPA would be impossible without tape recording the interviews. Trying to write down all that is said during a semi-structured interview would risk missing out important data, and could interfere with the building of rapport with the client, and also with the running of

the interview. The participants all gave their full consent to be recorded, and signed a consent form which included a paragraph detailing the terms of the recording, displayed in Appendix E. It was made clear to the participants that when they signed the form to give their consent to take part in the research, they were also consenting to their interview being audio recorded.

It was also made clear to the participants that their tapes would remain confidential in the sense that they will only be listened to by myself as the researcher, and no one else. However, there were limitations of the confidentiality, which are further discussed in the ethics and permissions section.

When I was considering how many participants to recruit, and how the long the interviews should last, I felt it important to consult the suggestions within existing literature. For example, Smith and Osborn (2008) suggested that qualitative interviews using IPA should usually last for an hour or more. In terms of participant numbers, Smith, Flowers, and Larkin (2009) suggested that for professional doctorate level research, the focus should be on the number of interviews, rather than the number of participants, and that the ideal number would be between four and ten interviews.

Bearing this in mind, for this piece of research I recruited eight participants who took part in one interview each. A pilot study was conducted before the rest of the research interviews commenced, which lasted for approximately one and half hours. The pilot participant met all the criteria for the clinical sample and took part in an interview conducted in exactly the same way as the rest of the research interviews, and using the same questions. The pilot participant was required to sign the same consent forms as all other participants, and her data was kept and will be destroyed in the same manner as all the other data.

After the pilot interview was completed, a discussion took place with the pilot participant about her experience of the interview, and the research questions asked. The feedback from this participant was then used to make necessary amendments to the way the subsequent interviews were conducted, and the research questions asked. However, as only minor amendments were made to the conduction of the interview, this participant's data was also used for data which was analysed for the research, and she became one of the eight participants recruited and interviewed.

After the interviews had been completed with each participant, they received a debrief. The debrief aimed to reiterate important information that was outlined when the participants gave their consent to participate, to ensure they understood and to thank them in writing for their participation. At the end of this debrief, there was also a page containing the details of various help lines and agencies which could offer the participants further support, should they have required it after their interviews. Additionally, I agreed to be available to phone the participant, if they required, approximately one week after the interview took place, to answer any further questions the participant may have had and did not ask during the debrief, and to encourage seeking further emotional support if necessary. However, none of the participants took me up on the offer of the phone call. Details of the debrief and examples of the services included for further support are displayed in Appendix F.

Transcription

Transcription commenced after the first interview was completed, in this case the pilot interview which was then used as an interview for the main research. The process of interviewing participants and transcribing the interviews happened in parallel. In each of the transcriptions, the process of looking for themes throughout each narrative occurred. Smith and Osborn (2008) suggested that it is advisable to begin by examining one transcript in detail first, before moving on to another, and therefore this was the approach adopted.

The transcription of the audio data from the interviews data was carried out by myself, the researcher, which enabled me to be a part of this process. Smith and Osborn (2008) outlined that transcribing data personally allows the researcher to enter into an enhanced interpretive relationship and engagement with the transcript. It additionally saved the expense of hiring an external party to transcribe, and also protected, as much was reasonably possible, the confidentiality of the participant, by not allowing any other party other than myself to access the raw audio data.

Ethical Considerations

When interviewing participants, I was aware that it was likely that they would reveal details about themselves, their children, and about the service through which their child received therapy. Therefore, I took care to alter any identifying details of the participants, of their children, and of the service from which they received therapy, to protect their anonymity. This was fully discussed with the participant before the interviews commenced, and was stated in the consent form which all participants signed (displayed in Appendix E). Smith, Flowers, and Larkin (2009) stated that researchers can only offer anonymity, and are unable to say that they can offer complete confidentiality.

It was also a possibility that discussing experiences of having had a child in therapy could have brought up sensitive issues, and a range of emotions, some of which may have been distressing for both the participant to talk about, and for myself to hear. In order to ensure the participants were contained and protected through this process, I was mindful to offer the research questions sensitively and gently, and used my counselling skills throughout all interviews. I also offered the opportunity for all participants to take a break from the interview, to terminate and reschedule the interview, or to terminate the interview completely, and would not have required the participants to state a reason for doing so.

I had the opportunity to, if I felt that I needed emotional support after conducting the interviews, to address this within my ongoing personal therapy, and also to discuss it with my research supervisor.

All costs of the research were met by myself. This included meeting the costs of the participants' travelling expenses, rent for private consulting rooms. An interpreter was not needed for any of the interviews but if this had of been necessary, the interpreter would have been required to adhere to the same agreement in terms of confidentiality as myself and my research supervisor, and would have been required to sign a copy of the consent form.

The audio of the interviews was removed from the recording device after each interview, and stored on my personal and private USB memory stick. The audio files were also backed up using an external hard drive. The data on both of these devices was encrypted and password protected. Electronic copies of any data relating to this research was also stored in the same way. All hard copies were stored in my private residence in a private room, and were locked inside a cabinet.

The data obtained in conjunction with this research has been used for the purposes of the research only, and has adhered to the Data Protection Act 1998. After this research is completed, the data will be kept for five years. This is outlined in the consent form to which all parties involved in the research consented to. The timeframe of five years will ensure that the data is kept long enough to allow the research to be published, but that it will not be kept longer than is necessary. After five years, the data will be destroyed appropriately. The ethics release form is displayed in Appendix G.

Analytic Strategy

The analysis of this research followed the steps advised by Smith, Flowers, and Larkin (2009). The first step consisted of reading and re-reading my data, whilst simultaneously

listening back to the audio recordings. This was with the aim of immersing myself in my data and to ensure that my participants were at the forefront of my analysis. Initial notes were then made on anything that appeared to be of interest. I made the initial notes in the margins of each of my transcripts. These initial notes included descriptive, linguistic, and conceptual comments, and I used a different coloured pen for each type – blue for descriptive, green for linguistic, and red for conceptual. The descriptive comments included noting the general content of the narratives, such as key words or phrases that were used, to begin to get an understanding of the main things that were of importance to the participants. The linguistic comments were focussed upon the types of language that was used by the participants, such as the use of metaphors, and also non-verbal cues such as pauses, stutters, or repetitions. The conceptual comments were the formation of the interpretive level of the analysis, and included me beginning to ask questions about what was emerging from my data and looking at the meanings of this and the participants' understanding and feelings. I also began to de-contextualize and deconstruct the meanings in the participants' narratives.

The third step of my analysis included identifying and developing any emerging themes. For each individual interview, I began to note down general themes on a separate sheet of paper for each participant, with the line numbers in the margin. Once completed, I went back through the list of these themes and began to try and organise them into groups and clusters of themes for each participant. I created a table for each participant with the possible themes, and included the line numbers from the transcripts. Connections and links across these themes were then identified in order to begin to identify possible over-arching master themes, a technique referred to by Smith, Flowers, and Larkin (2009) as abstraction. I began to group together individual themes which began the creation of my master themes. I tried to begin to label my emerging master and sub-themes by paying attention to essence of what was being said by the participants and staying close to my data, rather than being influenced by any preconceptions I might have had (Smith, 1999).

The process of polarization was also used at this stage, which involved looking at the emerging themes and seeing if there were any polarised differences within related themes that presented opposed feelings or views from the participants about a similar area. I also applied the processes of contextualisation and numeration to my themes. This involved me looking at key moments within the narratives of the parents to help identify connections between themes, and looking at the frequency of which certain themes were present within the narratives. I also examined the function of the emerging themes, such as how participants positioned themselves, and what the meaning of this was. These processes are outlined by Smith, Flowers, and Larkin (2009).

When the main master and sub-themes has been identified, I sectioned a large piece of paper into four parts each included one of my master themes. I then included each sub-theme under its relevant master, and began a process of collapsing down the subthemes, and highlighting the most salient sub-themes that made up the master themes. Some of the sub-themes at this stage were eliminated, and this process was difficult. I felt quite overwhelmed by the amount of data that this research had generated, and I wanted to attempt to do it justice by choosing themes that highlighted the essence of the experience that I had set out to capture, and showed a certain richness. The decision as to which sub-themes to merge and collapse, which would be eliminated, and which sub-themes highlighted which master themes was a decision that I had to acknowledge would in some part be influenced by me, and also by the aims of the research (Larkin, Watts, and Clifton, 2006). I have reflected on how I came to some of these decisions in the Discussion chapter.

Final tables were made for each participant highlighting quotes for each of the sub-themes that were present within their interviews, and then a final over-arching table which contained all of the participants' quotes and line numbers for each sub-theme. An example of an annotated transcript along with my initial noting and tables of my themes with relevant line numbers are displayed in Appendix H.

Terminology

Psychological Therapy

For the purposes of this research, I have used the phrases psychological therapy, therapy, and counselling interchangeably. Each of these phrases refers to what can be defined as psychological therapy. Throughout conducting this research, I have felt relatively torn about these phrases and which to use in what context. I was mindful that the word that I chose to use could have had different impacts upon my participants. Throughout the semi-structured interviews, I chose to adopt the term "therapy", as for me that best described what I was aiming to explore. Perhaps this was influenced by my training as a Counselling Psychologist, and how in much of my experience the words used to describe what I do with clients is more often referred to as therapy rather than counselling.

In a study conducted by Ridsdale, Godfrey, Chalder, Seed, King, Wallace, and Wessely (2001) that examined whether counselling was as good as Cognitive-Behavioural Therapy for chronic fatigue syndrome, a distinction is outlined between the two terms "counselling" and "therapy". Counselling is usually described as non-directive and client-centred, and aims to create an environment where the client feels able and safe to talk, and to engage in a process of understanding themselves better. Therapy is often viewed as more directive, and frequently includes a clear rationale for the treatment based upon on a thorough assessment and formulation of the problem, and involves the use of direct evidence based interventions.

Many of the participants used the term "counselling" within this current piece of research. Whether or not they made the distinction between counselling and therapy and viewed them as different processes was not clear in most cases. Only one mother reflected upon her personal distinction between the two terms. Perhaps during the interviews, it would have been more sensitive of me to adopt the individual language and phraseology of each of my participants, which could have possibly given me richer data.

Child/Children

I have used the terms child and children to describe any person under the age of 16 years.

These terms are inclusive of young children and adolescents.

Chapter Three: Results

In this chapter I will discuss and explore the results that came from the data analysis of my research. Four main master themes emerged from my analysis, which each included a number of sub-themes. These themes are described in detail in this chapter, and the master themes with their coordinating sub-themes are displayed below.

Table 1. Master Themes and Sub-themes

Master Theme One: The Enhancement of Relationships				
The Augmentation of Closeness	Connectedness	The Flow of Communication		
Master Theme Two: Exploring the Meaning of Having a Child with Mental Health Difficulties				
The Impact of the Difficulties	Perception of Stigma from Others	Reflection of Personal Attitudes	A Quest for the Origin	The Burden of Responsibility
Master Theme Three: The Journey of Therapy				
Finding the "Right" Therapist	Handing my Child Over	Seeking Own Support	The Balance of Outcomes	
Master Theme Four: Negotiating the Role of Parenthood				
The Role of a Parent	The Origin of Values			

Although this research generated a wide range of data, I have spent much time trying to organise the emerging ideas around the participants' sense making into sub-themes, and collapsing the various sub-themes into the four master themes. Inherently there was some

overlap in some of the themes, and some deliberation on my part as to which sub-theme best fitted in to which master theme, as at times it appeared as though one sub-theme could fit into a couple of the master themes, and I had to use my judgement to decide what the essence of the subtheme was. What I have achieved will hopefully be a sound reflection of what having had a child or children receive psychological therapy was like for the parents who participated in this research. I hope that I have given them a voice and done their experiences justice, and that this research will be used in the future by professionals working in children's services and family services. I also hope that my research will generate an avenue for further research to be done into this area.

The children who received psychological therapy were a mix of daughters and sons, and there were a range of reasons why the children received therapy, including an eating disorder, specific phobia, depression, anxiety, and suicidal thoughts and tendencies. The children received a range of different therapeutic approaches, and the age ranges of the children varied from toddlers to teenagers. All the children and teenagers were under 16 years of age at the time of their therapy, and their therapy had occurred within five years at the time of their parent's interview, and had already ended at the time of the interviews.

I have used direct quotes from the interviews with my participants in order to enrich and to bring alive some of the themes. I also wanted to ensure I used the participants' voices to illustrate the themes. Each quote is illustrated in bold, followed by the participant's name and the line numbers of the quote from the transcript. These quotes have, where possible, been taken in verbatim from the participants' interviews, although on occasion I have had to slightly alter some of the quotes in order to improve readability. This has only been when part of the audio recording has been poor quality and the exact wording could not be clearly heard, when an extra word may have had to be added in order to make the quote more readable, or when part of the text has had to be omitted in order to protect participant confidentiality. The following symbols and their meanings are depicted below.

Table 2. Symbols and Their Meanings

Symbol	Meaning
" "	Quotation marks depicting the beginning and end of a quote
' '	Quotation marks depicting a quote within a quote
****	Text omitted to preserve anonymity and confidentiality
….	Dialogue trailing off (at the end or middle of a sentence) or picking back up (at the beginning of a sentence)
(.)	Pauses and silences
-	Interruptions
[ ]	Words added by me to ensure readability
(italics)	Non-verbal cues

I have briefly introduced my participants in Appendix I, to give some context to their backgrounds, although I have chosen to keep introductions succinct in order to protect the anonymity of my participants. All the names used are pseudonyms that were either chosen by me or by the participant parent, and identifying details have either been omitted or anonymised. As all the participants were mothers, I will refer to them as mothers rather than parents throughout the rest of this chapter.

Master Theme One: The Enhancement of Relationships

The relationship between the parent and the child who had received therapy appeared to be an important factor for some of the mothers throughout the journey of their child receiving therapy, as were the relationships between family members in general. The mothers commonly reported that there was a close relationship between themselves and their child which was only enhanced throughout the process of their child receiving therapy. Some mothers reported positive relationships within the rest of the family as well, and that these relationships only strengthened during and after the experience of their child suffering a mental health issue and receiving psychological therapy. Some mothers spoke about varying relationships within the family, and that not all the relationships were close. The relationship and bond between the mother and the child receiving therapy was often discussed by the mothers, and a special relationship between the participant mother and the child who received therapy was also mentioned by a few of the mothers. This was described in the sense of this relationship enabling the mother to know her child inside and out, better than anyone else, and thus knowing what was best for her child in terms of help. Communication was also an important subtheme, although the level of communication seemed to vary within the different relationships between the mothers and children.

The three sub-themes of the augmentation of closeness, connectedness, and the flow of communication that make up this master theme highlight how the majority of the relationships between the mothers and their children were positively affected by the experience of suffering with a mental health problem and receiving therapy, and were enhanced and strengthened. Different aspects of the relationships between mother and child were also enhanced in most cases, such as the moments of communication.

Augmentation of closeness

The relationship between themselves and the child who received psychological therapy was described by some mothers as being close to begin with, and that this relationship was only

enhanced and made stronger by going through the process of therapy. Despite all of the difficulties that were described by the mothers, such as difficulties caused by their child's problems or how hard the process of therapy was, the relationship was something that was often described favourably and it appeared that this experience had pulled the mother and child closer together, as well as other members of the family in some cases.

> **"I'll say again, it just got stronger, it didn't get…and I hate using that word cuz it sounds like it wasn't strong to begin with. Erm, it is strengthened even more, is how I should put it... Yeah. So it's strengthened that which was strong and made it stronger."** (Ruby, 1012-1019)

Ruby emphasised the strength of her relationship with her daughter Lucy and that this was an important factor for her. She appeared protective of the fact that the relationship had always been strong and was careful to word, reword, and repeat her description of the existing strength and the strength that ensued, and appeared keen to emphasise this to me during her interview. She further explained that maintaining the relationship between herself and her daughter Lucy was the most important thing to consider throughout her experience of Lucy receiving therapy. Ruby described the relationship between herself and Lucy as if she wanted to protect, preserve, and maintain this relationship through all of Lucy's difficulties and therapeutic input, and that this relationship was sacred to her.

As well as herself and Lucy, Ruby described her whole family as very close and bonded and that she had felt it was this bond that had gotten them through Lucy's therapy successfully as family.

> **"I think, again I'm embarrassed to say but I'm going to say it, I think that a lot of families envy our family unit. I think we are very, erm,**

connected to one another. I think there's a lot of very equal

relationships in all different directions." (Ruby, 1005-1007)

The repetition of Ruby's descriptions of strength and balance within these relationships highlighted how integral this was to her, and how much of a role this played in them as a **"family unit"** getting through Lucy's problems and treatment together. Ruby also mentioned the relationship between Lucy and her brother as being strong, which enabled her brother to accept being a part of Lucy's therapy. Ruby mentioned that her son had not wanted to be part of the family therapy sessions, and had almost expressed a hatred at attending, but had done so out of the love for his sister and the commitment they had as a family to pulling together to help Lucy recover. In the following quotations, Ruby speaks for her son.

" 'I'll do anything…and I know you're trying to help my sister and I'll

do anything but, to be honest with you, I'd rather be doing sport at

school and I hate sport.' " (Ruby, 1086-1088**)**

"He absolutely loves her; she absolutely loves him." (Ruby, 1093).

Michelle and Lindsey also discussed their relationships with Sofia and Ben, and both described relationships with their children that were good and close before their child received therapy, and that the whole experience had not changed this closeness.

"We've always been close, that never changed at all…" (Michelle, 670)
"Erm, [our relationship] was good, erm, but at that point it was

probably good before as well." (Lindsey, 1841)

For Michelle, her relationship with her daughter Sofia was important to her and she reflected on the fact that it had been the lack of closeness in her relationship with her own parents that had made it so important for her that Sofia felt close with her.

> **"...we've never been close with like our mum or dad; close in some ways but not close like my daughter... I'm not so close with the older one. But, you know, it's never been that close relationship that I could tell my mum about boyfriends. I couldn't do that. Then that's why I want to be more close with Sofia…"** (Michelle, 1201-1207)

Michelle, unlike Ruby, went on to describe her family not as a family unit or as such a close bonded family, but mentioned that there were varying relationships within the family. She described her two daughters as being close with each other but that their relationship was also at times conflicting. Michelle said her relationship with her oldest daughter Anastasia was also conflicting and difficult at times, and that these conflicts may have impacted upon Sofia and caused Sofia to bring this tension to her therapy sessions.

> **"[Anastasia] like looked after [Sofia] for me as well when I was working, you know after school so they've got a good bond but again it's a bit, sometimes Sofia says like 'you're not my mum you can't tell me what to do', you know, [Anastasia] tries to… take over a little bit which I think [Sofia] brought up in the therapy as well."** (Michelle, 185-191)

Michelle also mentioned that Sofia's relationship with her father was also not a close relationship, but that her father did remain informed about Sofia's life and difficulties through Michelle. There appeared to be something more for Michelle about closeness than simply having knowledge about your child's life.

> **"...she doesn't feel that close with her dad, you know, even though I tell him what's going on but he doesn't really get involved but he knows what's going on."** (Michelle, 271-272)

Stephanie also spoke about how she had a close relationship with her daughter Keira, but that Keira had not had a close relationship with the rest of the family members. During a feedback session with Keira's nurse, Stephanie said that she had told her that Keira had spoken about issues to do with her relationship with her father and brother and sister, and that the relationship with her mother was the only close relationship that Keira felt she had among her family members.

> **"...she told me a lot of things that Keira had said about her Dad (.) Erm, how excluded she felt by her brother and sister, er, and that really I was the only one that my daughter felt that she was close to in the entire family."** (Stephanie, 220-223)

Pat spoke about how she was close with her daughter Amy. She described a closer relationship with Amy than she had with her son, and seemed to attribute this to Amy being a girl and them having a certain mother-daughter relationship that she was not able to have in the same way with her son. Pat also spoke about how the difficulties that Amy had gone through, and Pat being able to see her come through them and come out the other side made her relationship with Amy special, and that this whole experience had really made her feel closer to Amy.

> **"...even though I have a son who has been a doddle, an absolute doddle, he's never given me any trouble at all. Because it's been so easy, erm, as much as I love him in different ways, the sense of**

achievement and reward and pleasure for my daughter is very

intense, compared with him." (Pat, 226-229)

"I think it's because she's a girl as well. We share all that girly stuff."

(Pat, 233)

The mothers, in general, reported a close relationship with the child who had received therapy, and that the experience of their child having difficulties and receiving therapy had strengthened that relationship. The mothers did talk about varying relationships within the rest of the family. Some said that all of the family was close, whereas other mothers reported not such close, and at times conflicting, relationships between other family members.

Connectedness

Some of the mothers spoke about how as a parent, they felt a unique connection with their children. For some mothers, this manifested in the way that they believed that they experienced the same things as their child whilst their child was suffering, and perceived their emotions to be mirrored. This theme was also described by some mothers as a dual journey, a journey that both the child and the mother went on together despite the child being the one who was directly affected by their problems. Ruby said of her experience, **"…it did end up being a journey with duality to it."** (Ruby, 992).

It appeared that there was an element to the relationship between the mother and the child that enabled this connection and this parallel process to occur, and for the mothers to feel and experience what they perceived their children to be feeling and experiencing. There was also an element that through this connection, the mother really felt like they knew their child better than anyone else. Ruby for example described the connection between her and Lucy as something which almost transcended reality.

"I am so in tuned with my children that I have a certain link to them that's not real, it's almost psychic." (Ruby, 724-725)

She also described a parallel process between herself and Lucy by opening up about a very powerful vision she had one night, and even her description of it touched me and affected me in such a way I had a lump in my throat as she spoke. Ruby described that one night she had been awakened by a vision of Lucy as a young child standing at the bottom of her bed staring at her. Ruby said the young Lucy had indicated that she should follow her, but that when she followed her down the stairs, she disappeared. Ruby said that her bedroom was upstairs and that Lucy's bedroom had been downstairs, and she had seen that Lucy's bedroom light was on and so had gone in to tell her what had just happened. Ruby said that she found Lucy sitting on the edge of her bed contemplating suicide, and that Lucy had asked Ruby why she was there. Ruby had told Lucy that she had come up to get her, and that Lucy then began to cry and said that she had been thinking in her head that she had wanted her mum to come to her.

"…it was almost like her inner child coming to get me. I mean most people will think I'm absolutely cooked, but I actually think that happened and I'm grateful that we were that in tune, that whatever that was, I don't understand it, whatever it was, it happened." (Ruby, 740-744)

Ruby made sense of the vision by saying that it could have been Lucy's inner child coming to get her. She had expressed that it had not necessarily been a focus of hers to explain what this experience was and that she had not really understood it completely herself, but that she believed it had happened. This experience appeared to have shown Ruby the power of her connection with Lucy and the duality of their journey. She further made sense of this embodied experience by saying that Lucy had been battling with herself whether to

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end her life and that the connection she had with Ruby enabled a part of Lucy's soul to reach out for help.

"The pull to leave and the pull to stay, it was such a polarisation of souls that maybe one split away and came to get me." (Ruby, 760-762)

Furthermore, Ruby spoke about experiencing physical effects that mirrored the behaviours that Lucy was exhibiting with her eating disorder. The effect of travelling this dual journey together as parent and child, and of Ruby's perception of being so connected with Lucy she felt the same things, resulted in Ruby almost exhibiting the similar effects of an eating disorder.

"And so at one point I was, not anorexic, but I was struggling to swallow food..." (Ruby, 573)

The tension between the pull to leave and the pull to stay for Lucy, and the occurrence of Ruby's powerful vision of Lucy was interpreted by Ruby as evidence of the strength of the connection she had with her daughter, and that her daughter had been reaching out to Ruby to come and help her. Having Lucy suffering from an eating disorder, and being so distressed and suicidal had such an impact upon Ruby that as described above, she had begun to experience similar physical effects to Lucy. It is unknown how Lucy perceived her relationship with Ruby. Sarason, Sarason, and Pierce (1990) discussed the contrast between mothering and smothering, and implied that the same behaviour could be interpreted differently by the provider and the recipient, the provider believing they were mothering while the recipient felt smothered. The likelihood of children developed anxiety disorders for example appears to be lessened by their perception that the world is supportive and that it is safe to take reasonable risks, which can be emphasised by parents and parenting and appropriate mothering. However, when parenting is perceived by the child as

being smothering, it can lead to psychological harm and can leave children without a sense of independence and without the ability to explore and take reasonable risks (Johnson, 2010).

A special connection between mother and child was also described by Lindsey, and that as a mother she knew her child better than anyone else did and knew when something was wrong with him. She described how when she had first taken Ben to see someone for professional help, she had been that told that Ben was ok, but that she knew that he was not and that he needed help. She called this **"a mother's intuition"**.

> **"When you've got a baby and you feel that they're unwell and a doctor tells you they're not, actually you still know that they're unwell because you know your child... I think nothing's really better than a mother's intuition."** (Lindsey, 2027-2029)

Lindsey further highlighted the connection she had with Ben, by describing how she had experienced similar things to Ben in the moments that he would sink into a deep depression. Lindsey used the metaphor of Ben being at the bottom of a pit during these dark moments, and that in parallel she would also feel like she was at the bottom of the pit with him. Lindsey went on to speak about how Ben was able to come through this and feel happier, but then she felt as if she was left at the bottom of his pit. The way that she described being left at the bottom of *his* pit showed that she very much felt involved in Ben's experience and became a parallel part of his world during his dark moments.

> **"…he'd have the session where he was, you know, at the bottom of, you know, the darkest pit and then he'd go off with friends or whatever and be absolutely fine and leave me at the bottom of his pit…"** (Lindsey, 1576-1578)

Michelle did not describe her experience of a parallel process as vividly or as explicitly as some of the other parents did. However, it was apparent in the words she used that she believed she was experiencing the same emotions as Sofia throughout her therapy. In two separate quotes, Michelle repeated the emotion **"happy"** to describe both her feelings and her perception of Sofia's feelings, and described this in a way that suggested that when Sofia became happier, so did Michelle in parallel. Her second quote, referring to her children in the plural, further suggested that it was not just Sofia's emotions with which she felt she matched, but both of her children, and that part of being a parent meant that your emotion mirrored your children's.

> **"Obviously I was happier that she was happy…"** (Michelle, 980)

> **"...If they're happy then you're happy."** (Michelle, 1522-1523)

This use of repetitive language to describe the perception of matching emotions was also apparent for Stephanie. Stephanie described how Keira had not felt comfortable going through the process of therapy, and that it had brought to the surface all of Keira's fears which had pushed her out of her comfort zone. Stephanie picked up on Keira's sense of discomfort, and mirrored this with a description of how she herself felt at encouraging Keira to go for therapy to confront her phobia. Stephanie repeated the emotion **"uncomfortable"** which highlighted the paralleled emotions that she perceived both her and her daughter to be feeling during the course of the therapy.

> **"Erm, so that's uncomfortable. Knowing that you've put them in a position where they're going to feel uncomfortable."** (Stephanie, 177-178)

Brenda described a similar connection with her son Luke, when they had both in parallel felt scared. She acknowledged that as a parent, it was expected that you would feel the same things as your child, and that this connection would undoubtedly be present.

> **"He was very scared, actually... I was also scared, I guess. We often, our children, I think we often mirror our children's feelings."** (Brenda, 251-252)

The mothers seemed to highlight that there is a special relationship between mother and child, a connection that cannot always be described in words. This connection took on different forms for each of the mothers. For some it transpired in powerful visions that led them to their child when their child needed them the most, and for others it transpired in how the mother's emotions and experiences mirrored their perception of their child's emotions and experiences. The connections were evident in the language the mothers used, and the way they made sense of some of their experiences.

The flow of communication

Communication was a common theme when mothers spoke about their relationship with the child who had received therapy. Some mothers suggested that because of the difficulties their child was experiencing and the therapy that ensued, their child was able to be more open with them, and that communication flowed more freely than it might have done had they not been through this experience together, which had enhanced their relationship. Other mothers however described that communication was not so free flowing in the relationship between them and their child for various reasons, but due to the difficulties their child was experiencing, there were crucial moments of communication that broke through between them.

Ruby described the increased communication between herself and her daughter Lucy and how difficult it was for her to hear the distressing things that Lucy was experiencing. Ruby described this as though this depth of this communication was unique and not something that parents who hadn't been in her situation would experience with their children.

> **"...I don't think normally a mother gets to know all the darkest, deepest, demonic thoughts of somebody else's mind. I don't think, from my experience working with parents, I don't think other parents get to know the whole inner dialogue but she was sharing that with me and it was really upsetting."** (Ruby, 54-59)

Lindsey and Brenda on the other hand spoke differently about the communication between themselves and Ben and Luke. They described a relationship in which communication did not flow as freely as it had between Ruby and Lucy. Lindsey for example spoke about how when Ben had been suicidal, he chose not to discuss his thoughts of suicide with her. Brenda also spoke about a low level of communication between her and Luke, but she attributed this being a result of him having Asperger's, and that communication for him in general was not so easy. Brenda said that with Luke, she had to work at finding the right times through which to communicate with him.

> **"...he didn't, he didn't tell me, he didn't talk to me very often about, erm, about suicide."** (Lindsey, 719-725)

> **"...he wasn't normally communicative generally, though anyway, so it was... it was finding those moments to get through."** (Brenda, 137-138)

Brenda further spoke about the beginning of Luke's self-harm, and described an incident when she had come home and her younger daughter had come up to her and told her that Luke had blood on wrists. Brenda went to Luke and found he had made cuts to his wrists. It appeared that Brenda interpreted this incident as having been a way for Luke to communicate that he was feeling low and could no longer cope with his feelings and the things in his life that he was having difficulties with, such as being bullied at school. It was after this incident that Luke had then been able to speak to Brenda about the things that were upsetting him, and Brenda said that she had felt glad that he had eventually been able to speak about this with her directly.

> **"...it was a definite thing about 'I can't manage this anymore', and then he told me what it was that he couldn't manage, and it was... it was the stuff that was happening at school. So, it was good that he eventually had talked about it..."** (Brenda, 220-222)

The break through moment in the communication between Brenda and Luke was the incident in which he self-harmed. For Carol, she felt that there was break-through moment in her communication with Bobby after he had worked with his therapist to develop some creative ways of being able to cope with his negative emotions. Carol said Bobby's therapist had helped him to develop alter-egos which had helped him to find ways of coping with his depression. Through the development of these alter-egos, Carol felt that there was a new way in which to communicate to Bobby about his feelings, without having to ask him directly, which she had found very useful in increasing the flow of communication between herself and Bobby.

> **"So it gave us a vocabulary, I suppose, that…that we could communicate with. So he could say, you know, I could say to him 'Is Agent X bothering you a lot at the moment 'cause you look like you're**

stressed or struggling,' or, you know, 'Let's think about what…what would Bobby the Boxer do to help you at times like this?' " (Carol, 639-645)

Open communication being essential for children to feel listened to was also highlighted, especially by Lindsey. She spoke about when Ben had been feeling depressed, suicidal, and unhappy at school, and had wanted to change schools, but Lindsey had wanted him to stay at the same school. She described how she felt that Ben, despite him communicating this to her, had felt un-listened to. Lindsey may have been expressing an element of guilt or regret at not having such an open channel of communication with Ben, as she later went on to speak about how feeling listened to was essential for children, and that those that don't feel listened to end up experiencing difficulties. She suggested that she had been thankful that Ben had been able to use his therapy as a line of communication as he had not been able to communicate freely with his parents. Lindsey further suggested that there may have been things that Ben, due to him being a teenager, would not have felt comfortable with communicating to his parents, such as when he wanted to moan about them, and that having a different space in which to speak, outside of the relationship with his parents, was helpful.

> **"I think once you've, once you've opened the lines of communication there with somebody, anybody, then that's, you know, erm, enough to just let off some steam and, and feel listened to… I think the children that, that do end up in a desperate state are ones that don't feel listened to by anybody at all."** (Lindsey, 1802-1809)

> **"It's not useful for him to discuss it with his dad because he'll feel disloyal or I might hear about it or, you know, so to be able to moan**

about your parents in a safe environment is, is really useful for

kids…" (Lindsey, 1222-1224)

Despite Lindsey suggesting that there was not such an open communicative relationship between herself and Ben, she spoke about one time when she had wanted to be open with Ben about how scared she was that he would take his own life, as she felt it would put pressure on him not to do it. She said she had done so after a boy in Ben's year at school had taken his own life, and they had attended his funeral. After she had communicated this to Ben, Lindsey spoke about feeling guilty as she had not wanted Ben to feel bad for feeling suicidal. This suggested a tension within Lindsey between both wanting and not wanting her son to know how she felt. It highlighted that striking a balance in the communication between parents and children can often be difficult. The fact that Lindsey believed that communication was so important meant that she had wanted to share her feelings with Ben, but had paradoxically felt bad afterwards.

"…it's the only time I've ever spoken to him, to Ben, about how

scared I've been… afterwards I felt so guilty that I'd shared that with

him… I felt guilty for having said it because I didn't want him to, didn't

want to make him feel bad…" (Lindsey, 1479-1488)

Communication within each of the parent-child relationships appeared to vary. For some, the whole experience of having difficulties and receiving therapy had meant that the communication between the mother and the child was enhanced and was able to open and flow more freely than it may have done had the circumstances been different. Some mothers described an already strong and communicative relationship with their child, while others described a less communicative relationship. In the relationships where there was not a high level of communication, there did appear to be moments in which the mother was able to reach out and communicate with the child, and vice versa. Communication did not always

come as direct verbal communication, but appeared to come in other forms too, and was not always easy. There appeared to be a gender difference in the communication between the mothers and the children, with the mothers who had daughters reporting a greater flow of communication within the relationship than the mothers who had sons. This potential gender difference is further elaborated on in the discussion chapter.

Master Theme Two: Exploring the Meaning of Having a Child with Mental Health Difficulties

All of the mothers in this research described a certain exploration of what it meant to have a child with mental health difficulties, and a child that needed psychological therapy. A shared element of this experience manifested in them spending time describing and talking about what had been happening to their child before help was sought, and how they had seen their child suffer and watched their mental health decline. Mothers appeared to process what was happening to their child through acknowledging both how the child suffered, and the impact that it had on them as a parent, resulting in intertwined themes of desperation and helplessness at seeing their child suffer and accepting that their child needed professional help. Further common elements of the sense making process around this area included mothers reflecting upon the perception of stigma from others that they had experienced, expected, or feared. Leading on from discussing perceived stigma, the mothers also all reflected upon their own personal views, attitudes, and beliefs regarding mental health and therapy. A large amount of questioning and searching for where their child's problems may have started was common for each of the mothers, including a battle between an attribution to external factors and an underlying blame upon themselves for possibly causing the problems. This exploration almost felt like a journey for the mothers, leading them to reflect upon the origin of the problem right through to what this meant for their child's future.

The impact of the difficulties

The mothers in this research spoke about the impact of the difficulties that their children were having. Some mothers described the impact of the difficulties upon the child, and how they noticed negative changes in the child and a decline of their mood and personality. For some mothers there seemed to be number of small signs that added together showed how their child's mood was declining.

Tanya for example spoke about how even when Christopher was a toddler she had noticed a change in him, and that he had gone from being a child who was enthusiastic and full of energy, to a depressed three-and-a-half-year-old.

> **"He would sit in his room in the mornings, in the dark, on the bed, having been a really bright-eyed, bushy-tailed toddler. He would just sit and I would go in and say, 'Can I open the curtains?' 'No, don't. I'm tired, no.' You know, what's going on? 'I just want to sit in the dark and be sad.' "** (Tanya, 202-205)

Brenda said that she had also begun to notice negative changes in her son Luke. She said at the time she had not known that he had Asperger's, but had always classed him as "**a sensitive soul.**" (Brenda, 76). Brenda acknowledged that some of Luke's behaviour at the time had been attributed to his Asperger's, such as him being alone much of the time and being outside of his peer groups. But Brenda said even with these attributes, she noticed a decline in his behaviour around the time he began to feel low and began to self-harm. When she had first noticed the changes, Brenda said she had thought it was Luke just being a teenager, and she had not at first been overly worried, but that now looking back she could see that all the of the little signs had indicated a decline in Luke's mental wellbeing.

**"He'd become more withdrawn. His world had started shrinking, he…
he was withdrawing from his friends. Not that he had many. He was
morose, I suppose, a lot of the time... I suppose the most important,
biggest thing was his posture. He was very hunched..."** (Brenda, 88-
92)

**"...he did have times of, you know, rubbing his knuckles until they
scraped, bled. And picking round his fingers a lot, that sort of thing...
there were those little tell-tale things in hindsight."** (Brenda, 232-234)

**"I just thought that it was part of this adolescent thing. I just thought
it was part of his struggling with, as I say, all the things that
adolescents sometimes do."** (Brenda, 226-227)

The build-up of the children's problems appeared to manifest in different ways, but
sometimes for the mothers there were significant incidents that made them realise how bad
things had gotten. For Carol, the impact of Bobby's difficulties caused him to have a
meltdown over a small misinterpretation of something that she had said to him, and it was
then that she knew then that Bobby was feeling depressed. Carol also described how
Bobby's mood further deteriorated, and she could see his depression through the way he
spoke about and described things.

**"He had a meltdown, which he does from time to time, but a really
emotional like grief…sobbing, you know, that whole real, you know,
uncontrolled sobbing over just some miscommunication. I thought
that he was going a bit…getting a bit, erm, depressed again***(sighs).***"**
(Carol, 165-168)

> **"...he had black moods and, you know, he'd describe things like an adult would talk about if they were depressed, you know, 'there's clouds bearing down on me', you know, "if it's raining outside I can't possibly be happy'..."** (Carol, 445-448)

Pat spoke about how Amy's difficulties had led her to not want to go into school meaning she was absent a lot. Pat spoke about the impact this had had, and that it had gotten so bad that she had begun to receive letters which had threatened that if Amy continued to miss school, she would be prosecuted. The extent of the letters showed that the impact of Amy's difficulties had gotten very serious, and Pat felt that she was coping with it on her own due her husband being busy with work and not being at home a lot. This appeared to be a very isolating experience for Pat at what was a scary and uncertain time.

> **"My husband was er, extremely busy, and away from home a lot, out of the country as well, so it felt very much that I was coping on my own, and to see her so unhappy, and also missing huge chunks of school, refusing to go in, and getting threatening letters from the authorities that they would prosecute, at the point where I had the letter about prosecution, I think it even mentioned taking her into care."** (Pat, 50-54)

Lindsey spoke about the effect that Ben's problems had on him in a different way than some of the other parents. She spoke about Ben's suicidal feelings giving him a certain power within the family and control over his parents, as they were so scared he might take his own life that he was able to get them do things that they had not wanted to do. She spoke about this in the context of when Ben had wanted to change schools and she had not wanted him to, but that Ben had **"the power"** to make Lindsey change his school by threatening to take his own life, and that this had left Lindsey feeling "**powerless.**"

**"…we changed his schools, but you know, as I say, he, he then had
the power to, to make that happen because he, he basically
threatened to kill himself."** (Lindsey, 678-680)

**"You've got no choice at that point, do you really? But say it's, you
know, I'm not gonna accuse him of emotional blackmail because I
think he was so unhappy… But he, you know, I was powerless at that
point."** (Lindsey, 685-688)

Lindsey further highlighted the theme of feeling powerless by saying how her own behaviour
around Ben changed when he became depressed and suicidal, and that she had been afraid
to do anything which might have upset him or jeopardise his mood, such as tell him off. This
showed that Lindsey had felt powerless to have any effect upon Ben's behaviour and felt
unable even to discipline him without fear it might result in a decline in his mental wellbeing.

**"I felt very, you know, any sort of hint that he might be feeling that
way and I, I, erm, was afraid to upset him or tell him off or, you know,
do anything that might jeopardise stability of his mood."** (Lindsey,
618-620)

Some mothers also spoke about this theme in terms of the impact that it had upon them as
parents and how it affected their own lives, as well as their children's lives. Emotions such as
fear and helplessness were commonly mentioned. For example, both Brenda and Lindsey
spoke about fear, and underlying this fear was the thought that their child might get taken
away from them. Brenda spoke about the fear that Luke would get sectioned due to his
difficulties and Lindsey also spoke about how she had been so scared about Ben taking his

own life and not being there anymore, that for months she had felt the need to go and check he was still alive when he was asleep.

> **"...in the back of my head I was scared about being sectioned. His being sectioned**." (Brenda, 416-417)

> **"I'd be, sort of, sneaking into his bedroom after he'd gone to sleep to check that he was, you know, breathing, which is a horrible thing to, you know. It was like that for months."** (Lindsey, 511-512)

Lindsey also spoke about how the impact of having a child with suicidal ideation had had such a negative effect on her that it affected the way she viewed herself as parent, and made her feel like a failure. She appeared to question whether she had failed at providing the right upbringing for Ben, and that she had not done enough for him to make him happy. This impact upon Lindsey appeared to have made her question her whole identity as a parent, and made her judge her own success at parenting.

> **"It wasn't until, as I say, I think, I think there is an element of when your child is wanting to or talking about suicide there's an element of feeling like you've, kind of, failed as a parent."** (Lindsey, 744-746)

Lindsey spoke about how Ben's emotions had affected her own emotions, and built on this by suggesting that children are almost more resilient than their parents and are able to deal with the effects of mental health difficulties more efficiently. She said that she felt children are not always aware of the impact that their own emotions had on their parents, and that Lindsey had felt that when Ben had his particularly dark moments, he was able to come through it faster than she was, and that she was left struggling to cope with the effects long after Ben's mood had lifted.

"I think a lot of children are very unaware of how their moods affect their parents… Because, you know, it almost seemed to take me longer to recover from them than it did him." (Lindsey, 1587-1588)

Some mothers felt that the impact of having a child with mental health difficulties was so consuming that they needed something else in their lives to focus on to help them cope. This was important for Lindsey, who outlined she had needed something else in her life in addition to her children, and had started studying for a degree. This had enabled her to have something else to focus on, a form of escape, that helped her not to feel consumed by the difficulties that Ben and his brother were having. Lindsey, who had worked for the NHS and helped to run support groups for girls who suffered from eating disorders, said that she had noticed that the parents of the girls she supported in the group coped much better when they had for example stayed in work and had something else in their life as well as the problems at home, and that the parents who had given up work and become a full time carer to their child appeared to have suffered and coped much more negatively with the experience of having a child with mental health difficulties.

"But I felt like I had to be doing something at that point because I couldn't have the kids as the only thing in my life… it kind of took some of the pressure off, just giving me something else to focus on." (Lindsey, 1548-1551)

"…it means then that that becomes the entire focus of [the parents'] lives and they're absolutely drained by it and the ones that have been able to continue to work are actually much better because they have a release really, an escape." (Lindsey1559-1561)

The result of having something else to focus on was not always clear cut and had, for Lindsey, created some tension within herself. Lindsey said that even though she felt she had needed this distraction at the time, in order to cope, she had also felt very guilty that her degree was taking up a lot of her time and meant that she could not always be there for Ben. She had seemed torn between needing an external escape from the difficulties of having a child with mental health problems, knowing this would help her cope, and also feeling guilty that having this escape meant she did not have as much time to be there to support her children when they needed her time.

> **"…that makes you feel guilty because you're busy, you know, studying and doing what you're doing and then your child's got… and then I'm feeling guilty about the amount of time that I'm spending studying and not, you know, like the times that he wants to chat and I've got an assignment to get finished."** (Lindsey, 1536-1540)

The impact of the difficulties that the children experienced appeared to not only affect the child in negative ways, but affected the mothers as well. The mothers outlined how they had seen negative changes and declines in their children, from changes in their behaviours to changes in demeanour or personality. The effects that this had included things such as the child missing school, the child self-harming, and the child withdrawing from their world. The effect on the mothers was also apparent in the emotions of fear and helplessness, and of guilt when the mother needed an avenue of escape to help them cope with their child's problems and the impacts.

Perception of stigma from others

All mothers spoke about the stigma around their child having difficulties and needing psychological therapy. They commonly presented the theme of stigma not in terms of how they felt or as reflection of their own views, but in terms of how they felt other people perceived

their children having difficulties and needing therapy, about what this meant about them as a parent, and how other people viewed mental health and therapy in general. Different mothers discussed how they felt stigma coming from a variety of different sources including a general view from the public, from their immediate and wider family, from friends, and also from different staff they came into contact with, for example at their child's school.

Michelle for example spoke about how she felt that the general consensus around therapy was that it was for **"crazy people"** and suggested that in her opinion this was a narrow minded view and that she was more open minded and receptive towards therapy, but that it may have been her perception of this wider view that had prevented her from telling many people about Sofia's therapy.

> **"…people do think that counselling is for crazy people but no, I'm more open minded."** (Michelle, 385)

> **"Erm, I had like one friend that I told, my husband obviously he knows, yes and that's it. It is, you don't feel like you can, I couldn't tell my sisters; maybe because yes like they've not had problems with their children and you feel you can't say."** (Michelle, 1228-1233)

Following this, I had asked Michelle what she felt had been stopping her from saying anything to her sisters and other people. I had been interested to explore this further with Michelle as she had been clear that there had been some reason that she felt she could not say anything, and I wanted to know what had been holding her back.

> **"I don't know maybe just, what's the word for it, pride or; maybe its pride. You don't want to say that there's something wrong, yes. I think there's fear of being judged... definitely. Yes because you do think that**

you're doing the right thing, you know there's, no one teaches you

what to do as a parent; yes, it's hard." (Michelle, 1224-1250)

When exploring what had been stopping her from telling more people, Michelle reflected on the fact that she had feared that she would be judged negatively as a parent, and how difficult it had been. She mentioned that nobody is there to guide you as a parent, and presented this as a fear she had had about people judging the decisions she had made when parenting Sofia, due to Sofia developing difficulties and subsequently needing professional help. Similarly, Ruby also discussed how she had perceived judgement from other people and had also felt her parenting skills had been called in to question, and she may have been blamed for Lucy's problems. Ruby described how the **"undercurrent"** about Lucy's problems towards herself from others had become apparent through the remarks that other people had made to her, including friends and people in her own family.

"I could sense, often, an undercurrent with friends and wider family

circle people, kind of like what didn't you get right? It wasn't like

what did you get wrong, it was what haven't you done right with this

child." (Ruby, 568-571)

"And they'd say to me, 'Because you always look good, do you think

it's because she wants to grow up and be as pretty as you?' I'd think,

'It's not about me.' " (Ruby, 574-576)

Lindsey, like Michelle and Ruby, spoke about how she had also been aware of a possible judgement by others that two of her children had needed to go into therapy. Lindsey had felt that her parenting would have judged negatively, and that especially because she was a single mother, she would have been blamed for causing the difficulties that her children were experiencing by the rest of society.

> **"…I do know how I would be judged or how I might be judged, erm, having two children in therapy… and, the, the way people speak about, erm, children of, of single parents as well, certainly single mothers, erm, is almost, is almost, evidence that my kids are messed up because of what I've done, erm, and my lifestyle choice. So I'm more aware of the fact that, of, of how it's viewed than how I feel about it." (**Lindsey, 1421-1431)

The fact that Lindsey had felt like she would have been judged by others as causing her children's difficulties appeared to have a greater impact on her than her own views of the problems. This suggested that even though she may have viewed it differently, the effect of the perception of stigma for her was overriding. The perception of blaming of the parent was also evident for Tanya, although she perceived that a lot of mental health services also tended to blame the mother for the child's difficulties. Tanya said that that she felt if she had referred Christopher to CAMHS or an NHS service rather than take him to private play therapy, it would have been her as the mother that the service would have wanted to go into therapy.

> **"Now, working in CAHMS, in the NHS, I feel reasonably certain that it would have been impossible to get a referral for a depressed three-and-a-half-year-old… as a multi-disciplinary team, our response tends to be 'send that mother to a therapist.' "** (Tanya, 272-276)

Tanya appeared to be suggesting that there are different initiatives within NHS service provisions for children's mental health as opposed to private organisations. She described a certainty that she would have been judged and blamed as a mother for causing her children's difficulties if she had been seen within an NHS service, and

sent for her own treatment rather than her children being seen. In contrast, her portrayal of private psychological services was as less judgemental and stigmatising against parents and more willing to provide direct individual interventions for children. The implications of such a viewpoint could contribute towards a parent's willingness to seek help from an NHS service, perhaps having a preference for a private service. However, private psychological services are not always as accessible to lower income families, and therefore this could act as a barrier against seeking help.

Stephanie spoke about stigma from her family, not necessarily that she felt stigma coming from her family towards her or Keira for accessing therapy, but that she felt her oldest daughter and her husband in particular had a negative view of therapy. Stephanie spoke about when Keira's therapist had suggested that her family came in for a family session, and Stephanie knew that her husband and older daughter would categorically be against it. Stephanie said she had known her husband would have been against it as when she had previously had her own personal therapy, her therapist had asked if Stephanie's husband would also consider therapy, and he had refused at that point. Stephanie described her husband's view of therapy by reciting a metaphor he had used about opening a can of worms, to describe his feelings about therapy to her. The analogy of worms wriggling around in a can may have been used to paint therapy as something which was unpleasant, which fitted with how Stephanie had perceived her husband's views. She had also suggested the thought of therapy was scary for her husband, like the thought of delving into the unknown at the bottom of a pile of worms may feel. Perhaps Stephanie's husband had also used a metaphor in or order to help him to understand a concept unfamiliar to him and to make this concept more concrete, or to trigger an emotion in Stephanie to help her to understand his position. This metaphor seemed to have stuck with Stephanie and she was able to recall it and to use it as a basis for not asking her husband to come to a family therapy session with Keira.

"…he said, 'I have a can of worms, do I want to look in my can of worms? No I do not. What is in my can of worms will stay in there. If you wanna look in your can, see what's wiggling around in there, that's up to you, but I don't know what's at the bottom and it scares me, so I don't wanna start looking.' " (Stephanie, 241-147)

Pat also discussed how her daughter Amy had, like Stephanie's husband and oldest daughter, had a negative view of therapy, and felt that counsellors were trained to ask certain questions and respond in a certain way, and this was not a natural process. She also said that Amy had felt that counsellors would expose your private emotions, and this resonated with Stephanie's husband's description of therapy being scary, and perhaps Amy had also felt that to have your private thoughts and feelings unveiled would be uncomfortable and scary.

"[Amy's] perception of the whole process was that it was unnatural, erm… followed a format that counsellors had standard questions and responses. Erm, obviously a lot of digging into personal things, exposing of your feelings. Erm, so she hated the whole idea of it…"
(Pat, 35-38)

While Michelle, Ruby, Stephanie, and Pat discussed their perception of stigma from other people such as their friends and family, Carol spoke about her experience of the staff at her son Bobby's school and the covert way in which they had offered therapy for Bobby, which she had perceived as indicating there was some stigma around going for therapy. Carol said the staff had phrased the offer of help as **"Well, we've got somebody who's in school looking for children who she can work with."** (Carol, 174-175). She had been unsure if the offer had been made because there was genuinely someone at school who had some free time, or if they were directly suggesting that Bobby needed some help, and had phrased

it in this way to mask this stigma of therapy in order to protect Carol's feelings. She appeared to remain ambivalent about this. It was interesting that Carol had perceived this offer of help from Bobby's school as possibly being made in such a way to protect her feelings, highlighting that she believed there was a wider stigma coming from other people attached to someone needing help.

> **"...So I don't know, you know, whether it was just to protect me from the suggestion that he might need some help or what."** (Carol, 186-187)

Carol also spoke about how when Bobby was having difficulties, she found it easier to use the label of his diagnosis to describe what was going on for him, as she felt like telling people he had Asperger's would invite them to ask what that meant for Bobby and what they would need to do differently to support him. She said that she felt if she had just gone into listing "Bobby needs this, and Bobby needs that", she would have been judged by others as being a "precious" parent and someone who fusses over their son too much, and people would have reacted to this negatively. For Carol, it was almost as if this solid diagnosis of Asperger's was a safe way to tell people that her son was having difficulties, and almost provided a sound medical explanation that people may understand, and that just to go to people with a list about Bobby's needs would have been more difficult for them to understand and would have invited more stigma against her. Carol laughed at the end of her description, and perhaps this was a way to mask or to make light of what she felt had been a very difficult point in hers and Bobby's lives, dealing with telling people about Bobby's problems and being wary of stigma and judgement against her.

> **"You could say, you know, Bobby might find this a bit difficult he is on the autistic spectrum and has Asperger's. What does that mean? He finds social communication a bit difficult. It just makes it easier**

than, you know, than saying, well, Bobby… It makes you sound like a

fussy parent, you know? You've got to like… And…and people

switch off and think, 'oh God, not another one who has parents that

thinks their child is really precious!' " (Carol, 2276-2288)

"It's just being a bit more gentle with Bobby because he's got this

diagnosis. And then people go 'oh, what does that mean? How…?

What do I need to do differently?' rather than me imposing it all on

them, do it this way, here's a very descriptive list of how I want you to

look after my 14-year-old son. It's like, 'really?' You know, 'get over

yourself!' *(laughter)***"** (Carol, 2292-2296)

The problems that are associated with diagnostic categories have been discussed by Bentall (2004), Bennett and Hacker (2003), and Boyle (2002), such as problems with reliability, validity, and reductionism. Cromby and Harper (2012) further suggest that a more favourable approach to mental health problems is not to focus upon a diagnosis but to examine individual challenging behaviours and experiences. The relationships between social and psychological as well as biological factors in the causation of mental health problems is increasingly being recognised, signifying a shift away from the medicalisation of human distress (Cromby, Harper, and Reavey, 2013). Perhaps Carol's preference for using the label of Bobby's Asperger's Syndrome was a way for her of medicalising his difficulties in an attempt to avoid the stigma that may have come with a consideration of the social and psychological elements of his difficulties, and the role she may have been seen to have played within these elements.

Stephanie further reflected on the theme of stigma by suggesting that she felt that other people, including potential clients, had a certain negative view that therapy was for **"weak"** people and needing to get professional help was seen as **"weakness"** and a sign you were

not strong enough to deal with your own problems. She reflected on when she had used to work as a massage therapist and how her clients had opened up to her and spoke to her about the struggles they were facing, and how Stephanie had suggested to them that maybe they could go seek counselling as a form of support to help them cope with these problems. Stephanie reflected that it was this perception of weakness that made people not want to formally go and seek professional help, but rather to use times such as having a massage in which to create a channel to speak to someone about their difficulties. She also spoke about how she felt that a lot of people do not really understand what happens in counselling or what it is for, and the negative connotations that come with the unknown. She mentioned the stigma attached to counselling, especially when it is needed for a child, and the fact that many people may question that if their child is diagnosed with a mental health problem, they may worry that it is for life.

> **"I encouraged quite a few people to go and seek help. But it is hard.**
> **And a lot of people are very very resistant. Because it is perceived as**
> **a weakness." (**Stephanie, 1163-1164)

> **"…if somebody doesn't understand what counselling is about, they're**
> **probably in a greater anxiety, a greater fear, about what could**
> **happen… There is a huge stigma attached to it. So is my child always**
> **going to have mental health problems? And it's a weakness isn't it.**
> **It's always perceived as a weakness."** (Stephanie, 1111-1119)

Stephanie continued her reflections upon how she believed mental health problems were seen as a weakness and as enduring, by discussing how different companies such as pension providers and life insurance companies treated mental health problems differently to physical health problems. She discussed this in a way that showed she disagreed with the different treatment and that she felt this was a form of discrimination and stigma against

anyone who had suffered with their mental health. She suggested that some insurers and

companies would ask for information regarding current and historic mental health problems

in a different way to how they would ask about physical health conditions, and that this

suggested that it was widely believed that once someone has suffered with a mental health

condition, they will always suffer with it in some way. As opposed to a physical health

condition, which one only had to report if they had been affected by it in the last five years.

> **"…you have an operation and you have something out and then it's
> over and done with. So on a form it would say within 5 years. Doesn't
> say that about depression. It says have you ever. So it is still
> perceived as a, as, err, as a weakness. Once you've had it, you're
> always susceptible."** (Stephanie, 1169-1174)

The increased stigma directed at mental health problems and also developmental and

neurological conditions, compared to physical health problems, was also felt by Carol. She

said that when Bobby was referred for help, she had felt that it had been a long process for

Bobby to get his diagnosis of Asperger's, and that because it was not a physical health

condition, she had felt that the professionals working with Bobby had all been very careful

when giving him the label of being on the autistic spectrum, as they had been trying to avoid

the stigma and negativity of having such a label.

> **"...they're just being careful, aren't they, to not upset people and
> make it a…a negative thing to get the label... You know, if it's
> something physical, you have some tests, you get a diagnosis,
> that's…that's it, and then you get the treatment. But with this it was
> all, yeah, a lot more careful to avoid stigma and stereotypes..."** (Carol,
> 467-475)

The perception that being mentally ill was different from and more severe than just generally experiencing difficulties such as stress and anxiety was highlight by Stephanie, who described how her daughter had said to her that she had felt that her therapist was implying she had mental health difficulties but that she herself did not think she did, and that it was *only* stress and anxiety. Stephanie seemed to be highlighted how her daughter perceived that stress and anxiety were different from being mentally ill, and that by suggesting she may be mentally ill Keira's therapist had offended her. This suggested that Keira also had some stigmatising views about what it meant to have mental health problems and to be labelled with this, and that she did not want to be given that label.

> **"…she also felt, that she had anxiety, everybody has stress and anxiety, and that this person was giving her a mental health problem that she didn't feel she had. Erm, so she was- said 'she's saying I'm dysfunctional. And I don't feel like dysfunctional… people have stress, and I do worry, but I don't think that makes me mentally ill.' So, erm, she was very affronted."** (Stephanie, 262-271)

Tanya spoke about when Christopher had started to receive play therapy, she had been open about it to the staff at his nursery and to the other parents coming to the nursery. She said that some of the other mothers would come up to her and ask her questions about Christopher's play therapy and about his difficulties and were curious about Tanya's experiences. Tanya said that she had felt that lots of the other children were having similar kinds of issues as Christopher, but that it was never really talked about, and she **"didn't really realise the cultural, sort of, apprehensions that other people might have"** (Tanya, 571-572) until these experiences at the school gates. Tanya said that after the other mothers had asked her things about Christopher's therapy, they would then act in a way to suggest they did not want it known that they had asked her these questions. For Tanya, she seemed to interpret this reaction from the other mothers as showing that the conversations

about therapy should have been secret and that the other mothers could have been ashamed or embarrassed about enquiring, and that was a real apprehension about openly discussing the fact that your child was having difficulties and receiving therapy.

> **"…mothers would come to ask me questions and stuff, and then they wouldn't meet my eye after that because they wouldn't want to be, wouldn't want to have to acknowledge that they've had this conversation."** (Tanya, 579-581)

A perceived stigma coming from others had seemed to prevent Lindsey from speaking openly about Ben receiving therapy, and also about when her other son had then needed therapy as well. Lindsey had felt negatively affected by this stigma and unlike Tanya, it had caused her to want to almost hide the fact that two of her children needed therapy. Perhaps there was an element of shame and embarrassment for Lindsey caused also by the fear of judgement for others.

> **"I wouldn't particularly go around boasting about the fact that I've had two children in therapy, that doesn't feel very good, really."**
> (Lindsey, 1412-1413)

Reflection of personal attitudes

All of the mothers, during their interviews, had reflected upon their personal attitudes towards mental health and psychological therapy, and discussed where they felt these attitudes had come from and what experiences in their life had contributed and changed their views. On the whole, there was a consensus that personal attitudes towards mental health and towards psychological therapy were affected mainly by personal experience, such as growing up with counsellors in the family and having therapy normalised, having a positive personal experience of receiving support, or working in the field of counselling.

Ruby for example discussed how her own personal attitude towards mental health was that it should be seen and treated in the same way as physical health. Ruby acknowledged her views had been affected by her personal experiences as a child, and that having a mother who was a counsellor had normalised counselling for her. She also said that as she worked in counselling and had supported many parents who had been in similar situations as herself, this had continued to shape her views and helped her to remain open to and positive about counselling. She described this positive view of therapy as her "mission statement" and this reflected how much this attitude had been a part of her life.

> **"My mother was a counsellor. I was always surrounded by counsellors, therapists. It was just part of my world growing up. I used to say to people as a little girl, 'Why are people ashamed? If you've got an infection you go to a doctor. If there's something wrong with your mind you should go and sort it out,' and that was my very childlike view. And it was a very open platform for discussion in our lives."** (Ruby, 146-149)

> **"I think that, erm, it's kind of my mission statement: if you can identify it and there's help, get the help."** (Ruby, 166-167)

Interestingly, Stephanie, similar to Ruby, also used an analogy of going for therapy as being like going to see someone about your physical health. Stephanie described this as an attitude that she currently held and one that she had tried to pass down to Keira when she had suggested to Keira that she go for help for her blood phobia. The metaphor Stephanie used about how a plaster cast would help knit bones together highlights her view that, similar to Ruby, if there is a problem, for example if something in your mind is broken just like your bones can be broken,

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you should go seek help in order to contain and heal the break. It showed that Stephanie believed that mental health problems, like broken bones, could be healed through therapy and that she disagreed with the attitudes and stigma she had previously outlined as coming from other people, about how mental health is often seen as something which is enduring and which once affected, one is affected for life.

> **"It was, I'm putting – this is a service. It's just the same as if I was taking you to, I don't know, have a plaster cast put on a broken wrist. This is a service. And they are going to help you achieve this at the end. So a plaster cast helps your bones to stay in one place so that they can knit together. This service is going to help you get some clarity in your head, and deal with it, in a different way, so that you can be like this at the end, there will be an end point…"** (Stephanie, 1084-1089)

Stephanie further described how she viewed mental health as a **"continuum"** upon which people moved up and down depending on what is currently going on in their life, and that many different external factors can affect where someone lies upon this continuum. She described her views on mental health as it being something that is more fluid and changeable, and dependent upon many different things that may change from week to week, so someone could for example be experiencing mental health problems, dysfunction, or distress one week, but the next week could be achieving a lot, functioning well and feeling healthy. Stephanie also spoke about how her views had changed since she herself had received her own personal therapy. She said before her own experience, she had had negative views and perhaps shared some of the wider stigma and theme of **"weakness"** she had previously outlined. She described how it was her own personal experience of counselling, the effort she had put in to it and how much her intensive sessions and self-

exploration had required of her, that had changed her views; from believing that those who went for therapy were **"weak"**, to believing that in fact it was the **"strong"** people who went for therapy and were able to see it through.

> **"Erm. I believe in the mental health continuum… it's a constant sliding up and down. And you just hit the point, because of what you're dealing with. So the people who go for counselling, do I think they're weak and do I think they're flaky and do I think that they are doomed? No, not at all. Not at all. I probably did, yeah. I used to think that if you went for counselling you had no friends to talk to."** (Stephanie, 1122-1134)

> **"I used to think it was the weak who went for counselling cuz they needed the support. I actually have a very different view of it now. I think it's the strong that go for counselling, because they've got the energy to see it through."** (Stephanie, 1148-1150)

Stephanie also said that because her counselling had had such a positive impact upon her, not only had it changed her views about counselling and how she viewed those that sought counselling, but that it made her want to work in the field of counselling. She said that she had been looking into undertaking training as a Counselling Psychologist when she completed her PhD, as she had wanted to help others in the way that she felt she had been helped.

> **"It was having my own therapy that made me want to go into counselling, 'cuz it had such a profound effect on my life."** (Stephanie, 22-23)

Like Stephanie, Carol spoke about how her own personal experience of counselling had changed her view about it. She spoke about receiving her own personal counselling for postnatal depression, and that before this counselling she had felt negatively about therapy and had almost felt a sense of shame at having to go speak to someone professionally. She also used the term **"scary"**, which resonated with Stephanie's earlier description of how her husband had told her that the thought of therapy and finding out what lay deep inside him **"scares"** him.

> **"I think…actually, thinking back, erm, I didn't like the idea that people could know me better than me—and that I found a bit scary.** (Carol, 299-300)

> **"…maybe shame or, you know, embarrassment about going and speaking to somebody."** (Carol, 314-315)

Carol had made a suggestion that she had held stigmatised views of therapy before she had received it herself, and had also not really expected her counselling to have made a huge amount of difference to her. She said at the time she had wanted **"a magic wand... I wanted everything to be perfect and gone away"** (Carol, 279-283) but had not expected counselling to achieve this for her. Through receiving postnatal counselling, Carol said it had changed her attitude and she had gained a better understanding of herself and was able to shed some of her negative preconceptions. She said this attitude had been beneficial in enabling her to give better support to her son Bobby when he had needed therapy.

> **"I see it as kind of a toolbox really... and, you know, there's this problem or a difficulty and you just kind of have to look for things that might help, and if CBT hadn't have made any difference or**

changed his views on things, then I'd think, 'Well, we're wasting our

time here, what else can we try?' " (Carol, 269-272)

 "So I guess I've learnt through it as well, so I'm…I feel more

empowered to help him as well by being open minded and saying,

you know, it might help, it might not, as in, you know, give it a go,

you've got nothing to lose, have you?" (Carol, 282-285)

"...through the postnatal counselling I realised that actually they don't

know me better than me, they just help me see who I am more

clearly." (Carol, 305-306)

Brenda and Pat also spoke about how their personal experiences of therapy in the past had

given them positive attitudes towards therapy. Brenda explained that she had received

therapy herself about ten years before her son Luke was referred, and that she had only

stopped her therapy for financial reasons. Brenda said that her positive experience had

subsequently affected her views about Luke being referred for therapy, and had enabled her

to be more open towards him receiving therapy, and to have more trust in the process of

therapy. Pat also said she had been in personal therapy for four years and described it as

"wonderful". She said it was this positive experience that had made her want to train as a

counsellor, and like Brenda, made her favourable towards her suggesting that her daughter

Amy went to see someone when she started struggling to cope with bullying at school and

began to exhibit signs of anxiety and have panic attacks.

Lindsey, similar to some of the other parents, said she had always had a positive attitude

towards therapy. She said that she felt therapy was such a useful tool for self-reflection that

she believed everyone could benefit from receiving it, even if there were no current

difficulties that directly needing addressing. Perhaps it was Lindsey's favourable attitude towards that counselling that led her to work in a counselling related field.

> **"I've always been very for it. I actually think everyone should have counselling, even if you don't have problems 'cuz it's not gonna do any harm."** (Lindsey, 1079-1080)

> **"I think [counselling's] quite useful just to understand yourself better."** (Lindsey, 2156)

Tanya said her personal attitudes towards therapy had been born out of the culture that she had grown up in. She described how therapy in America was a lot more common and that there was no stigma attached to going to see a therapist. She said there was not a culture of therapy being for **"mad"** people, and that the only negative view she had held was that when people received a lot of therapy and spoke about it a lot, she felt that they were rather "**self-involved**".

> **"Well, it's just that people talk about, 'when my therapist says this and my therapist says that,' and there's no stigma, particularly… Erm, if anything, it's more just a little bit of, 'oh, you're so self-involved," rather than a 'you're mad'…"** (Tanya, 295-297)

Tanya also spoke about how her experience with Christopher had changed her attitudes towards therapists. She described how she had initially taken Christopher to see a child psychotherapist, and that he had told Tanya that Christopher's problems were simply due to him having so far got by in life using his charming charisma, and that now he was having to work things and he did not like it, and that was the problem in a nutshell. Tanya said she and her husband had both disagreed with the psychotherapist's conclusion of Christopher and

his problems, and that it had made her question the authority of the people in such professions. Tanya said she had used to believe that therapists had a supreme knowledge and she would not have questioned what they said, but since she had felt the child psychotherapist had been very inaccurate about Christopher's problems, it had taught her that she could question, that therapists could sometimes be wrong, and that they were just normal people. She used the metaphor of the Wizard of Oz and how he was just a normal man behind a curtain. The use of this metaphor highlighted how Tanya had once seen therapists as great and powerful, but that she had learnt that they too are just ordinary people, and that she could question their opinions.

> **"I think I would I have had the going in position of therapists are being… people who are wise and understood things that I couldn't understand, and I wouldn't have questioned, and all of that."** (Tanya, 305-308)

> **"…it's, kind of, like the Wizard of Oz. There's the man behind the curtain and maybe he's just a guy…"** (Tanya, 309-310)

Unlike the rest of the mothers, Michelle said that before Sofia had begun to have difficulties, she had not really thought about therapy or formed any preconceptions, and it appeared that by taking part in this interview she had been able to reflect on this. She said that she had not known much about therapy **"…because I've never had to, I've never needed it before… my daughter, what happened with her."** (Michelle, 371). From the way Michelle spoke about this and her reluctance to verbalise what Sofia had gone through, it appeared that her whole experience of Sofia's difficulties and therapy had been an unexpected process that she was still making sense of, and that she had not had the same previous experiences with personal therapy or of therapy being a normal part of her world and family environment when growing up that the other parents had had.

Although Michelle had previously said that she was more open minded and receptive towards therapy than other people were, and that she felt others viewed it as being for **"crazy people"**, the way Michelle spoke about Sofia first going to see someone suggested that although she may not have directly shared the view of others about it being for crazy people, she did view having a mental health problem as not being **"normal"**. She spoke about her daughter believing she was bipolar and that Michelle had felt reassured when she was told that Sofia was not going to be diagnosed as bipolar, but she had then not wanted her to be diagnosed with depression either. She used the words **"normal"** and **"wrong"** a couple of times, creating a distinction between the two and suggesting that if someone had mental health problems there was something wrong with them, whereas someone who is psychologically healthy is normal. Although she did not further reflect or elaborate on the topic, it was interesting that this theme appeared to emerge in her dialogue, and hinted at her underlying personal attitude towards mental health.

> **I wanted to say to them is she, because she thinks she is [bipolar]... And they said no, no she's definitely not. And...it was [reassuring] but because they said that and also the depression thing I didn't want her, I didn't want to think that she was a depressed child."** (Michelle, 340-354)

> **"…I said well has she got anything… because that's what you want to know; has my child got anything wrong with them."** (Michelle, 600-601)

> **"...then to say to her you're normal you know, that's what they're saying to her…there's nothing wrong with you, you're normal."** (Michelle, 926-931)

Lindsey was the only mother to speak about possible gender differences in seeking professional help, and her attitude that among men there was more of a reluctance to go and seek help unless they had reached a breaking point and ended up in a desperate situation. She described her perception about men's views about therapy, that it was a last resort option, whereas she felt women were more open to counselling and would be more likely to go just because they felt it might be helpful for them in some way at that point in their lives, rather than seeing it as a last resort option to help with a desperate situation. She also said that despite feeling that men viewed therapy this way, she thought that Ben was more open to counselling and was more ready to talk to people about his issues, which she felt was a useful trait for him to have, and that she felt lucky he was like this rather than sharing the above general view of most males.

> **"I think, erm, certainly men are not happy to [talk to people about their issues]. I think a lot more women go to see a counsellor than men. I think men have to be, kind of, in some sort of dire situation before they go for counselling, whereas a lot of women think, you know, I should probably see a counsellor because I think it'd be useful."** (Lindsey, 1360-1365)

Carol further spoke about her personal attitudes towards the terminology of "counselling" and "therapy", and the terms "having" and "in". She reflected on how for her, different terminology had different connotations, and that she viewed the terms "having counselling" and "being in therapy" as meaning very different things. It was almost as if for her, there was a continuum of mental health needs upon which these different terms sat, from "having counselling" being at the lower end in terms of needs and severity, "having some therapy" being in the middle, and "being in therapy" being at the more serious end. For Carol, having counselling meant that someone was experiencing some difficulties and had willingly chosen

to go and get some support and had asked for it, and there was a choice and an element of control for that person, whereas being in therapy meant that someone had very serious issues, such as a drug or alcohol addiction, and had lost control and needed to be taken in to therapy. She referred to the term being in therapy as verging on being sectioned, and that by this point the person had lost control, and it was more something that was being done to them, such as being taken in to therapy, or rehab. Carol also used the metaphor of using pain killers, and the difference between taking a few painkillers and being on morphine to highlight her views of the differences in severity between having counselling and being in therapy.

> **"In therapy, erm, I'm thinking, you know, drug addicts and alcoholics and, you know, inpatient, really, really, intensive rehab kind of 'in therapy' rather than having a bit of counselling. It's…I suppose it's the difference between taking a couple of paracetamol and being on morphine all the time."** (Carol, 2128-2131)

> **"So having a bit of counselling, that's, you know, that…that's fine, you're just chatting to somebody and getting a bit of clarity on how you're thinking. In therapy I see it as more, erm, erm... instead of me asking for help, it's more the help has been suggested that it might be beneficial... Sort of external bodies saying, you know, we really recommend that you are on this medication... Losing control over it: 'in therapy'."** (Carol, 2186-2203)

The connotations of language appeared to have affected Carol's view of Bobby receiving help, and it had determined how she described Bobby's help to other people. She said that she found it much more positive to describe Bobby's help as them having got Bobby some counselling to help with his current difficulties, and that to describe Bobby as being in

therapy would have suggested that they had sent Bobby off somewhere to get treatment as they had not been able to cope with him, which for Carol sounded very negative and was not how she viewed the situation for Bobby.

> **"Bobby's finding life a bit of a challenge at the moment... we've got him some counselling to help him sort of help him through that change. It's much more positive isn't it than 'we can't cope with him, we've had to send him into therapy'."** (Carol, 2300-2304)

All of the mothers displayed a personal positive attitude towards therapy. Most of the mothers outlined that their positive attitude had either come from experiences they had had growing up, such as being surrounded by therapists that normalised the process of therapy, or by having a personal experience of therapy at some point in their lives which had been positive for them. The mothers commonly reflected on how their attitudes towards therapy had changed, and that some had originally shared the negative stigmatising views of therapy that they had perceived by others. They reflected on what had helped them to change their views, and how their positive views had affected their own attitudes when their child had needed to receive therapy.

The terms counselling and therapy had been used interchangeably through this research, but one mother did speak at length about how the two terms for her at different connotations and she had a different attitude to each of the concepts. The power of language in such a context is important, and this made me reflect on how for the purposes of this research I had used the terms interchangeably but had not fully considered how this may have been viewed by the participants, or in fact how this may have affected them.

A quest to make sense of the origin

This quest was present in all of the mothers' interviews. It appeared in one sense to be a search for a cause due to external factors, and in another sense that the mothers were questioning their own role in the causation of the problems. Both of these elements were present in all of the interviews which made this a very common theme, and a strong contribution towards each of the mothers' exploration of making sense of their child having mental health difficulties. When the mothers questioned their own role in their child's difficulties, there was an element of guilt suggested and an element of self-blame that had seemed upsetting and confusing for the mothers.

For example, both Ruby and Michelle began by attributing the start of Lucy's and Sofia's problems to external experiences they had had when they younger. For example, Ruby spoke about a negative experience Lucy had at school with a teacher, and the effect that moving to a new place had on Lucy. Michelle spoke about Sofia being rejected by a boy at school and questioned whether this incident had triggered off Sofia's depression.

> **"We then, we left **** and we came to settle here and I think that's where she started to look for greater control because nothing made sense here. She understood life in **** and this was a grey, dark, cold, unfriendly place, by comparison. So I was watching her very carefully sink further and further into sadness that then became depression."** (Ruby, 24-28)

> **"We hadn't left **** yet but she had the most punitive class teacher I've ever come across. The most wicked woman. And this impacted so badly on my daughter that she became very sad. She wasn't depressed but she was sadder every day than I'd ever seen her."**
> (Ruby, 178-181)

"I think she had a first sort of relationship with a boy as well at that stage which she got rejected so I don't know if that triggered [the depression] off." (Michelle, 364-365)

Ruby then, later in her interview, shared how she had begun to question whether she had been to blame in part for causing Lucy's problems with eating and control. The amount of questions that she asks herself suggests that there was an element of torment for Ruby, almost a battle against herself to decide if she was the cause of Lucy's eating disorder. She described an element of over processing that went on in her head, a suggestion that she was eager to discover the cause and was going over and over things to see if that cause was her.

"So that was the only time that I'd start to feel, have I got anything wrong? What have I done? What's it like being her mum? Having me as a mum, what does that feel like? What have I done? Have I colluded with the idealist perfectionism that she's carried from as soon as she could talk? Have I colluded with that? Have I been part of creating somebody that looks for control issues to feel better about herself?" (Ruby, 576-581)

"That was a sort of stigma that I would have, this over processing when everything was quiet, going on in my own mind. I'd think, "Is it me? Have I done this?" (Ruby, 586-588)

Michelle also moved on from looking at external causes for being the trigger of Sofia's depression, to questioning her own role in Sofia's problems and if things that had happened in Sofia's childhood had made her the way she was and prone to such difficulties.

"I know she had like a lot of childminders when she was young… Six

or seven childminders. So I don't know whether that made her clingy

to me as well, yes. She wet the bed a lot, so I don't know; all these

things… I'm thinking is that why she's like she is now. From

childhood she was always, yes very clingy and emotional child and

then maybe she just carried on being like that. It's quite... So maybe

there's a reason for her being like that and then you know, you don't

realise at the time…" (Michelle, 744-773)

Stephanie appeared to share a similar battle through searching for the origin of Keira's

phobia of blood. Stephanie spoke about questioning whether Keira had this phobia due to

something that Stephanie had said or done in the past, or how Stephanie had reacted to

certain situations. When Stephanie recalled these memories, she stuttered a bit before she

revealed what she thought she might have said to Keira to contribute to the development of

the phobia, and there was also a short pause. This suggested it was still difficult for

Stephanie to think about this incident.

Stephanie moved on from questioning her own role in producing Keira's phobia of blood, to

deciding it was a different incident she was not involved in that had contributed to Keira's

phobia. She said that Keira had told her that she felt her phobia of blood had started after an

incident which had involved her younger brother, in which her brother had fallen over at

school in the playground, and his tooth had gone through his lip which, along with scraping

his face, had causing a lot of bleeding Stephanie said Keira had felt responsible for helping

her brother as she was his older sister, but that she had felt unable to help him because she

had completely freaked out over all of the blood, and that since that time she had had a

terrible reaction to blood. Stephanie's verbal utterances when she had been describing how

she'd questioned her own role may have suggested that this was a quest that she was still

on and had not reached a final decision about what the cause may be, despite wanting the

cause to have stemmed from the incident with Keira's brother and not because of something she had done. Regardless, it appeared important for Stephanie, as it was for the other mothers, that she located the origin of Keira's phobia.

> **"…there may be some things that I've done, erm, that have added to her phobia. You know, I've – I – I said to her, at one stage, 'is it to do with because when you were small and you fell over and I used to say (.) …well if it isn't bleeding it's not hurt. And so, so did I introduce the idea that blood was to be feared and that meant you were hurt?' "**
> (Stephanie, 187-191)

Michelle's quest for the origin of Sofia's problems did not exhibit the same questioning and role of guilt and self-blame as Ruby and Stephanie. Perhaps this was because Ruby and Stephanie were further down their quest and had spent more time reflecting upon the origin of their child's difficulties. Their own experiences of personal therapy and the counselling environment appeared to have enabled them to be more self-reflective and to go deeper into this self-reflection than Michelle had had the chance to.

Lindsey also touched upon her questions about what had caused Ben's depression and suicidal ideation. Lindsey began her interview by saying that she wanted me to see the bigger picture of who Ben was and why he might have had the problems he had had. Lindsey mentioned that Ben also had a medical history and that he had suffered with epilepsy which caused him to have seizures. She had described the effect this had had on Ben, and suggested that this may have been one of the reasons that he developed depression. Lindsey's non-verbal cues were apparent here, and she cleared her throat a couple of times within one sentence. This showed that perhaps Lindsey was feeling uncomfortable thinking back to why Ben might have had difficulties and remembering that some of them might have been caused by her separation from Ben's father.

> **"...it's all kind of part of the bigger picture of... sort of who he is and, and, *(clears throat)* erm, why he might have had difficulties and also he's got quite *(clears throat)* he's got quite a medical history…"**
>
> (Lindsey, 15-17)

When Ben had first gone to see a professional about his difficulties, Lindsey said that she had felt that the counsellor had interpreted much of what Ben was going through to be the result of her separation from her husband, and of Ben's relationship with his father. Lindsey had commented how she had thought that this explanation of Ben's difficulties was "**superficial**". It appeared that while she did not necessarily completely disagree with what the counsellor had said, she felt there had been more to it than that. There were elements of Lindsey accepting that her separation from her husband could have played a part in causing Ben's depression and his thoughts of suicide, but that she also believed that there were other factors involved and it was not solely because of her and her husband.

> **"In her, in her summary, erm, that we got, we got posted after the session, erm, it really looked like all of his issues were to do with his relationship with his dad and our break-up, erm, which I think was quite a superficial summation of what the problems were."** (Lindsey, 1132-1135)

Searching for the origin of the child's problems appeared to make up an important part of the mothers' sense making around having a child with mental health difficulties. It was apparent that the mothers needed to find a reason why their child was suffering, and that this quest was an active process for them. This active process almost seemed to be ongoing as some of the mothers seemed torn between wanting to pin the cause down to external factors that

had occurred in the child's life, and accepting that they themselves may have done something to enable the development of their child's problems.

The burden of responsibility

It was a common theme for most of the mothers who took part in this research to make sense of having a child with mental health difficulties by expressing how they had felt a huge responsibility to help their child, and that this responsibility had fallen mainly upon themselves. Perhaps this was because each of the mothers had been the primary care giver to the child, and had taken on much of the responsibility for other things their child needed whilst growing up. No mother directly called the responsibility a burden, but the way some described it showed that it had been a heavy load for them to carry and had been very difficult, and often it felt as though they were alone in taking on this responsibility. Some of the parents spoke about how they felt it was their job to do as much for their child as possible and help as much as they could before they sought professional help, and that professional help was only sought after the parent felt they had reached the end of the line in terms of how much they could personally do to help, or how serious the problem had gotten.

Pat expressed how difficult it had been for her seeing Amy go through the torment of being bullied at school, and how there had been nothing worse than seeing Amy unhappy, ill-treated and abused, and suffer physically due to the emotional pain she had been feeling. Pat described how she had felt **"totally responsible for solving it."** (Pat, 117-118). Pat further reflected upon what it was that had made her feel so responsible for sorting things out for Amy. She had explained that she had felt that her husband had not had the time to be able to deal with helping Amy, and was protective around the fact that her husband worked very hard and long hours, and there was a suggestion she had felt guilty about this when she had tried to ask him for support. There appeared to be a stereotypically gendered distinction going on in Pat's mind, of herself as the mother being responsible for the children while the father went out to work and earned the money. Pat also reflected on how she had

felt responsible for protecting Amy, and that as Amy's mother she was the one who should make these negative things that were happening to Amy stop.

> **"I felt that, you know, my husband wasn't around enough, and wasn't-didn't have the space in his head, or his life, to deal with it. He would come home very late, very tired, and you know I did, I did come to try to get him to support me, but it was very difficult for him, coming home every night to me in a state, crying, erm, and having to take that on at the end of his difficult day, so that's why I felt it was much more my responsibility."** (Pat, 124-129)

> **"It's just, responsibility is the word that I think of most. It is about, you know, you've brought this child into the world… I feel responsible for taking care of her, so if bad things are happening, it's up to me to make sure that it stops. It is, for me, has been the most difficult thing in my life I've ever had to do, is to- to try and protect her." (**Pat, 217-223)

Lindsey similarly spoke about how as Ben's mother she had felt the responsibility of getting help for Ben when mentally he became unwell. Lindsey compared this responsibility to the responsibility of parents needing to get help for their children when they had physical health problems, and this comparison showed that she viewed mental health as being as important as physical health when it came to being responsible for helping her children. Carol also spoke about Bobby's mental health needs in comparison to the physical health needs of her other son Billy, and described how she felt equally responsible for getting help for Bobby as she did for ensuring Billy had the correct medication for his asthma.

**"...in the same sense that when your children are physically unwell,
you know, it's your responsibility to see that they get the medical
help that they need."** (Lindsey, 1416-1417)

**"It doesn't matter what the label is, he's still who he is, and it's just a
case of finding things to help him with his problems in the same way
that Billy's got asthma and he has medication. And if that medication
doesn't work we try something different and, you know, you just do
what you can to help the symptoms at the time."** (Carol, 396-399)

For a lot of the mothers, it appeared that they felt that the responsibility of helping their child
with mental health difficulties lay with them, and they seemed to take action by firstly doing
all that they could to help their child themselves. The mothers seemed to be the ones who
then took action to get help for their child, and branched out to get this help from a variety of
sources, the GP being the most common first step for help. Ruby for example described how
she had felt responsible for helping Lucy through her problems, and the way in which she
described carrying and holding Lucy suggested that Ruby felt Lucy relied very heavily upon
her support through the difficult times. Ruby appeared also to share the view that it was
important that she as a parent sought professional help for Lucy when things got
increasingly difficult, and that if she had tried to carry Lucy through these difficulties alone
then she would have felt almost neglectful of Lucy's wellbeing. Ruby described how although
the responsibility of helping Lucy lay with her as a mother, it was her duty and the
responsible thing to do to share the burden of responsibility and get Lucy the professional
help she needed.

**"I mean although I knew I was carrying her and getting her through
and holding her, it would have felt very remiss of me if I was doing
that in isolation without any practitioners to back me up. And I would**

have felt like a bit of a charlatan and a bit deluded to think that I could

do it alone." (Ruby, 1043-1047)

Pat highlighted this by speaking about how she had felt she had done all that she could to help her daughter Amy, and that she eventually reached a point where she realised there was nothing more she on her own could do to help. She, like Ruby, realised she must share the responsibility of supporting Amy with the professionals. Pat had asked Amy to get some help but Amy had refused, and so Pat had told Amy that she had to go and there was no choice about it anymore. Here, Pat was taking action to get Amy the help she needed and fulfilling her responsibility as a mother to see that her child was supported appropriately. Pat had appeared to reach the point where she was almost desperate to help Amy and did not see a way she could further help on her own. The way she described being unable to cope with it anymore suggested that Pat herself had also almost reached breaking point.

"I reached a point where I couldn't cope with it any more, didn't know

what to do... I'd been asking her if she would see somebody, and she

was absolutely refusing to, and, and eventually, when I realised that

there wasn't anything more that I could do to help, erm, I said, well

I'm sorry, it's not now a question of asking you, I'm telling you,

you've got to go." (Pat, 9-17)

Carol further spoke about how as a mother she knew that she could not ultimately take away all of Bobby's problems, but that she did feel responsible for doing something to help him with these problems. She seemed sad in a way that she could not just remove Bobby's problems and take everything negative away from him, but that she had coped with this by taking on the responsibility of actively doing something to help him to improve his life.

"I can't make him not autistic, but I can give him strategies and ways of thinking and ways of coping that he can then use to make everyday life that bit easier." (Carol, 375-377)

Master Theme Three: The Journey of Therapy

Finding the "right" therapist

Some of the mothers described how it had been important for them to find the "right" therapist for their child. While some were able to pinpoint and describe qualities, attributes, and behaviours of therapists that were both positive and negative, and helpful and unhelpful for their child, other mothers described a certain match between therapist and child, and were not always able to verbalise what this consisted of. It seemed that sometimes, therapist and child just clicked and were just a good fit together. The mothers spoke about how their child had seen multiple therapists, who were just not right for the child, and the mothers appeared determined to keep searching for the right therapist and not to continue sending their child to the wrong therapist. Sometimes it was the mothers who noticed that it was not a helpful relationship between the child and therapist, and sometimes it was the child who reported to their mother that they disliked the therapist and did not wish to continue seeing that particular therapist. Some mothers also appeared to believe that the right therapist for their child needed to be someone who had certain credentials and certain experience, and they were prepared to spent time searching and waiting to find the right person with the right qualifications and experience to help their child.

Ruby said that Lucy had seen a few different therapists, and had reported back to Ruby that **"they just don't get me"** (Ruby, 37,) and **"I can't engage with her."** (Ruby, 381). Ruby had illustrated that for Lucy, there wasn't a specific negative quality, but a feeling that the therapists simply did not understand her and she was not able to connect with them. There were other therapists that Lucy had seen, that Ruby was able to pick out negatives that had

made her not want her daughter to continue to be seen by them. Ruby described this as though there was a balance that therapists needed to achieve in order to be good therapists and to connect with their clients, which seemed to exist between two polar opposites, of being rude and unwelcoming and being overfriendly and overfamiliar.

> **"The others were very, very frosty, very cold and arrogant, the first one quite rude at the door. The first one I went to the doorstep with her and she was very, very clinically cold and very unwelcoming. The other one practically was at the point of inviting us for dinner, so completely inappropriate."** (Ruby, 381)

Brenda said that Luke had seen two therapists and that the second one had been a good fit for Luke, but that the first therapist he had seen had not been such a good fit. She had mentioned a connection that Luke had had with his second therapist that had not been there between Luke and the first therapist. Brenda had felt that the first one had not understood Luke the way the second one had, and perhaps like Lucy had illustrated to Ruby, that Luke had been unable to engage with her.

> **"He was very helpful, very skilled. Connected really well with him... there was one woman that we saw before and I didn't quite get a sense that she'd got him in the same way..."** (Brenda, 471-474)

Brenda went on to discuss some of the qualities of the two therapists, and said that the first one had been very direct with Luke and that he had not liked it. The second therapist Luke had seen was described by Brenda as being a warmer person, and had been able to help Luke identify the areas in which he was functioning well, which had been more helpful for him than being challenged. When she described the positive qualities of Luke's second therapist, Brenda said that at the time this was the kind of person that Luke had needed, and

this illustrated that perhaps in order for a therapist to be the right therapist, the qualities they have and the way they work need to match what the client needs at that particular point in their lives.

"I think one of the reasons that he didn't like her is perhaps because she was quite direct." (Brenda, 487-488)

"...she pushed him a bit... she challenged him." (Brenda, 492)

"He's what I'd call soft. A very soft, warm person... And so just the person that he needed at the time, actually... I think he did a lot of acknowledging of Luke, really. And… yeah he was quite… he was very reflective, and acknowledged and validated him. I think just identified his strengths, and the things that he did do well." (Brenda, 516-527)

Michelle described Sofia's therapist as someone who made the effort to relate to Sofia and see things from her perspective. She also mentioned that he made Sofia feel **"normal"**, and this appeared poignant for Michelle. After describing earlier how many parents perceived stigma from other people about their child needing professional help, and Michelle suggesting that she felt others often saw counselling as being for **"crazy people"**, it seemed important for both Michelle and Sofia to feel that Sofia was not crazy, just because she was experiencing these difficulties. This seemed to be something that Sofia's therapist managed to achieve, and that helped him to build a relationship with her and helped Michelle to also feel comfortable that her daughter was happy with her therapist.

"…I know she said he was very, not, he sort of like went to her perspective a lot… She could relate to him and she found it

comfortable talking to him… Like I said he came across you know, went to her level… And then to say to her you're normal you know, that's what they're saying to her…" (Michelle, 703-927)

Tanya spoke about how she had felt she had found the right therapist for Christopher through the way that the therapist had worked with Christopher, and how the therapist's non-directive nature had allowed Christopher to work out his problems and helpful solutions for himself.

"This woman's creating this space – although, I probably didn't use that phrase then, but I do now – creating this space, and he's…she's with him and reflecting it back to him, so that he's working it out for himself, and it was fantastic." (Tanya, 433-437)

Lindsey talked about the right therapist in terms of her own experiences of counselling. She said that she had been to see a few different counsellors, and that on occasions she had seen a counsellor once and had not gotten on with them, and so had not been back to that counsellor. Lindsey said that this had not been a problem for her, as she had then been able to move on to a different counsellor, but she acknowledged that sometimes one bad experience with a counsellor, and meeting a counsellor with whom you were not suited, could put people off counselling as a whole and put them off finding a different counsellor. Lindsey said that she felt that the relationship between counsellor and client was the most important thing within the dynamics of counselling. This highlighted how for her, there was not necessarily certain attributes or qualities of a counsellor that she would look for, nor even what it was that the counsellor offered, but the essence lay in the relationship between client and counsellor, and the suiting of this.

"I think a lot of people will go to a counsellor, not have a rapport with them and never go to counselling again because it, you know… which is a shame… it's more about the relationship than what's being offered." (Lindsey, 1087-1094)

Lindsey further reflected on how important she viewed the relationship between counsellor and client by describing how she had disliked the first counsellor she had taken Ben to see and had not really been able to pinpoint exactly why, but she had just felt that the relationship wouldn't be helpful for Ben. Lindsey also discussed the second counsellor she took Ben to see, and said that she had felt much happier with how the relationship would be between Ben and this counsellor compared to the first counsellor.

"Erm, as I say, I wasn't, the first lady, erm, I wasn't keen on at all, erm, and I don't know why. But she, erm (.) I just knew that it wasn't gonna be a useful relationship." (Lindsey, 1125-1127)

"And, erm, the second lady we saw, was, from the minute we met her I knew it was gonna be a productive relationship…" (Lindsey, 1165-1166)

"I'm trying to think of the differences between her and the first one, 'cuz it was nothing, erm, it was nothing I could put my finger on that wasn't, that, you know, that was wrong with the first lady we saw." (Lindsey, 1171-1174)

Stephanie, like Lindsey, stated that she thought the therapeutic relationship was the most important factor in the experience of counselling. She also reflected on how she felt that a negative experience between Keira and her counsellor had put Keira off counselling in the

future and that despite the positives that Keira had gained from therapy, the rift in the therapeutic relationship meant that she would not consider counselling in the future.

> **"I think, personally, erm, one of the most beneficial parts of therapy is the relationship that you have between therapist and client."** (Stephanie, 868-870)

> **"…it reinforced, erm, how easy it is to, erm (.) put somebody off counselling."** (Stephanie, 904)

Finding the right match between the therapist and client was also something that was picked up upon by Pat. Pat spoke about this fit in terms of the personalities of the client and therapist needing to match up with each, and that this was an important factor in determining whether someone had a good experience of counselling. Pat spoke about there being a problem with matching counsellors and clients, and had previously reflected that Amy had been referred to CAMHS but that after a few sessions Amy had felt the therapist had not been right for her, and they had then decided to go and see a private therapist, which appeared to be a much better match for Amy in terms of the therapist's personality and attitudes.

> **"...I met this woman who I knew personally, and liked and felt very confident that she would be right for my daughter, in apart from being very local. I felt she had the right kind of approach, right sort of attitude and personality."** (Pat, 251-253)

> **"I think the problem with all of this matching counsellors and clients, is, it is a match in a sense, you know, and I know myself, from my experience in my training, that not every counsellor is a good**

counsellor. Or particularly the right person, you know, personality for the client, and it's about finding the right match." (Pat, 268-271)

There were varying things that the mothers spoke about when describing the right therapist. For some mothers there were tangible qualities that were positive or negative, but for most mothers it appeared that there was something about finding the right therapist that could not so explicitly be explained. It was apparent that all the mothers felt that there were very much right or wrong therapists for their children, and that it was essential to find the right one.

Handing my child over

Some mothers spoke about what the experience of handing their child over to a therapist had been like for them, and how this had felt. It seemed that this was a difficult thing for some of the mothers, and that trusting someone else with their child and handing the responsibility of care over to someone else was a big step for them. Some mothers also spoke about despite this being huge for them, it also felt positive, and that once their child was put into the care of someone they trusted to help, it came as a relief. Trust was a big element of handing their child over, and for some of the mothers they only felt safe handing their child over when they felt that their child was receiving the best help by the best people in the field.

Ruby described how Lucy had had to wait for treatment but that eventually she was able to see a specialist in the field. For Ruby, it had seemed important that Lucy was seen by someone who had experience working with young girls who had been through what Lucy was experiencing, and that by getting someone with these credentials it had enabled her as a mother to trust that this professional was going to be able to help Lucy.

"They got her a top child psychotherapist whose specialism was girls in crisis. That's why we had to wait then. I had huge trust in the whole system." (Ruby, 437-439)

Because Ruby had felt she had found the best care for Lucy, she described what it felt like for her when Lucy was in her sessions, and how because she felt like Lucy was receiving the best care, it enabled Ruby to trust that Lucy was safe and protected from harm and being helped. Ruby described this as feeling free and able to, for that short period of time, focus on something else and not have to worry about Lucy. This time during which Ruby felt free seemed hugely important for her and she described it as not only supporting Lucy, but supporting her as well. Her descriptions of feeling settled during these times evoked a feeling that for Ruby, this was her escape time. It also echoed the sentiments of respite for carers.

"I'd feel so liberated when I left there because she was in safe hands. That's how it felt. And I could go off and focus on shopping or whatever I had to do without knowing the phone would ring and I'd have a tearful or hysterical or absolutely desolate child on the end of it. I knew for that hour and a half I had a breathing space. So in that sense it was hugely supportive for me too." (Ruby, 543-547)

"I always felt very settled when she was there." (Ruby, 554)

Stephanie, similarly to Ruby, had wanted the best care for Keira and described how she had wanted Keira to see a counselling psychologist as Stephanie understood the level of training and expertise that counselling psychologists had. When Keira was referred to a nurse practitioner and not a counselling psychologist, Stephanie described that she had felt very disappointed, and that this had made the process of Keira going for therapy, and of

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Stephanie feeling comfortable handing her child over for therapy, much more difficult for her. Stephanie described that not only had it been hard to trust that Keira was going to receive the best help by seeing a nurse practitioner and not a psychologist, but that she felt that this meant the professionals did not view Keira's need to be as a high as Stephanie knew it was.

> **"...that- that made it hard... I was disappointed she didn't, erm, get a counselling psychologist.... Erm. I was very disappointed because (.) I felt that she needed that level of expertise. And, erm, I thought it was unfair. I felt that she got second best..."** (Stephanie, 550-554)

> **"Erm, because, yeah, after- after her going through it for so long, and that is then my training, is that knowing the difference between a nurse practitioner, a counsellor, a counselling psychologist... And saying, this is where I position your need. I position your need over here, and actually having it two notches down I thought was kinda crap."** (Stephanie, 562-567)

Brenda spoke about an incident when she had to take her son Luke to the Accident and Emergency department after he had self-harmed, and how she felt all the professionals there were quite overcautious when dealing with Luke. She said that she thought it was because when people were working with adolescents, there was a greater responsibility in managing the risk, because if something went wrong there was a lot of finger-pointing about where it had gone wrong and who was responsible. For Brenda, this over-cautiousness that she had perceived had made her worry about handing Luke over to the care of the professionals, as she had felt that this handing over of him meant that she could potentially lose control of the situation, especially if the professionals thought that Luke was a risk to himself and needed to be sectioned. It was this fear of the loss of control over her son's care that appeared to make it difficult for Brenda to be able to feel comfortable letting the

professionals take care of Luke in hospital, and made this part of her experience feel very scary. Unlike Ruby, Brenda had perceived handing her child over at the most critical and serious time to be more anxiety provoking than feeling like she could relax and feel settled that Luke was being cared for by good doctors.

"**But that was annoying, I mean it was… that, that made it scary actually...**" (Brenda, 415)

"**...it was that control, yeah, yeah… That other people, yeah… could easily take control.**" (Brenda, 435-436)

"**So… so, yeah perhaps it was about control for me.**" (Brenda, 446)

Handing their children over into the care of someone else appeared to be a mixed experience for the mothers, some feeling that it was positive and others feeling more negatively about it. Different things affected how the mothers viewed this experience, and it seemed that the qualifications and experience of the professionals was an important factor in determining how the mothers felt about letting someone else take the responsibility on of helping their child at the most poignant time. For some mothers, the handing over of their child almost set them free for a short while, while for others they saw it as losing control over their child's care and that there was a possibility their child might be taken away from them.

Seeking own support

Seeking support for themselves was a common theme that came up in the interviews with the mothers. Most mothers did end up seeking support for themselves and acknowledged how hard the whole experience had been for them as well as their child. Some mothers had chosen not to seek professional support for themselves, but appeared to have had other avenues through which they felt supported. Ruby used the metaphor of refilling her own

coffee cup to illustrate how important she felt it was that she had gotten support for herself as well as support for Lucy, and that she felt by getting this personal support she had felt more able to support Lucy. Ruby was a counsellor herself and had worked with parents in similar positions as herself, and explained that she often used this metaphor to encourage the parents she worked with to get support for themselves, and felt that she should follow her own advice. I felt that this showed how, as I'm sure is common to many practitioners, sometimes it can be easier to support others and neglect our own needs, but the importance of getting support for ourselves can be invaluable in helping us to cope and to offer even better support to others.

> **"I realised that unless I started meeting my own needs a bit more I was going to go under with her. So I went off and got my own counselling… Because I always practiced preaching to the parents I work with: if you don't refill your coffee cup, who is going to fill it up again for you? You're useless unless you meet your own needs. I started to question why I wasn't doing that for myself."** (Ruby, 234-243)

Carol reflected on the support she had received, not just professional support but also support from her friends and family, and how this had made coping with Bobby's therapy and his difficulties much easier for her. She acknowledged that it had been hard at times for her, but that through the good support she received, it had not been as testing an experience as it may have been for other parents.

> **"I'm quite laid back about everything really. I'm not…I don't see it as a big…I think probably 'cuz I've had really good support, I don't see it as the big battle that I think lots of people do."** (Carol, 250-252)

This was not the case for all parents. Michelle did not seek her own support when Sofia received therapy. Perhaps, unlike the other mothers, as she had had no previous experience with therapy or counselling either on a personal level, professionally, or through her family growing up, she had not considered the importance of seeking support for herself. Michelle reflected on this a lot during her interview, and at one point she became quite upset and tearful when she reflected on the fact that she had not been offered any support.

> **"You can tell; like I got upset because it's still raw isn't it; it's still something that you think yes it would have been nice if that was there then."** (Michelle, 1515-1516)

Reflecting on this during the interview appeared to be a process for Michelle which she had not reflected upon before. Her tears appeared to come from feeling let down that she had not been offered support by the service where Sofia attended, and reminiscing about how difficult the experience had been for her and how helpful some personal support would have been. She described the reflections as **"still raw"**. The connotations that came with the use of the word **"raw"** depicted something that is sore and painful and unhealed, and this appeared to accurately reflect how Michelle was feeling when she reflected back on being offered no personal support. Her tears showed this was a pain not yet healed. She mentioned that to go externally and seek support for herself would not have been something she would have thought about doing at the time, but that if she had been offered support in parallel to Sofia, this would have made it easier to accept and easier to attend as well.

> **"I wouldn't have gone [for my own counselling] but it would have been nice if I had gone for Sofia and it was there and it would have been easier for me to go. You know otherwise you'd have to make another, you know it's quite a big decision then to do that for yourself but if it was just there it would have been an easier step I think.**

[That's] quite a big decision to make but if you're going for your child and it was there it would have been easier for you to just open the door, or knock on the door if it was there. Because we're all just sort of told to just get on with it aren't we, not told but we're just expected to just get on with things and then if that was there that would be nice." (Michelle, 1525-1552)

Michelle's repetition of the fact she felt that seeking her own counselling would have been **"a big decision"** reflected perhaps how she felt about her daughter having to receive counselling, and how much this must have impacted on her. It highlighted that Michelle had felt the need for her own support, but had not felt able to go and seek it herself and upon reflection, had wished the service seeing Sofia would have offered this to her. At one point during her reflections upon this, Michelle said **"that's a good idea"**, and it appeared that I was witnessing her current sense making process around this part of her experience, and that it had not been something she had thought much about before doing this interview. This theme appeared to become quite important for Michelle throughout her interview the more she reflected on it, and she ended up suggesting that support for herself and for parents was the main thing that was coming out of her interview. She also reflected on her reasons for participating in my research, and that she had hoped that taking part would be a way of her being able to speak to someone about her experiences, a chance she perhaps felt she missed out on while Sofia's therapy was current.

"A support thing, that's what's coming out of this, like a support thing that you're trying to do, is good. For parents." (Michelle, 1259-1264)

"I thought maybe it would be good for me as well, saying I knew my daughter had problems and I thought well it would be nice to talk to

someone. So it was like good for me as well as good for you…"

(Michelle,1286-1288)

Lindsey did not seek her own professional support either during the course of Ben's difficulties and therapy, although she acknowledged that she would have liked to have done. Lindsey reflected that she had had other forms of support, such as a good supportive network of friends, but that she had felt like she should have gone for professional support as well. She spoke about one time she had been with Ben's therapist, and that she had wanted so much to open up to her about her own emotions, and to offload. Lindsey said she had not felt it appropriate to do this as it had been Ben's therapist and they had both been there to support Ben, but that this had not stopped her wanting to. It showed how much Lindsey had wanted to reach out to someone about how hard this experience was for her, but that she had had to contain it.

> **"I've just had to talk to friends really and I'm lucky 'cuz I've got a lot of good friends that, that are, you know, useful to talk to, but they're not trained professionals."** (Lindsey, 1448-1450)

> **"…I remember the one time sat with [Ben's therapist] and, erm, I felt quite emotional and I actually wanted just to tell her how bad it felt for me, you know, and how scared I was, erm, and, and just offload a little bit…"** (Lindsey, 1457-1459)

Seeking support for themselves appeared very important to the mothers. The ones that had gone and got professional help for themselves appeared to have felt like it had been crucial in helping them to cope. The ones that had not gotten support for themselves appeared, in the way they spoke, to have felt regret about this and acknowledged how useful the support could have been. Friends were a common form of support for many of the mothers, although

it appeared that the support from friends alone was not as valuable as seeking professional support.

The balance of outcomes

Most of the mothers spoke about the outcomes of their child's therapy and how the therapy had ultimately facilitated positive changes in their children. Some mothers discussed negative as well as positive aspects, but it seemed that most of the mothers were glad that they had sought professional help for their child, and that the outcomes of the therapy had affected their own experience in a positive manner. The descriptions of the positive changes that the therapy had elicited highlighted that the mothers had been able to come through the difficulties of seeing a negative decline in their children, and felt that although things may not be perfect and that therapy had not been a magic wand, their child's future was now much brighter. Some of the mothers had appeared to make sense of the outcomes of their child's therapy by applying it to what it meant for their child in the future, and for important aspects of the child's life.

Tanya spoke about how she had wanted a non-directive type of therapy for Christopher as he had been so young. She said this was a reason that she had been interested in accessing play therapy for him. She said that when play therapy had been explained to her, she had liked the way it aimed to move at the child's pace and let the therapist get to know what it was like to walk in the child's shoes, rather than it being a directive type of therapy that was going to do something to Christopher that potentially might not work. However, after Christopher had received three years of play therapy she felt that they were still not completely there in terms of solving his problems.

Tanya described the process of Christopher's therapy as **"a long, slow drip, drip"** (Tanya, 220), but that the play therapy had made a lot of difference for Christopher and it had felt like they were moving in the right direction with helping him, which was positive for Tanya. The

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analogy of **"a long, slow drip, drip"** made me think about a dripping tap; the tap drips because it is broken, which initially sounds negative, and it continues to drip slowly as it is not yet fixed. It is often thought that the more we listen to something like a dripping tap, the louder it seems to become and the more annoying it gets. Which is comparable to negative symptoms feeling worse and worse the more we pay attention to them. Perhaps Tanya was trying to suggest that they were not all the way there with sorting Christopher's difficulties, like the tap is not fixed as it continues to drip. But she went on to say that there had still been improvements for Christopher and that she hoped the improvement would continue. Maybe this was her way of not paying attention to the remaining negative symptoms that Christopher was experiencing, so not paying attention to the noise of the dripping tap, but trying to focus on the positives that had come from the therapy and the improvements that had been made so far. Tanya had said the experience had also been positive for her as even though she had not directly been involved in Christopher's therapy, she had been included enough through the feedback in order to feel that Christopher's therapist and herself were working together as a team to help Christopher.

> **"It felt like play therapy was the right way to start and it did make a**
> **huge difference, and there was a lot impact, but we were, by no**
> **means, all the way there at the end of his three years of play therapy.**
> **But, you know, it felt like we were moving in the right direction…"**
> (Tanya, 216-220)

> **"So it's almost as if we were working together to figure Christopher**
> **out and it felt like we were really in it together."** (Tanya, 506-507)

Lindsey spoke about the positive outcomes that Ben's therapy had had on him, and described these changes as having started from almost the first time he had begun to see

his therapist. She spoke about how receiving therapy had enabled Ben to feel more positive emotionally, and had been a step in helping Ben to begin to mature.

> **"…from the minute he started seeing [his therapist] certainly, erm, he
> felt a bit safer and calmer and erm, I think it helped him grow up a bit
> as well."** (Lindsey, 1844-1844)

Ruby similarly said that throughout the whole of Lucy's therapy, she had seen how positive the changes were, but that Lucy might not have agreed that the therapy had been as successful as Ruby had believed. Ruby made sense of Lucy's different reaction to Lucy not being as aware as she had been of how intensely the therapist had worked with Lucy and how he had helped her to elicit positive changes.

> **"I think he was superb and I think the feedback I got from Lucy each
> week showed me that he was doing his job so brilliantly and making
> her unpack the relevant things that she didn't want to revisit… I think
> she's not fully aware of quite how deeply he worked with her and how
> successful that therapy was."** (Ruby, 64-68)

Carol spoke about the outcomes of therapy were positive for Bobby as well, and that during his CBT with his therapist at school, Bobby was able to come up with two alter-egos that represented how he reacted to the negative emotions he was experiencing; Bobby the Boxer was the strong parts of Bobby that were able to counteract the negative feelings that he had, and Agent X represented the weaker part of himself that felt vulnerable to the negative emotions. Carol said that the creation of these alter-egos had given Bobby a toolbox which he could use to cope with his depression.

"...between them it was really creative, really amazing the ideas that he came up with about the toolbox that Bobby the Boxer could have to fight off Agent X, and what Agent X had that Bobby felt that he couldn't fight against." (Carol, 639-641)

Pat spoke about the outcomes of Amy's therapy as helping her to start on a road of personal change. This description showed that perhaps Pat, like some of the other mothers, felt that Amy's therapy had not completely solved all of her problems or been a magical cure, but that it had helped her with a journey of personal change which she would be able to continue herself, and that this journey would change Amy's future and had made it brighter and more positive. Pat said that she had seen a change in Amy and the way that Amy handled difficult situations, which was much more positive.

"...I knew that she'd started on a road to personal change that was absolutely vital for her, and would make all the difference to her life. And clearly it is. The way she goes about things now." (Pat, 702-704)

Stephanie described the positive changes that had come from Keira receiving therapy to address her blood phobia, and that this had been so important in terms of Keira's academic future. Stephanie had previously described how Keira had loved Biology but had been finding it difficult to cope with the aspect of blood involved, but since receiving therapy to address this phobia Keira was now able to pursue her interest in this subject.

"…she now copes with blood so much better that she's doing a Biology A-Level. Which is massive. And I think that was her driving force in going to therapy in the end." (Stephanie, 872-874)

"It's good to see that she can cope with what she has now. That's very positive. I already knew that she was resourceful, and I'm glad that she hasn't- is managing it for herself now." (Stephanie, 901-903)

Stephanie however did describe some negative aspects to Keira's therapy, namely that she felt Keira's therapist had breached Keira's confidentiality by sharing too much with Stephanie, and that this had such a negative impact on Keira and how Keira viewed her own therapy. Stephanie said that she had been happy with the outcomes of Keira's therapy, but had not been happy with the process of it and how the outcomes were achieved. For Stephanie, this led her to worry about what this may mean for Keira in the future if she experienced further difficulties. This led Stephanie to have a mixed view of Keira's therapy.

"So erm, so it was good and bad. Yes she addressed what I wanted her to address, or she wanted to address, erm yes she had a successful outcome, it's completely decimated her idea of what counselling and therapy is about. That makes me sad personally." (Stephanie, 895-898)

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Most of the mothers described positive outcomes from their child's therapy. Although not all of the mothers felt that therapy had been a cure and the end of all of their child's difficulties, there was a general consensus that the therapy had elicited some change and some improvement for their child, and that it had made their child's futures brighter and more positive. The therapy was generally seen as helping the child to start their journey down a road of change, and that it had equipped their child with necessary and valuable skills on which they could continue to build.

What it meant to be a parent was a recurring theme across the interviews in this research. Most of the mothers spent time in their interview reflecting on what it meant to them to be a parent, what they viewed their role as a parent to be, and what values they held as a parent. The role of parenthood was further explored by the mothers highlighting the things that they tried to do for their children. Each mother's values played in a part in how they had tried to parent and what they had felt had been important, and this had led on to the mothers thinking about where their values had come from and why they had been the type of parent they were.

The role of a parent

Most of the mothers discussed what they had felt their role as a parent was, what they had felt parents "should" and "shouldn't" be like, and the concepts and values they had prioritised with their children. Pat for example described parenthood as being both the best thing that had ever happened to her and also the most difficult thing. When describing what being a parent meant to her, she described a need to protect her children from experiencing bad things and suffering, and this theme of protection seemed to be of the essence of what it meant to Pat to be a parent. Even though she felt she could not protect Amy from experiencing negative things, she relished the feeling of seeing Amy come through her difficulties and be happy again, and spoke about this with a passion that highlighted how being a parent added something special to her life. Her language around "growing" and "blossoming" almost depicted her daughter as a blooming garden full of life and colour, and highlighted how special and colourful the journey of being a parent had been for Pat.

> **"Being a parent, well, it's really sort of the agony and the ecstasy for me… It is, for me, has been the most difficult thing in my life I've ever had to do, is to- to try and protect her. At the same time, I mean obviously things are very different now. When you've resolved it, and**

when you see, erm, your child growing and blossoming and

everything coming good, it's the best thing that's ever happened to

me. It's the most rewarding thing in my life, really." (Pat, 215-226)

Ruby spoke about her ideas of parenting, and like Pat she spoke about a parent as having the role of protecting their child, and having to save and protect your children from dangers. The whole process of Lucy having difficulties and receiving therapy appeared to be, for Ruby, a journey of exercising her parenting values by her trying to save Lucy from hurting herself through her eating disorder, and highlighted the value of protection.

"I think that as a parent, when I became a parent for the first time

I…because of the constructs of my childhood and the things I

remember as being important, I felt that it had always been my role to

save my children from things. So therapy for me was a part of that. It

was saving my child from danger and she was at danger from

herself." (Ruby, 1034-1038)

Stephanie spoke about her views on parenting, and described her role as a parent as being a **"caretaker"** to her children. She appeared to feel that parents should not be overbearing or intrusive into their children's lives or try to mould their children into some mirror image of the parent, but instead should be able to stand back and be able to guide and advise their children and encourage them to discover their own paths in life. The images that are elicited from the work **"caretaker"** are that of a job in which the employee is responsible for taking care of a building or a property, making sure everything is ok at that property, fixing things, and making sure the building is clean, secure, and well maintained. This may be how Stephanie viewed her role as a parent; to make sure her children were ok, to help fix things when they went wrong, and to make sure they were well looked after, but not to directly interfere with who they were as individuals or to try and mould them into something specific.

"I've always raised my children- my theory on- on- children, is that they came out of me somehow (.) erm, and, erm, (.) but then I'm just a caretaker. They are born who they are and there is a little bit of nurturing involved there where I influence them and I help them with moral issues and I give them guidance and, and teach them about respect, and tolerance and things. But they are who they are and they need to be treated who they are…So I guess it's about my whole life philosophy, it's about, you know, you are not part- I was never one of- you are part of me, you are mini me, you are- I shaped you in my own image and a bit like a God thing..." (Stephanie, 383-399)

Stephanie further reflected on her ideas about parenting by acknowledging that although she held her own ideas, parenting was something that would be different for every parent and that the right way for one parent with their children might not necessarily be the right way for another parent with their children. Stephanie reflected about how it might have been for her children growing up with her style of parenting, and that in some ways although Stephanie felt she had done what was best for them and had stayed true to her own philosophies about how parents should be, this might have made it difficult in some ways for her children. She weighed up her own values against the way that other people chose to parent, for example those that brought their children up a certain way. Stephanie spoke about how being given certain expectations as a child may have made it easier, as it gave children either a **"comfort zone"** or something to **"rebel against"**. Despite this weighing up and acknowledging of different styles of parenting, Stephanie appeared to have been happy about the way she had brought up her children and showed no regret at her parenting style, and believed that she had followed her own values.

"I think it is different for everybody, you know, I- I've deliberately not, erm (.) erm (.) encouraged a particular religion, I've not encouraged them to take any particular path. Erm, maybe that's hard for them at times, maybe it's easier to be given things and then maybe rebel against it, or maybe to be given things so that you create a comfort zone, so maybe it's made it harder for them at times. But it's always about, listen to what's inside you and then go with that." (Stephanie, 413-418)

Carol appeared to share similar values to Stephanie, and said that she had always seen her role as a parent as being able to encourage each of her children to be individuals. Carol said that she had worried about having three children, but that she viewed each of her children as individuals and had tried hard to show them this and to show that they were all special in their own ways.

"I try and keep everybody quite balanced 'cause I do worry about having three, having a middle child who is a typical middle child, but they're all quite unique with different skills and…you know, strengths and things... They're really quite individual children so it's nice to have their…to be able to treat them as individuals." (Carol, 123-131)

Lindsey spoke about how she felt that a parent's role was to listen to their children and show their children that they would always be heard. Lindsey had earlier reflected on how she felt communication was vital for children, and this perhaps also fell into her values as a parent. She felt that by making herself available to talk to, she was showing her children that they would always be listened to, which was validating for a child and their growth and nurturing.

"I do think as a parent pretty much the only thing that's fundamentally important is to be listening to your children all the time and make sure that even if you're really busy, that they know you're available to talk to." (Lindsey, 1782-1784)

Lindsey also spoke about the negative parts of being a parent, and she spoke about this in terms of the things that she felt parents should never do within their role, for example harm their children. The fact that she had been made to feel like she had failed as a parent by having not just Ben receive therapy, but then her other son then needing it as well, appeared to have made Lindsey question her parenting style. She reflected on how she had never harmed her children, but questioned some of the things that she could have done more of or done better. She also viewed the fact that two of her children had needed therapy as meaning her family had **"fallen apart slightly"**, and appeared to have held herself responsible for this. Lindsey appeared to give great weight to the power of parenting skills in determining a child's happiness and whether they developed problems.

"My, my middle one since has had difficulties, erm, and with two of them, all of a sudden you do feel like, you know, I've got one with this problem and another with that problem and actually, you know… my, my parenting skills are clearly not all that because we've fallen apart slightly..." (Lindsey, 757-769)

"...there have been times when I've just felt, erm, quite ineffective as a parent. Erm, I know I've not ever, kind of, done anything, erm, harmful to them, but, you know, you feel, erm, perhaps that you've not been as, erm, kind of, involved in their lives as you should have been or as, as mindful of their, erm, of their issues..." (Lindsey, 800-806)

The origin of values

Most of the mothers who had thought about what their role was as a parent and what their values were also spent time considering where they thought their values had originated from. At times, the mothers highlighted either a corrective or replicative script from their own childhood and how they had been parented themselves, to how they chose to parent their own children. Some mothers picked out positive things from their parents that they wanted to replicate within their relationships with their children, and other mothers discussed negative aspects about the way they were raised and how they had either consciously or unconsciously chosen to parent their children in a different way that steered away from those negatives.

Tanya highlighted a balance between replicating and correcting how she herself had been parented. She said that she had taken some of her own values and ideas of parenting from her own parents, but that she had also developed some of these values as a reaction against her parents and the things they had done that she had grown up to disagree with.

> **"Erm, well, obviously, some [values came] from my own parents and**
>
> **then some in reaction, against them."** (Tanya, 387-388)

Tanya also spoke about how her mother and mother-in-law had both sent her parenting books, but as one came from America and one from England, the content of the parenting books was completely different. Instead of being confusing, Tanya said she had actually found this helpful as it had allowed her to find her own way of parenting that was not solely reliant on what was said by the experts, as the two conflicting sets of advice had shown her that even the experts did not always agree. Tanya described this as **"liberating"**, and this concept of liberation appeared helpful for Tanya in allowing her to be free in what she chose to do with regards to raising her children.

"…my mother-in-law, who's English and my mother, who's American, sent me parenting books and they disagreed on everything important. They disagreed on feeding, on sleeping, on all kinds of stuff, and I thought, "That's great. You know, clearly, the experts don't know as much as they think they know, and I can pick and choose and make it up, and so, maybe, it was just a continuation of that, liberating and, there's not a right way. We can find our own right way." (Tanya, 376-382)

Stephanie reflected on how she had felt her mother had been very controlling when she was growing up, and that this had made her decide to actively not be so controlling with her own children. She also reflected on how her own mother had made her feel in comparison to her brothers, and that she had been made to feel like they were more important to her mother than she was. This perception for Stephanie growing up appeared to be very profound, and had shaped how she had then treated her own children, and had made her work very hard to ensure all of her children felt equally loved and equally important.

"…because my mother was so intrusive I decided not to be that intrusive." (Stephanie, 404)

"…My two brothers, erm, were always brilliant, apparently, erm, and I was always a pain in the arse… So, erm, I'd- I- I remember her telling me, err, yes but your brothers are special but I do love you. So, that's an interesting one. So I have with my own children being at pains to tell them there are no favourites, you're all very different and I love you for who you are. But it doesn't mean I love one more than the other, you're all loved equally, you're just given what you need."
(Stephanie, 446-465)

Lindsey reflected that she had tried to encourage Ben to be independent as he grew older, and that she felt the origin of the value of independence had come from when she herself had been growing up and had been ready to leave her parents' home. She said that the way she had felt had influenced the way she tried to be with Ben, wanting him to be independent but also wanting him to know that she would still be there for him if he needed her.

> **"I know when I left home, you know, I was ready to be completely independent and you don't, the last thing you want is parents that aren't allowing you to be that… And I do want him to be independent, erm, and know that I'm there but I'm there when he wants to come to me rather than, you know, rather than chasing him."** (Lindsey, 1703-1710)

Pat spoke about how her own experiences with her mother when she was growing up had positioned her as being the one who had been responsible for her mother, and that her mother had relied quite heavily upon Pat to look after her and to help her. This appeared to have shaped Pat's views of how she would be as a parent, and Pat had made a conscious decision that she would not be like that with Amy. Rather, she had the view that a parent's role was to protect the child, not that the child should protect the parent, as it had been in her own childhood.

> **"I grew up in a situation with my parents, where my mum was very very unhappy, and er, she really used me as her counsellor as soon as I could talk, I think, so that I was given a sense of responsibility for her happiness, and always felt that I had to do something for her, to help her, which erm, I couldn't really do, apart from listen to her, you know." (**Pat, 125-133)

Each of the mothers had their own understanding of the origins of their values. Most of their values appeared to have come from their own parents and their own childhood experiences. The mothers seemed to have either then wanted to be with their children how their parents had been with them, or to actively go against how their parents had been and to parent their own children in a different way. It highlighted how powerful parenting can be and how much of an impact it can have upon on child's life, the values and attitudes they develop, and the roles in which they see themselves.

Chapter Four: Discussion

In this final chapter, I provide an overview of the main themes that emerged from this study, and link these themes to existing literature. I hope this will show how this study presents support for much of the literature that is already in existence, thus validating some of the individual experiences of the mothers who took part. I will discuss the challenges that I faced whilst doing this research, both methodological and the procedural, and outline how I have tried to address these challenges. I will discuss the transferability and quality of this research, and the strengths and limitations, with a view to showing how future research could be conducted that builds on this study. I will also include an account of my personal reflexivity in relation to carrying out this research.

Overview of Findings, Theory, and Research

The Enhancement of Relationships

The relationship between the mother and the child was something that was reflected on by most of the mothers who took part in this research. It was commonly reported that the mothers felt that they already had a close relationship with the child who received therapy, and that through the journey of the mental health difficulties and the child receiving therapy, this relationship was enhanced and made stronger and brought the mother and child even closer together. Some mothers felt quite protective over this relationship, and wanted to emphasise to me how close and strong it was. What was very salient within the relationships between the mothers and children was their perception of the presence of a unique connection between parent and child, a connection that was not always tangible, but enabled the mothers to feel and experience what they believed their child was feeling and experiencing. This caused a parallel process to occur for the mothers, and resulted in many mothers believing that their feelings mirroring those of their child.

McMahon (1995) emphasised that women are deeply connected to their children, and other previous research has indicated the presence of an important connection and

interdependence for women within their relationships (Miller, 1986; Jordan,1991). This was present for the mothers within this research, who outlined a special connection between themselves and their child. This special connection or bond between mothers and their children has been outlined in literature on attachment theory, and emerging literature on the parent-child connection. The bond between the mothers in this study and their children was evidential through the way that they described their perceptions of mirrored emotions, parallel experiences, and even powerful visions which led them to their children in a time of need. This could provide support for the existing literature. However, due to the suggestion that in society there should be this strong bond between a mother and a child, it is also possible that the mothers were keen to emphasize that this bond was present between themselves and their child to reduce the risk of further stigma or suggestions of bad parenting and of causing their child's difficulties.

The suggestion of a connection between mother and child within this study could also be explained through the concept of intersubjectivity. This term refers to an awareness of a shared meaning with another person (Trevarthen and Hubley, 1979; Bretherton, Mcnew, and Beeghly-Smith, 1981; Stern, 1985; Chazan, 2003). It has been suggested that this intersubjectivity is present in humans from infancy, and is apparent through emotional signalling (Emde, 1988). The mothers in this study felt connected to their children in a unique way, perhaps highlighting the presence of intersubjectivity within the mother-child relationship.

Communication was a theme within the interviews, which manifested in varying ways. For some mothers, a high level of communication was present between themselves and their child, and their child was able to discuss painful and private things with them. For other mothers, communication was more difficult within the parent-child relationship, and was not as free flowing. It was interesting that the mothers who described good communication with their child had a daughter, whilst the mothers who described limited communication with

their child had sons. It appeared there was an effect of gender present within the mother-child relationship which appeared to impact upon communication. Mothers who had a son reported less communication than the mothers who had a daughter.

Some studies have been done into the gender differences in parent-child communication, but with regards to sexuality. Nolin and Peterson (1992) used questionnaires to gather information from 84 families, along with focus groups, to examine if there were gender differences in factual, sociosexual, and moral discussion about sexuality. They found that parent-daughter communication was wider ranging and more open than parent-son communication, and that these gender differences were more obvious when the information being communicated was factual, moral, and included the transferring of values.

A further study conducted by Adams, Kuebli, Boyle, and Fiyush (1995) looked at the emotional content of parents' conversation with children about past events. This study found that the degree of emotion language used by the parent was equal for both male and female parents, but that there was a difference in the terms involving emotions that were used depending on the gender of the child, there being greater and more varied references to emotions within the language used with daughters than with sons. This highlighted that perhaps there is an unconscious bias in the way that parents communicate with their children depending on their gender, with girls being communicated with more openly about topics such as sexuality, and the language used with girls involving more references to emotion. This would provide support for there then being an effect on the way that boys and girls grow up communicating with their parents, which could account for the gender bias in communication that was apparent within this current research.

A meta-analysis of studies that reported gender differences in verbal ability was conducted by Hyde and Linn (1988). They reported no statistically significant differences in verbal ability between males and females, and no gender differences in cognitive processing. This would

suggest that the gender differences that are present within communication are socially

constructed, as highlighted above, through possible differences in the way that parents

communicate with and educate their sons and daughters about important topics, and

through the differences in language that are used, rather than there being a biological

explanation such as a difference in the cognitive processing and verbal ability between

males and females. Lezin, Rolleri, Bean, and Taylor (2004) also suggested that there was an

iterative effect within communication; the more that certain elements such as openness,

support, protection, and encouragement are communicated, the more likely it is that a

trusting environment is created through which future communication becomes stronger and

more productive.

This study could provide support for these theories, as some parents did comment that their

relationship with their daughter differed from the relation with their son. Like Pat for example,

who said her relationship with her daughter Amy differed from that with her son as Amy was

a girl, and they shared "girly stuff". Further more specific research would have to be carried

out into this area to provide more support for this. However, a number of the sons of the

mothers in this study had been diagnosed as being on the autistic spectrum. Autism, as

outlined by The National Autistic Society (2015), is a lifelong developmental disability that

affects an individual's social communication. It is therefore possible that it was due to their

son's autism that some of the mothers experienced less of a flow of communication and not

necessarily accountable by gender differences.

Making Sense of Having a Child with Mental Health Difficulties

All of the mothers in this research appeared to try and make sense of what it meant to have

a child with mental health difficulties. The mothers spoke about the impact of the mental

health difficulties upon both the child and upon themselves, and the negative changes they

observed in their child leading up to the commencement of therapy, as well as the negative

effects it had on upon their own lives. Themes of fear, desperation, helplessness, and powerlessness were present for the mothers here.

These experiences support previous qualitative research that has been done into the experiences of parents (Pejlert, 2001; Daly, 2005; Benderix, Nordström, and Sivberg, 2007; Johansson, Anderzen-Carlsson, Ahlin, and Andershed, 2010; Lindgren, Åström, and Graneheim, 2010; Kemp, 2013; McLaughlin, McGowan, O'Neill, and Kernohan, 2014). These studies, as outlined in the Introduction chapter, highlighted that the impacts of having a child or adult child with mental health difficulties resulted in common experiences for the parents, including feelings of helplessness, powerlessness, multiple loss and unresolved grief, and feelings of failing as a good mother.

The perception of stigma from other people was also a very salient part of how the mothers in this study made sense of having a child with mental health difficulties. The mothers outlined their perception of stigma coming from a variety of different sources, including their family and friends, and that there was a variety of stigma as well. Some mothers felt that because they had a child with mental health difficulties, other people would blame them and judge them as a mother. Some mothers acknowledged that there is also a general stigma around counselling and needing professional help, and that many people are fearful of it and judge those who need it as being weak. On the whole, the stigma that was perceived by the mothers was negative and judgemental, and caused some mothers to be apprehensive about speaking openly about having had a child need psychological therapy.

This could offer an explanation as to why the majority of mothers that came forward to participate in the research had experience within mental health, whether it be personal or professional. The perception of stigma that contributed to the mothers' apprehension about speaking openly about having a child receive therapy may have deterred a lot of other parents from coming forward to participate and to share their stories for fear of judgement,

particularly if some parents had had experiences with mental health services or professionals. The fact that most of the participant mothers had had positive experiences of mental health services may have made them more willing to come forward to share their stories.

In a study looking at parents who had a son or daughter suffering from severe mental illness living in a care setting, it was found that the parents experienced stigma which was apparent in their narratives through the way that mental illness was labelled, their relations with both the public and the mental health professionals involved in their children's care, and their own experiences of shame (Pejlert, 2001). The experiences of the mothers within this study of their perceived stigma provide support for these findings, as some of the mothers perceived stigma to come from the general public and other mothers, the staff involved with their children, as well as their friends and wider circle of family. Perhaps the stigma felt by the mothers in this study also relates to the way that certain language, including stigmatising language, is used which highlights normative assumptions about being a parent and raising children (Burman, 2008). When parents are seen not to be adhering to these normative assumptions, stigma and judgement are cast upon the parents. The mothers in this study highlighted certain stigmatising language in relation to mental health and seeking therapy as including phrases such as "crazy", "dysfunctional", "wrong", and "weak".

These results also highlight, as found by Huxley (1993) and Jorm and Wright (2008), that stigma around mental health is still in existence. Ben-Porath (2002) found that such stigma could result in mental health difficulties going untreated. The stigma perceived by the mothers in this study did not affect their willingness to seek help for their children, but perhaps this was because of the mothers' own positive attitudes towards therapy and seeking help for their children, which over-rode the negative effects of the stigma they perceived. It did appear that such stigma resulted in the mothers in this study feeling reluctant to speak openly about their child receiving therapy and having mental health

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difficulties. This provided support for Jorm and Wright's finding that there was a reluctance to disclose mental health problems by young people and their parents.

The mothers reflected upon their own attitudes towards mental health and therapy, and in general there were positive personal attitudes from the mothers towards therapy, and open non-judgemental attitudes towards mental health. It appeared that the views of the mothers, for the most part, had developed from their own personal experiences. It was also common for the mothers to have held stigmatised views regarding therapy and mental health before having a related personal experience that changed their views.

It was common within this study for the mothers to have joined a therapeutic profession due to their own previous experiences. Glickauf-Hughes and Mehlman (1995) suggested that children develop a type of emotional antennae which can predispose them to seek a career in a therapeutic profession. In Glickauf-Hughes and Mehlman's study, they suggested that it was children of narcissistic parents who were predisposed to join such a profession, in a bid to form a corrective interpersonal experience. In contrast, the mothers in this study who had joined a therapeutic profession reported some positive interpersonal experiences, such as receiving personal therapy that had a positive effect on their lives, or a pleasant experience of growing up with parents who were in the profession. While there may be varying reasons why people join such professions, it seems that personal interpersonal experiences, whether positive or negative, affect this career choice.

The mothers appeared to spend time searching for the origin of their child's problems, and it appeared to be important to them that they found out why this had happened to their child. This quest manifested itself through a tension within the mothers between attributing causation to external factors such as the child being bullied at school, or an external negative experience the child had had, and the mothers questioning their own role in causing their child's mental health difficulties.

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Within the literature, it is suggested that there exists the concept of scepticism which for Cavell (1988) appeared to be a failure to accept human finitude. For Cavell, taking care of scepticism was comparable to accepting one's humanity, and accepting one's finitude. Raemakers and Suissa (2012) suggested that this concept is connected to raising children, through parents attempting to find clear answers to different forms of unpredictability, uncontrollability, and dependence of surprises, which suggests an anxiety and fear towards the unpredictability and unconditioned encounters in life (Hogan and Smith, 2003; Smith, 2010). Perhaps these theories provide an explanation for the mothers' need to find a cause and origin of their child's difficulties within this current research. This quest by the mothers in this study could also support theories that the incessant quest for certainty is an existential feature of the human condition, and our dissatisfaction at not having answers that provide us with certainty (Wittgenstein, 1953; Cavell, 1988).

The fact that seven out of the eight mothers had either a personal experience of receiving psychological therapy or a background working within mental health may have contributed to their quest to find the origin of their child's difficulties. It may have enabled them to develop the reflective capacity to question if they themselves may have somehow contributed to the child's difficulties, and to consider their role in how this might have occurred. Undoubtedly the data collected from these mothers provided rich and reflective accounts of their experiences, more so perhaps than if a group of mothers had been interviewed whom had not experienced personal therapy or a career in mental health. The mothers were capable of allowing themselves to go on a journey to seek answers, to be aware of this, and to subsequently be able to explore and reflect upon this quest by engaging in an existential process.

The mothers' tendency to blame themselves was outlined by Furman (1995), and the feelings of guilt surrounding this have been suggested to be more prevalent within women rather than men (Izard, 1977). The self-blame that the mothers in this current study outlined

is also relevant to literature that examines the presence of stigma and the tendency for the mother to be blamed for their child's mental health difficulties, and for the mothers to then internalise this blame (Sheppard, 2000; Corrigan and Miller, 2004; Jackson and Mannix, 2004). It is unclear whether the mothers in this study perceived external stigma and blame, and then internalised this blame causing them to search for an origin for their children's difficulties that was because of something they did or said, or whether this guilt and blame was present for them even before they experienced a wider stigma.

The themes of self-blame were also present in much of the qualitative research that examined parents' experiences of having a child or adult child with mental health difficulties. Feeling like they had failed as a good mother (Daly, 2005), feelings of secrecy, shame, helplessness and guilt (Pejlert, 2001; McLaughlin, McGowan, O'Neill, and Kernohan, 2014), feeling personally blamed for their child's problems (Lindgren, Åström, and Graneheim, 2010) and spending time questioning the cause of their child's problems, leading to feelings of guilt, anxiety and confusion (Kemp, 2013) were also present within the previous research. The process of blaming themselves and questioning their own role in the causation of their children's difficulties appears to be a complex experience for parents, particularly mothers, and something of which practitioners working with children and families should be mindful.

It was a common part of the sense making process for the mothers to express a responsibility to help and protect the child who was suffering from the mental health difficulties. Some mothers reflected upon how they had felt alone in taking on this responsibility, and spoke about the responsibility as if it had been very heavy for them to carry alone. It was common for the mothers to have tried to do all they could to help their child, before accepting that the problems were too much for them to handle alone. The mothers then engaged in a process of being the one to take action to get professional help for their child.

Parents are most often the ones held responsible for creating the best conditions in which their child will thrive, to ensure the growth and wellbeing of their child. Raemakers and Suissa (2012) suggested that this view of responsibility means parents are primarily concerned about the development of their child, and are willing to do whatever it takes to ensure their child is developing correctly and their needs are met, and address any challenges or risks that may present themselves.

This view of responsibility matches how the mothers in this study position themselves, that they were willing to do anything it took to help their child. However, Guldberg (2009) proposed that while it is the responsibility of the parents to fulfil this role, it was also not the ultimate responsibility of the parent to protect their children from every single potential risk that may be encountered. Perhaps the mothers in this study did feel this was their responsibility, due to their child having a mental health difficulty, in which case it would seem that when a child suffers with a mental health difficulty the sense of responsibility that the parent feels increases. Raina et al. (2004) suggested that being a carer for a child with a disability is a role that for the parent will extend the course of the child's lifespan, and there is also literature that suggests that this will correlate with an increase in parental stress (Hauser-Cram, Warfield, Shonkoff, and Krauss, 2001). The extent of the care-taking role and the stress this causes could be attributed to the sense of complete responsibility the mothers in this study felt to help their children.

Existing literature also suggests that women in particular feel a primary responsibility for their family and family relationships, which is founded upon their internal sense of responsibility, moral code, and their identity (Elvin-Nowak, 1999; Boney, 2002). If this is indeed the case, the fact that all the parents in this study were mothers would suggest their sense of responsibility towards their children and family may be increased compared to perhaps a father. Because the mothers felt ultimately and solely responsible for taking care of their child, this may have also increased the feelings of guilt within the mothers at their child

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suffering mental health problems (van Mens-Verhulst, 1995; Sheppard, 2000; McNab and Kavner, 2001).

The Journey of Therapy

There appeared to be, for both the mothers and their children, a sense that there was a "right" therapist. This concept of the "right" therapist manifested in different ways for the mothers. For some mothers, they could not pinpoint concrete qualities that made the therapist right for their child, but described a sense of the therapist just being a good match for or a good fit with their child. For other mothers, there were positive qualities that their therapist possessed which made them right for their child. There was a consensus that the relationship between therapist and child was an essential part of the therapy, and it was perhaps the importance of the therapeutic relationship that made it so essential for the mothers to ensure they found the right therapist for their child through which a good therapeutic relationship could be achieved.

Weiner and Gallo-Silver (2015) suggested that when a parent is looking for an appropriate therapist for their child, they should focus on manner, tone of voice, posture, and eye contact, and that it is through these points that one would be able to get an insight into the therapist's personality, and decide whether or not the therapist was a match for their child. They highlighted the importance of the therapist's personality, which was a common feature in the mothers' reflections about their children's therapists in this research. Many mothers felt that the personality of the therapist had to be a good match with their child in order for the therapist to be suitable. Weiner and Gallo-Silver also emphasised that important factors to consider were that the parent and child both felt comfortable with the therapist, and that they trusted the therapist. The feeling of being comfortable with the therapist included making the child feel at ease and feel able to share their feelings. Some of the therapists appeared, according to the mothers in this study, to achieve this with their children and connected with the children in a way that fostered these qualities.

What the mothers described appeared to be a therapeutic alliance between their child and the therapist. The existence of a therapeutic alliance was proposed by Bordin (1979), and is thought to originate from Freud's (1913) theory of transference and the idea that a valuable attachment could develop between therapist and patient. Bordin suggested this was a relationship between a client and their therapist which was collaborative in nature in order to surmount the difficulties and afflictions of the client.

The mothers in this current research spoke about how they felt the therapeutic alliance was the most important factor between a therapist and their client, and that it was this relationship that for them determined whether the therapist was right for their child or not. The importance of the therapeutic alliance has been widely discussed in previous literature, and has even been said to influence the outcome of therapy over any other factor, including the type of therapeutic approach used (Gelso and Carter, 1985, 1994; Horvath and Luborsky, 1993; Shapiro, 1995; Krupnick et al., 1996). Bordin (1979) proposed that this may be the case not because the therapeutic alliance is healing in its own right, but because through this alliance the client is enabled to believe in the treatment and therefore closely adhere to it. The importance that the mothers in this current research placed upon the relationship between their child and the therapist appears to support the consensus in the literature and therefore provides a justified account of why the mothers may have been so concerned with finding the "right" therapist for their child.

The mothers also spoke about what it was like for them to hand their child over into the care of someone else. For some mothers this was a positive and liberating experience, while for other mothers this experience was negative and anxiety provoking. A theme of trust was present here for the mothers; trust or a lack of trust that the professional could help their children and that their children were in safe hands, and a lack of trust that the child wouldn't be taken away from them and that they would lose control of their child's care.

These different experiences also provided support for the experiences reported in previous literature. In Pejlert's (2001) study, it was found that there was a cultural conflict between the families of the person with severe mental health difficulties, and the system that was providing care for them. This conflict was interpreted both as a threat to the parental role, and an experience of comfort and confidence in the care that was being provided. This current study provides support for these theories. Some parents expressed comfort and relief at handing their child over into the care of professionals, and trusted the professionals to take good care of and to help their child, while other parents feared losing control of their child's care, which could be seen as a threat to their parental role.

Most of the mothers reflected on the theme of seeking support for themselves. Personal support appeared to be very important for the mothers during the experience of having a child suffer from mental health difficulties and receive therapy. Most of the mothers sought professional support for themselves, and the ones that didn't acknowledged during their interviews that some support would have been helpful for them during this experience. Support came from both professional sources as well as friends, although the professional support the mothers received appeared to be the most helpful in aiding them to cope with what was happening to their child. The metaphors that were used and the emotion that was displayed throughout this theme highlighted how important this was for the mothers.

The benefits of support, such as attending support groups, has been highlighted in previous literature, such as Peijert (2001) and Johansson, Anderzen-Carlsson, Ahlin, and Andershed (2010). However, the mothers in this study did not attend a support group but chose to either not seek support for themselves at all, or to seek one-to-one support with a professional. Perhaps the mothers, considering their perception of stigma and that they feared judgement, and also in part blamed themselves for their child's difficulties, would have found it difficult to attend a support group where there were many other people present. A support group may have been a valuable experience for some of the mothers, as they would have had the

chance to connect with other mothers or fathers who had been through similar experiences to themselves and to share their experiences. This may have relieved some of the feelings of being alone in the struggle of coping with their child's mental health difficulties (Daly, 2005).

The essence of the study by Daly (2005) was a theme of multiple loss and unresolved grief. This highlighted the profound effect that having a child with suicidal ideation had upon the mothers, and highlights the need for mothers to have their own support through such an experience. Other studies examining the importance of parental support through experiences of children being physically ill as well as mentally unwell highlight that support for parents through these experiences is essential, and that professionals are not always aware of the acute need for this support (Wheeler, 2005). Wheeler further outlined that the perception of professionals regarding parents' need of support was not always accurate compared to the actual need reported by the parents.

The outcomes of the child's therapy were commonly discussed, and it appeared that the mothers all felt that therapy had brought about positive changes in their children. The mothers acknowledged that the therapy had not been a magic cure for their children, and that for the most part there was still some way to go on the journey of recovery. But the therapy appeared to have given the children tools which they could use to cope, and had made the mothers feel that their children's futures were brighter. In this sense, the mothers appeared to have made sense of the therapy by seeing it as a positive stepping stone towards recovery for their child.

The results of a study by Nevas and Farber (2001) found that parents whose children received psychological therapy were generally positive about the therapy, and saw positive outcomes. They did suggest that the positive findings of their study may have been due to the type of parents that took part, mainly parents whose children had completed their

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therapy and not dropped out mid therapy, and therefore benefitted from the therapy. The mothers in this study all had children who had completed the course of their therapy, and perhaps this provides an explanation as to why they generally reported positive outcomes. There may have been different experiences with regards to the outcomes of therapy if the mothers had had children who had dropped out therapy or discontinued their therapy for some reason.

The mothers in this current study reported positive outcomes for their child after psychological therapy which were similar to the hoped for outcomes that were expressed by the parents in the study by Cohn, Miller, and Tickle-Degnen (2000), including the mothers reporting that the child and mother had both learnt strategies to help the child to cope with their difficulties. Previous research highlighted the effect that parental beliefs and expectations could have on their child's therapy, such as the study by Elliott (1995) which reported that parental expectations for their child's therapy which were not met resulted in a negative influence upon the continuation of treatment (Elliott, 1995).

This could suggest that whatever the type of therapy a child receives, psychological or occupational, the parent's experience of the outcomes of the therapy may be dependent upon their original hopes for the therapy, and that if hopes and expectations match outcomes, the overall experience will be positive. It could also suggest that there are certain areas within which parents would like to see an improvement that would contribute positively to both their lives and the lives of their child. This provides insight for practitioners working with children, and highlights the importance of working with parents to identify their expectations for their child's therapy in order to ensure that parents feel their expectations are being met, and if they feel they are not being met, this can be addressed appropriately by the therapist.

Negotiating the Role of Parenthood

The mothers who took part in this research explored what it meant to them to be a parent. They expressed their own values, and what had been important to them when they had raised their children. Themes of protection, independence, and valuing each of their children as individuals emerged for the mothers here. The mothers appeared to have tried to negotiate a balance within their role of being a mother, between protecting and guiding their children, while also ensuring their children achieved a degree of independence and felt able to be who they were and to each feel equally loved.

Ramaekers and Suissa (2012) identified that within the realm of parenting, it appeared that there was the existence of a scientific discourse which suggested that there was a clearly outlined correct and incorrect way of parenting, and that through this discourse it was then possible to succeed at being a parent and that there was an achievable end point of parenting. They disagreed with this dominant discourse, and outlined that they viewed the role of parenting as an open-ended process which involved many different aspects, including the parent's own values, which could not be so acutely captured. They viewed parenting as being affected by a parent's own individual experiences within the dynamic contexts of their lives.

It was further acknowledged by Raemakers and Suissa (2012) that when what it meant to be a parent was conceptualised from the first person perspective, from within the parent-child relationship, the ideas of what a parent should and should not do, and the needs and rights of children, were often present. This resonated with the reflections that came from the mothers within this research. The mothers appeared to reflect on what they had tried to achieve with their own children based on their own values, and had taken into consideration each of their children's needs and to ensure their children's needs were met through their parenting style. While there were shared concepts such as protection and promoting individuality and equality amongst siblings, each mother's ideas on what it meant to be a

parent appeared to be unique to each mother and derived from their own values and experiences. Some of the mothers reflected on how they felt that what it meant to be a good parent would be different for everybody, and that their own parenting style had been based upon what they felt their children needed from them, for example protecting or saving or guiding.

Styles of parenting have been widely discussed within previous literature. As discussed in the Introduction chapter, Lezin, Rolleri, Bean, and Taylor (2004) suggested that there are different styles of parenting; permissive parenting, authoritarian parenting, and authoritative parenting. The mothers in this study appeared to have tried to achieve an authoritative style of parenting by providing warmth and affection for their children, guiding them through life and outlining certain expectations, but not being overly controlling or intrusive or laying down a set path the children must follow. In this sense, the mothers believed that they were doing their best to achieve the best style of parenting in order to promote wellbeing and a healthy development within their children.

Stephanie described how she had achieved this balance by describing her role as a mother as being a "caretaker" to her children. There was a sense that the mothers accepted that they were not perfect mothers, and reflected on how some of their parenting choices may have been difficult for their children, and it appeared that they had aimed to be "good enough" authoritative parents. The concept of the good-enough mother, proposed by Winnicott (1953), entails the mother initially being totally acclimatised to her infant's needs allowing the infant to have a sense of omnipotence. Gradually the mother becomes less adapted, in small steps as the infant grows, and the infant learns to become more independent through learning about loss, in a stage Winnicott refers to as relative dependence, before reaching independence. Winnicott suggested that the role of the mother is to firstly create illusion for their infant, through which they experience early comfort, and then to move on to create disillusion which aims to gently initiate the infant into the social

world. The good enough mother resonates with the concept of the authoritative style of parenting described by Lezin, Rolleri, Bean, and Taylor (2004), and appears to be what the mothers in this study strived towards when raising their children.

The idea of being a good enough parent within early years parenting has also been discussed by Gutman, Brown, and Akerman (2009, p.v), who suggested that there were two different levels of being a good enough parent; the level that leads to the most well-adjusted and competent children promoted "high levels of maturity, expectation, supervision, disciplinary efforts, sensitivity to and support for a child's needs", whereas good enough parenting that only produced moderate levels of expectation, discipline, and responsiveness would only raise good enough children. With all these different notions around what it means to be a good or good enough parent and the impact of parenting style upon children's outcomes and wellbeing, it appears that to strike the correct balance is difficult to achieve and puts a lot of pressure on parents. This struggle appeared to be present for some of the mothers in this research, particularly Lindsey who reflected that she felt she had failed at being a parent and felt ineffective.

The mothers also spoke about the origin of their parenting values, and how they felt their values had developed from experiences with their own parents and from the things that they had felt were important, positive, or negative from their own childhoods. Byng-Hall (1986; 1995) outlined the presence of scripts within the family. He described two types of scripts; a replicative script, through which past experiences were likely to be repeated, and a corrective script, through which past experiences will be attempted to be changed and modified. The origins of the values for the parents in this study highlight the presence of family scripts. Most of the mothers reflected upon how there were things that their own mothers did or attributes that their own mothers displayed that they with their own children had consciously tried not to replicate, therefore displaying a corrective script. This, for many of the mothers, appeared to be a conscious process of actively behaving differently with their

own children than their mothers had with them, despite the suggestion by Byng-Hall that some of the corrective script parents display tends to occur outside of conscious awareness. Perhaps as most of the mothers worked within a therapeutic field and had received their own personal therapy, they had been able to develop a sense of self-reflection involving their own upbringings, which had enabled them to consciously choose a corrective script and to actively engage in not replicating what they saw as their own parents' mistakes and short-comings.

Crittenden, Dallos, Landini, and Kozlowska (2014) further discussed corrective and replicative scripts, and also outlined the idea of "pendulum parenting" (p.95) to discuss extreme versions of corrective scripts within parents, whereby the parent attempts to correct the negative things from their own childhood by swinging to opposite extreme of what they felt were the negative aspects of what their parents did. Such extremeness of the corrective scripts for the mothers within this study was not evident, although some parents did reflect on how they felt that some of their parenting choices may have been difficult for their children, such as not giving them a defined path to follow, but they adhered to these choices as they were determined not to be like their own mothers.

Some parents, like Tanya for example, displayed both a corrective and replicative script. This was highlighted by Byng-Hall (1995) as being common, and when both types of scripts are present there is often a tension between them. It was unclear how much of a tension the presence of both scripts presented for Tanya, although it would seem that she found this rather liberating, as it allowed her to choose bits to replicate and bits to correct, and to formulate her own unique style of parenting. Carter and McGoldrick (1988) identified six family life cycle stages, which consist of launching the young adult, the couple, families with children, families with adolescents, launching children and moving on, and families in later life. Perhaps whether a parent chooses to replicate or to correct their family script could depend on what stage they are at in their family life cycle, what tensions are being

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experienced, and their family life cycle experiences during their own childhood and adolescence.

Significant Findings and Contributions to the Field

This research highlighted the importance of parents being simultaneously supported when their child was receiving psychological therapy for mental health difficulties. This could contribute to the practice of practitioners who work in both children and family services, by highlighting the importance of a systemic network of support. This does not necessarily mean that parents and children need to be treated simultaneously in the same service or via family therapy, but that child practitioners should be mindful that parents are offered their own support, or at least referred on to where they may access their own support.

Systemic therapy is a useful type of therapy that would aid in the treatment of children with mental health difficulties along with their parents. Hedges (2005) outlined that the Milan and Post-Milan approaches that are present within Systemic Therapy enable there to be a shift from an individual line of thinking to an interpersonal position. Gregory Bateson (1972) had a strong influence upon the Milan team. Bateson explored the archetypes that exist within human interactions, studying the intermingling of humans with animals and the environment, with a focus upon communication. There was a shifting consensus for Bateson from viewing problems as having a linear causation and exploring them through the individual mind, to a more circular causation with viewing the mind as part of a circuit. The Milan team saw the world in terms of patterns of relationships, and drew upon Bateson's work and ideas, particularly several concepts that were felt to be important; paradoxes, levels of meaning, the evolutionary nature of systems, patterns of information, feedback and reoccurrence. When families came for therapy, this mode of thinking enabled the Milan team to be able to view an individual member's difficulties as being embedded within the family system (Becvar and Becvar, 1996), and to shift from a psychoanalytic to a systemic emphasis.

The post-Milan approach was developed by Boscolo and Cecchin in the late 1970s (Boscolo, Cecchin, Hoffman, and Penn, 1987). Whilst remaining congruent with the original ideas of Bateson and the Milan group, they developed depth and complexity to these ideas which became closely aligned with a social constructionist way of thinking, suggesting meanings are socially constructed, which questioned the positivist standpoint (Hedges, 2005).

Adopting a systemic approach may help "liberate individuals from the oppressive and pathologizing frameworks that had predominated" (Dallos and Draper, 2000, p.23). Simultaneous treatment of both child and parent would also be of benefit to both children and parents in similar situations to the mothers in this research. Chazan (2003) outlined that simultaneous treatment involved one practitioner treating both parent and child separately. The benefits of this type of treatment are that a wide range of issues within the family as a system can be addressed and changed, due to both members of a dyadic relationship, and two members of a family, changing simultaneously.

Families tend to seek therapy when difficulties occur within a specific stage of the family life cycle (Carter and McGoldrick, 1988). Research has been conducted into children's experiences of family therapy, which highlights that children are not always treated equally and can often be excluded from discussions with professionals (O'Reilly, 2006). Children are also often placed as the problem within the family system and when this happens, Lobatto (2002) suggested that the children then associate with this and do not always feel able to express their views on the difficulties when invited to do so by the therapist. Perhaps this is why some therapists may opt for separate simultaneous treatment of parents and children. Whichever approach is adopted, it is vital that therapists are sensitive to the experiences of both children and their parents, and remain thoughtful around the inequality of how children are often treated within the family system and family therapy.

The perception of stigma was a prevalent theme within this research, and some mothers felt this coming from a variety of sources including the staff that worked with their children. This highlights how practitioners working with the parents of children with mental health difficulties could be mindful of the perception of stigma, and also of the self-blame that the parents feel about their child's difficulties. A sensitive approach to the parents may enable the parent not to feel stigmatised or judged by the professional.

Certain techniques and types of therapy could be employed by practitioners working with parents, particularly with the mothers of children with mental health difficulties, to help them address and work through their feelings of guilt. For example, compassion-focused therapy, developed by Gilbert (2009), would help mothers to develop and work with experiences of inner warmth, safeness, and soothing, through learning to be compassionate towards themselves. Client-centred therapy that created the core conditions of congruence, unconditional positive regard, and empathy (Rogers, 1951) would enable such mothers to feel accepted and not judged, and be able to communicate and work through their true inner feelings with their therapist. Mindfulness may also help the mothers to reflect on their current feelings without judgement, which would enable them to be more accepting of their current reality. Mindfulness based therapies may also be helpful, such as Mindfulness-Based Cognitive Therapy (Piet and Hougaard, 2011) and Acceptance and Commitment Therapy (Hayes, 2004).

As outlined by Daly (2005), professionals working within any provision of care that centres on the family could benefit from being guided within their interventions by phenomenological research, which acknowledges the maternal perspective in the experience of living with children and teenagers with mental health difficulties.

Transferability and Quality

Issues to do with reliability have been previously discussed in the Methodology chapter.

Although this research did not aim to make large sample generalisations about the findings

or to discover a theory, there was an aim to make some contribution to the field of

Counselling Psychology. Therefore, this research provides an account of the experiences of

mothers who have had a child or children receive psychological therapy, and could be

applied to other mothers who have been in a similar situation and share similar

characteristics to the mothers who participated in this research. The links with previous

literature and research highlight how the findings of this research contribute to and support

existing theories. However, there were limitations to this research which undoubtedly affect

its transferability, and I have outlined these limitations in the strengths, limitations, and ideas

for future research section of this discussion.

I attempted to be transparent within my research, by outlining my epistemological standpoint

and my analytic strategy within the Methodology chapter. I also used direct quotes from my

participants to ground my analysis in the data, and to make this apparent to the readers of

this research.

According to Madill, Jordan and Shirley (2000), the epistemological standpoint that a

researcher takes within their qualitative research could provide the context for understanding

the reliability of the research. I outlined that I took the epistemological viewpoint that

experience is not fixed, but is constructed through interpretation. Therefore, I acknowledge

that my own interpretation has played a part in this research. I have reflected upon this

within the epistemological and personal reflexivity sections within my Methodology, and have

remained aware of how my own preconceived ideas may have shaped my interpretation of

my data, and therefore the results of this research. Whilst conducting my analysis and

writing my discussion, I have been mindful to bracket off my own preconceived ideas, and

the use of a reflective diary, my own personal therapy, and also feedback from my research supervisor has aided me in this process and increased the quality of this research.

Challenges

In this section I will address the challenges that I was faced with during the course of this research. I have attempted to address both the methodological and procedural challenges that I was presented with, and how I attempted to address or overcome these challenges.

Methodological Challenges

I will attempt to address some of the limitations of IPA that are relevant to this research. I have chosen to reflect upon the role of cognition, language, culture and narrative, and embodiment and emotion, as outlined by Smith, Flowers, and Larkin (2009).

Cognition

Smith, Flowers, and Larkin (2009) describe in depth how IPA is concerned with cognition. They outline that cognitions are indirectly accessed through the individual's process of meaning making, and also thorough their accounts, stories, narratives, and language. They also outline the role of the different layers of reflection within IPA research; pre-reflective reflexivity, the reflective "glancing at" a pre-reflective experience, attentive reflection on the pre-reflective, and deliberate controlled reflection (p.189). These layers exist as a sequence, the depth of reflection increasing through the first three layers until the last layer, which constitutes the phenomenological reflection that is present within IPA research. The essence of cognitive activity that is present for the participants lies within the second and third layers, occurring through their reflective activity. The role of the double hermeneutic comes to light here too, as the researcher enters the fourth layer of reflection by attempting to make sense of the participants making sense of their experiences.

This presents a challenge; we as researchers are not able to directly access the participants' layers of reflection, without them first being filtered via the participants' cognitions. Willig (2008) also acknowledged that this may present a limitation of IPA, as the focus on cognition may result in less attention being paid to the embodiment and emotion of the experience. However, Smith, Flowers, and Larkin (2009) address this concern by suggesting that IPA research does place importance upon embodiment, and refers to the embodied nature of cognition, and also how the body reminds us of emotions, which also hold cultural and cognitive dimensions. I tried to address these challenges by paying attention to some of the non-verbal interactions that were happening during the interviews, such as when the participants laughed, or stuttered, or shed tears. I also tried to pay attention to what was happening for the participants within the layers of their own reflection, and also looked at and tried to make sense of the metaphors they used, and the descriptions and displays of their emotions.

Language and Culture

Data can be acquired through many different ways within an IPA study, including interviews and written forms. The meaning making within this data is also expressed in different ways using different forms of language, including the use of metaphors and certain discourses. IPA views understanding an experience as a process which cannot avoid being intertwined with an individual's language, as well as their culture. Therefore, our interpretation of an experience will be affected by language, whether it be that language shapes, limits, or enables our interpretation. Smith, Flowers, and Larkin (2009) also suggested that to understand the experiences of our participants, IPA research requires us to understand to some extent the cultural positions and terms of reference of our participants. One's language and culture therefore become a structure through which meaning is made.

Whilst this is a strength of IPA, and enables IPA to explore the role of language in how an individual makes sense of and applies meaning to an experience, it could also be viewed as

a limitation of IPA. Willig (2008) acknowledges the function of language in giving meaning to an experience, but also outlines that for different people, the meanings within language and words may differ and may be constructed differently. The variations in which language is used by different individuals may mean that the same experience or phenomena will have different meanings depending on the words and narratives that are at the disposal of the individual. This presented a methodological challenge within my research which may not easily be overcome. I tried to address this challenge by representing the true voice of my participants and using their own language through direct quotes within my analysis, and showing how I used the individual language of the participants to interpret their meaning making process. I also acknowledged within my Methodology chapter that I took a relativist ontological standpoint throughout this research, and was open to the fact that there would be many different interpretations that could be applied to the knowledge generated through my research.

Further challenges for me within this research included fitting my results into the boundaries of an IPA study. These struggles appeared to have been shared by Fulder-Heyd (2011) through her research into women's experiences of psychological homelessness and identity management. Fulder-Heyd described how she had tried to develop an understanding of how her themes related to each other, and that she tried to create a model of the participants' story. She reflected on how this may have almost caused a shift towards a Grounded Theory perspective, and the tensions that this caused for her. Whilst I shared some turmoil around the boundaries of IPA, I did not feel that I was trying to create a model of my participants' stories. I did however feel that the scale and depth of my data was almost overwhelming when considering the size of a doctoral level IPA thesis, and it was a challenge for me to debate where to stop, and how deep to go with my interpretation. I wanted not to remain bland and descriptive, but to do justice to IPA and engage in fruitful interpretation. I addressed this struggle by visiting and revisiting my data numerous times to ensure my interpretation was born from my data and that I could justify the process of my analysis.

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When exploring the concept of a parallel process occurring between mother and child, I had originally grouped this under Master Theme Three, The Journey of Therapy, as I had initially thought that the perception of a parallel process described by some mothers between themselves and their child had occurred as a result of the journey that the mothers had gone on with their child through therapy. However, upon further exploration and interpretation, I felt that the mothers were describing an increased connectedness with their child through this difficult time that allowed a parallel process to occur, which was more appropriate to be included as a subtheme of Connectedness within Master Theme One, The Enhancement of Relationships.

I had also identified a subtheme around the mothers feeling that they knew their children better than anyone else and that they as the mother "knew best" when it came to their child's needs and care. I decided to collapse this concept into the subtheme of Connectedness, within Master Theme One, as the mothers describing a feeling of knowing their child best appeared linked with feeling a unique connection to their child through which the mothers experienced and felt what their child did, leading them to understanding their child's experiences better than anyone else present in the child's life.

Within Master Theme Three, The Journey of Therapy, I had originally included a subtheme which explored the qualifications of the therapist, as it had appeared that some of the mothers had expressed that this had been important to them, while some of the mothers had not mentioned this or had said it had not been as important to them as the personal qualities of the therapist. However, when I explored this subtheme further and applied interpretation, I felt that the essence of what the mothers were discussing when referring to the importance of the qualifications of their child's therapist was tied into having trust in the therapist to help their child, and feeling comfortable handing their child over into the care of the professional. I

therefore explored the mothers' feelings about the qualifications of their child's therapist within the subtheme Handing my Child Over rather than delegating a separate subtheme.

The subtheme of The Burden of Responsibility was also placed within Master Theme Two, Exploring the Meaning of Having a Child with Mental Health Difficulties. I moved this subtheme from Master Theme Four, Negotiating the Role of Parenthood, where I had originally grouped it as I had started to interpret the burden of being responsible for the wellbeing of a child as being a part of how the mothers were making sense of their role as a parent. In this sense, I was suggesting that the mothers were experiencing their role as a mother to include the ultimate responsibility to provide appropriate care and support for their children. However, as I continued with the layers of interpretation and explored this subtheme in more depth, I made the choice to move it into Master Theme Two as I ultimately felt that the mothers were experiencing an increased responsibility, above and beyond what would normally be encountered, which almost became a burden due to their children suffering mental health difficulties.

Such decisions were reached, as described previously, by visiting and revisiting my data and engaging in the double hermeneutic of trying to make sense of the mothers' making sense of what they had experienced. As I moved through the sequence of the layers of interpretation outlined previously by Smith, Flowers, and Larkin (2009), I was able to make conscious, albeit difficult, decisions as to how to form my master themes, how to label my subthemes, and which original themes were in fact part of a wider subtheme and experience.

Procedural Challenges

Recruitment presented a challenge for me throughout this research. It took a long time to recruit participants for this study, and it appeared that people who had had this experience were not as willing to come forward to speak about it as I had anticipated. This also resulted in a sample of parents coming forward that had a favourable attitude toward therapy, and

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although they perceived stigma from others around having a child who had mental health difficulties and needed therapy, they did not themselves share these stigmatised views. I have reflected further on the sample in the next section.

Where to recruit presented a challenge for me also. I had approached services via a letter asking them to display a poster in their waiting rooms and some services were happy to do this, although this method meant I would not directly be accessing parents whose children had already finished their therapy, which was part of the criteria. The most successful routes of recruitment appeared to be via social media, and via a mental health charity that agreed to advertise my research in their monthly newsletter.

The terminology used within this research presented a further challenge. I have outlined the terminology within the Methodology section and have reflected upon how the use of some of the terminology I chose to use may have impacted upon my participants. For example, I used the term "therapy" interchangeably with "counselling". These terms were commented upon by one participant, who reflected in depth on the different connotations that the two terms had for her. However, this did not seem to have been of importance to any of the other participants. While some chose to use the term "counselling" instead of "therapy", I found no evidence that the interchangeable use of this term affected the participants understanding or recall or description of their experience. The reflections of one of my participants on these terms did however highlight for me the importance of terminology and of being sensitive to and aware of this when conducting research.

Strengths, Limitations, and Ideas for Future Research

This research set out to explore the experiences of parents who had had a child or children receive psychological therapy. Only mothers came forward to take part in this research, which meant it ultimately ended up being a project which explored *mothers'* experiences and not *parents'* experiences. This could therefore be a limitation of the research, as I had

originally set out to interview parents of both genders, but the research ultimately lacks exploration of the experiences of fathers who had had a child or children receive psychological therapy. This would make a good justification for doing future research that looks at how fathers experience this.

Furthermore, each of the mothers who came forward to participate had chosen to seek therapy for their child. No mothers came forward who had had a forced referral for their child, for example through Social Services. The experience of parents whose children receive psychological therapy through a forced referral may be different to the experience when there is a choice involved. This means that although the sample achieved good homogeneity, it is a limited sample and only explores the experiences of mothers from one particular group.

Despite these limitations, many of the findings and themes are closely related to a study done by Kemp (2013). Some of the closely related themes included the mothers making sense of the impact that their daughter having therapy had on both themselves as a mother and also the impact on their daughter, the mother's experiences of changes that they encountered in their relationships with their daughters, including changes in closeness and communication, and an exploration of the ongoing closeness in their relationship with their daughter. The mothers in this study also appeared to strive to find meaning and to identify the causes of their daughters' mental health difficulties. These themes relate to the themes that were present within my own research, including the parents trying to make sense of the impact that their child's mental health difficulties had and reflecting on the outcomes of therapy, trying to look for the origin of the child's mental health difficulties, and reflecting on the augmentation of closeness and the flow of communication within their parent-child relationships.

The replication of some of Kemp's (2013) findings within this piece of research, along with some of the other qualitative research done on the experiences of parents, is a strength and increases the reliability of the study. It shows that there are some common experiences for mothers who have had a child receive psychological therapy, whether their child is a young child, an adolescent, or an adult.

I also reflected upon my criteria including the child's therapy already having to have come to an end at the time of the interview with the parent. This may have caused some issues regarding memories, and that all experiences and the sense making process of these experiences were in fact a sense making process of the memory of an experience. This may have affected the data, and the parents may have made sense of their experience differently than they may have done whilst the experience was current. Heineman (1998) outlined the possible implications of remembering and forgetting, and the importance that psychoanalytic theory has placed upon memory and the verbal reconstructions of memories and past events. For the purposes of this research, I took the stance that, as outlined by Willig (2008), the perception of my participants was the most important reality within this research. However, an idea for future research may be to interview parents whose children are currently receiving therapy, which would make an interesting comparison to my research, and would give insight into the role of a remembered experience versus a current experience.

Personal Reflexivity

As I previously reflected upon in the Methodology chapter, I found the balance between being a researcher and being a therapist difficult and felt I stepped back and forth between each of the roles throughout this research.

I also felt in one sense that as I was not a parent myself and therefore had not had a child receive psychological therapy, and thus no direct shared experience with my participants,

that this would put me in good standing to be able to remain objective when analysing my data and not to be biased as to which parts of their experiences were most salient. I had hoped this would allow me to stay close to the data and not let my own personal feelings and experience impact upon what came from my analysis. Stephenson and Loewenthal, (2006) conducted a study on the effect on counselling and psychotherapy practice of an absent father in the therapist's childhood, and the study highlighted that researchers often tend to focus on those descriptions and experiences within narratives that mirror or validate their own experiences.

Despite having no direct shared experience, I had to remain aware that I came into this research with certain preconceptions. For example, I held beliefs that there is a general consensus of stigmatising around mental health which in particular is directed towards parents who have a child with mental health difficulties. This was a salient subtheme that came out of my analysis, with every mother reflecting on their perception of stigma. I have reflected on how salient this subtheme was, and wondered if I had unconsciously focussed on exploring this theme within the interviews as I had connected with it, and as it had mirrored my own feelings and views about stigma. As previously outlined in the Methodology, I remained aware of my own preconceptions and used these as a source of insight, whilst in parallel remaining explicit about how my preconceptions may have shaped my interpretation of the data and the analysis.

During some of the interviews, the experiences that the mothers shared were very powerful and I found myself being deeply moved by them. As stated in the Analysis chapter, the experience of Ruby and her vision of her daughter caused me to feel a lump in my throat and I was very emotionally affected by the power of this vision and the effect that it had upon Ruby. I felt, through her description, the connection she perceived with her daughter and I found my counselling skills to be important here. I felt through using my counselling skills, I

was able to acknowledge my own reactions and to later reflect upon what that meant, whilst being able to stay in the moment and listen to Ruby.

I felt my counselling skills came into practice many times throughout the interviews, highlighting the balance I was trying to find between being a researcher and a therapist, as previously discussed in the Methodology chapter. There was a moment when Michelle became tearful and showed distress at thinking back to how she was not offered any support for herself, and how this was still raw for her. This was another example of when I had to employ my counselling skills in order to "contain" Michelle, and to make sure she felt listened to and emotionally supported at that moment (Bion, 1959/1962). Bion coined the theory of containing to explain how a mother may receive projections from her infant, processes these projections, and then is able to alter and return the experience in a more acceptable form to the infant. This process can also occur within a therapy relationship, with the therapist acting as a container, as the mother may to her infant, taking in feelings and thoughts from their client and reframing them so that they are more constructive and less disparaging. As Michelle had expressed that she had not received support for herself in the past, I felt as if I was acting as a therapist as well as a researcher and engaging in the process of containing.

Conclusion

I have attempted to represent the voices of the mothers who participated in this study, and to highlight their meaning making processes with regards to having had a child or children receive psychological therapy. The most salient parts of this process of finding meaning included the parents exploring their relationships with their children, exploring what it meant to have a child with a mental health difficulty, how they and their children were affected by the journey of the therapy, and negotiating the role of parenthood. I hope that this research outlines the complexities of mothers' experiences of having had a child or children receive psychological therapy, and that the impact of a child's therapy is much more far reaching than just the experience of the child, providing a systemic framework within which to work

with children, parents, and families. There were many shared experiences between the mothers, and many experiences which relate back to previous literature, theories and research within similar areas.

The fundamental findings of this research have aimed to inform the practice of professionals working within children's services, and those working with the parents of children with mental health difficulties, and thus make a contribution to the field of Counselling Psychology. There are also limitations of this study which I have reflected on, and I have taken care to also reflect upon the challenges that this research presented and how I attempted to address these challenges.

The insights that this research has provided into the experiences of mothers who have had a child or children receive psychological therapy can be used by practitioners to address issues such as the perceived stigma, the mothers' self-blame, their need for their own support, how they feel about handing their child over into the care of someone else, and the way that they negotiate being a parent. The ideas for future research also provide a base upon which further research within this area could be conducted and provide further valuable insights into the field, as these experiences highlight a relatively underrepresented area of research.

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To Whom It May Concern,

I am a Trainee Counselling Psychologist, and I am conducting some research through City University, London. I am researching what it is like for parents whose child goes through therapy. The aim of this research is to gain a greater understanding of what this process is like for parents, and what this experience means to them, so that as professionals who work in children's services, we can learn how best to support the parents of the children whom we are working with. This will help to enrich the process of therapy for the children, parents, and professionals.

It seems that the number of children being recognised as experiencing emotional difficulties, and who go on to receive psychological therapy is increasing, and children's services are always trying to make this experience as helpful as possible for both the children, and their parents and carers.

I am interested in having a discussion with you about whether I would have the opportunity to interview parents whose children have received therapy through your service. I would be glad to send you further information about this research, and information that can be sent on to any parents who would be interested in participating. I have also attached a copy of the flyer I will use to advertise my research to parents. Further information is available for parents on my website: http://parentexperience.yolasite.com/. This research has been granted ethical approval by City University, and is being supervised by a Research Co-ordinator.
.
My email address is ███████████████, and my mobile number is ████████. I look forward to hearing back from you.

Yours sincerely,
Julia Clark
Trainee Counselling Psychologist
City University London

Appendix B - Recruitment Poster

Appendix C –Example of Social Media Post

Hello to all parents!! Has your child had therapy? If so, I want to give you the chance to share your experience. I think it is important to give all parents the chance to talk about their experience of this, whether it has been positive, negative, or a mixture of both. If you would like to take part in this research, you can either choose to take part in an interview, or you can write about your experience. Please visit my website if you would like to take part, or would like more information:

http://parentexperience.yolasite.com/

Or contact me at ██████████████████   Thank you!!!

- **Can you tell me about what it was like for you when your child was referred for therapy?**
  - ➤ (Prompt): What did you think about therapy before your child was referred?
  - ➤ (Prompt): Have your feelings about therapy changed now that your child has received it?
  - ➤ (Prompt): How?

- **Can you tell me a bit more about what life was like for you as a parent during your child's therapy?**
  - ➤ (Prompt): How did you feel?
  - ➤ (Prompt): Do you feel it affected your relationship with your child? How?
  - ➤ (Prompt): What was it like not being able to know what happened in your child's sessions?
  - ➤ (Prompt): What is life like for you now that your child had finished therapy?

- **What did you think about the service that worked with your child?**
  - ➤ (Prompt): What did you think about the professionals involved in your child's therapy?
  - ➤ (Prompt): What did you think about the service?
  - ➤ (Prompt): How did you feel?

- **What do you think were the good things about your child's therapy?**

- **What do you think were the difficult things about your child's therapy?**

- **Is there anything you would like to discuss, that you feel has not already been covered during this interview?**

Information and Consent Form

I am a Trainee Counselling Psychologist studying at City University in London. As part of a Professional Doctorate in Counselling Psychology, I am researching:

What Are Parents' Experiences of Their Child or Children Receiving Therapy?

This research is being supervised by Professor Carla Willig.

I will invite you to meet with me, and to take part in a 90 minute interview which will be audio tape-recorded. I will ask you some questions about your thoughts and feelings about having your child, or children, go through therapy. You are free to answer in as much or little detail as you would like, and can talk about this in any way you want to.

If you decide to take part in the study, please be sure to ask any questions (and make sure you get satisfactory answers) if you are not sure about anything you have been asked to do. If taking part in this research causes you any distress or anxiety at any point during the interview, for any reason, please tell me and I will provide you with appropriate support, and stop the interview if necessary.

You are free to decide that you no longer want to take part in this research at any point during the interview, and free to remove your interview data from any future analysis and/or publication without giving a reason, up until one month after your interview. After this date, removing data will unfortunately not be possible, due to impact this loss would have upon the research. All data will be kept for five years after the research is finished. After five years, all data will be destroyed.

All the information you give during your interview will be used for no reason other than research (including possible publication), and will be made anonymous so you can not be identified. Only myself and my research supervisor will be able to see your data before it is made anonymous. Your data will remain strictly confidential in line with the terms in the Data Protection Act 1998. The only times confidentiality will have to be broken is if there is a concern that you may hurt yourself or someone else, or a risk of harm to your child/children.

Thank you very much for agreeing to take part in this research!

Information and Consent Form

I hereby fully and freely consent to participate in this research.

Participant's Name: _____

Date: _____

Signature: _____

I hereby fully agree to abide by all the terms outlined in this form

Researcher's Name: _____

Date: _____

Signature: _____

CITY UNIVERSITY LONDON

<u>Debrief</u>

The research you have taken part in was titled:

What Are Parents' Experiences of Their Child or Children Receiving Therapy?

The main aim of the research was to get a better understanding of the experiences of parents whose child, or children, go through therapy. You took part in an interview, lasting about 90 minutes.

Talking about any issues to do with your children, their therapy, and your experience of this, may be very sensitive and perhaps emotional. If you feel you have been affected by taking part in this interview, and need extra support, please talk to me about this. Please also look at the extra sheet given to you with this debrief, which gives contact details of agencies that might be able to offer you further support.

If you felt your interview left you feeling very emotional, I can arrange to phone you one week after your interview. This will also give you the chance to ask any further questions that you did not ask after your interview or during your debrief.

You are free to decide that you no longer want to take part in this research. You can remove your interview data from the research, at any time without giving a reason, up until one month after your interview.

If you have any further questions or want any further information, please talk about this with me.

Thank you very much for taking part in this research!

<u>Debrief: Contacts for Further Support</u>

All the details below are correct as of 3rd August 2011.

<u>Samaritans:</u>
Samaritans provides **confidential** non-judgemental emotional support, 24 hours a day for people who are experiencing feelings of distress or despair, including those which could lead to suicide.

Website Address:www.samaritans.org.uk
Helpline: 08457 90 90 90
Email: jo@samaritans.org
Post: Chris, P.O. Box 9090, Stirling, FK8 2SA

<u>SANE:</u>
SANE exists to provide emotional support and information to anyone affected by mental illness.

Website Address:www.sane.org.uk
Helpline: 0845 767 8000
Email:sanemail@sane.org.uk
Support Forum: See website

<u>Counselling Directory</u>
Counselling Directory provides the UK with a huge counselling support network, helping those in distress to find a counsellor close to them and appropriate for their needs. This is a free, confidential service that will hopefully encourage those in distress to seek help.

Website Address: www.counselling-directory.org.uk
Telephone:0844 8030 240

<u>YoungMinds:</u>
YoungMinds is the UK's leading charity committed to improving the emotional wellbeing and mental health of children and young people. YoungMinds offers free advice and support for parents worried about their children's behaviour, emotional problems and mental health.

Website Address: www.youngminds.org.uk
Telephone:0808 802 5544
Email:parents@youngminds.org.uk mailto:parents@youngminds.org.uk

<u>Women's Aid National Domestic Violence Helpline:</u>
Women's Aid is the key national charity working to end domestic violence against women and children.

Website Address:www.womensaid.org.uk
Helpline: 0808 2000 247

Appendix G – Ethics Release Form

ETHICS RELEASE FORM FOR STUDENT RESEARCH PROJECTS

All students planning to undertake any research activity in the School of Arts and Social Sciences are required to complete this Ethics Release Form and to submit it to their Research Supervisor, **together with their research proposal clearly stating aims and methodology**, prior to commencing their research work. If you are proposing multiple studies within your research project, you are required to submit a separate ethical release form for each study.

This form should be completed in the context of the following information:

- An understanding of ethical considerations is central to planning and conducting research.
- Approval to carry out research by the Department or the Schools does not exempt you from Ethics Committee approval from institutions within which you may be planning to conduct the research, e.g.: Hospitals, NHS Trusts, HM Prisons Service, etc.
- The published ethical guidelines of the Health Professions Council and the British Psychological Society (2010) should be referred to when planning your research.
- **Students are not permitted to begin their research work until approval has been received and this form has been signed by Research Supervisor and the Department's Ethics Representative.**

Section A: To be completed by the student

Please indicate the degree that the proposed research project pertains to:

BSc   M.Phil   M.Sc   **D.Psych**   n/a

Please answer all of the following questions, circling yes or no where appropriate:

1. Title of project

What Are Parents' Experiences of Having Had a Child or Children in Therapy?

2. Name of student researcher (please include contact address and telephone number)

Julia Clark
███████████████████████████████████████

3. Name of research supervisor

███████████████████████████

4. Is a research proposal appended to this ethics release form?   **<u>Yes</u>**   No

5. Does the research involve the use of human subjects/participants?   **<u>Yes</u>**   No

If yes,

a. Approximately how many are planned to be involved?   Eight

b. How will you recruit them?

I will contact a range of private or charitable services that offer therapy for children, located by recommendation through word of mouth, and by searching using internet search engines.
Once potential services have been located, I will make contact and request to speak to the service manager. I will explain who I am, and what my research is about. Care will be taken to emphasise the potential benefits this research could have for their service, so as to encourage them to be willing to take part. If they agree to take part, and to help recruit participants, this would require them to contact previous clients who have used their service, and ask if they would be willing to participate. If their client was willing, I would ask that either my details be passed onto the client to make contact with me, of that the client give permission for the service to pass on their contact details to me, who will make contact with them. Once contact with the client is made, I will explain again in full who I am, what my research is about, and request we meet so that we can discuss the research further.

I will also design a flyer and a website, which will provide more details about my research, who I am, and invite participants to participate. I will ask the services I contact to display my flyer in their waiting rooms, and I will include the address to my website on my flyer.

c. What are your recruitment criteria?

(Please append your recruitment material/advertisement/flyer)

> Participants must be over the age of 18 years, have had at least one child who has had therapy previously, but who is not currently still in therapy, and have been the primary caregiver to this child at the time of their therapy. The children must have been under the age of 16 years at the time of their therapy. Participants must live within, or be able to access, an area accessible to London, either by private or public transport.

d. Will the research involve the participation of minors (under 18 years of age) or vulnerable adults or those unable to give informed consent?   Yes   **No**

d1. If yes, will signed parental/carer consent be obtained?   Yes   No

d2. If yes, has a CRB check been obtained?   Yes   No

(Please append a copy of your CRB check)

6. What will be required of each subject/participant (e.g. time commitment, task/activity)? *(If psychometric instruments are to be employed, please state who will be supervising their use and their relevant qualification).*

> Each participant will be required to take part in one semi-structured interview, which will focus on their experiences of having had a child or children in therapy. This interview will last for approximately one and a half hours, during which the participant will be asked a series of questions open-ended questions. All interviews will be audio tape-recorded.

7. Is there any risk of physical or psychological harm to the subjects/participants?

          Yes   No

If yes,

a. Please detail the possible harm?

> The risk of harm, if any occurs, would be psychological distress rather than harm, which could occur through the participant possibly talking about sensitive experiences, and their feelings and reactions to these experiences.

b. How can this be justified?

> When asking someone to talk about any kind of lived experience, there is a risk that it may bring up sensitive issues and feelings. The research would not be able to be conducted without taking this risk, and the risk f psychological distress is not guaranteed, only acknowledged as a possibility.

c. What precautions are you taking to address the risks posed?

> As I am a second year Trainee Counselling Psychologist, I am able to employ counselling skills throughout the interviews, and I have experience in dealing with clients who are experiencing psychological distress. Also, I plan to provide the participants with a sheet of sources and services in which they can access should they feel they need further support after the interviews. These services will include various help lines. I shall also make myself available to phone the participant one week after their interview, if they should require it.

8. Will all subjects/participants and/or their parents/carers receive an information sheet describing the aims, procedure and possible risks of the research, as well as providing researcher and supervisor contact details?

Yes   No

(Please append the information sheet which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

> An information and consent form is displayed in Appendix C of the research proposal, and a debrief is displayed in Appendix D.

9. Will any person's treatment/care be in any way be compromised if they choose not to participate in the research?

          Yes   **No**

10. Will all subjects/participants be required to sign a consent form, stating that they fully understand the purpose, procedure and possible risks of the research?

          Yes   No

If no, please justify

| |
| |

If yes please append the informed consent form which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

| An information and consent form is displayed in Appendix C of this research proposal. |

11. What records will you be keeping of your subjects/participants? (e.g. research notes, computer records, tape/video recordings)?

| I will be keeping both hard copies and electronic copies of research notes, transcriptions, and also audio files of the recorded interviews. |

12. What provision will there be for the safe-keeping of these records?

| All hard copies of data shall be kept in a locked cupboard at my private address. All electronic copies of data will be encrypted and password protected. All data shall be anonymised. |

13. What will happen to the records at the end of the project?

> The records will be kept for five years after the research is completed. During this time, they will continue to be stored securely, with hard copies being kept in a locked cupboard at my private residence, and electronic copies being encrypted and password protected. After five years, the records of data will be destroyed.

14. How will you protect the anonymity of the subjects/participants?

> The only people who shall listen to or read unedited data shall be myself and my research supervisor. Otherwise, all data that contains identifying details will be anonymised to protect participant confidentiality. However, should any child protection concerns arise, which indicate there may be a risk of harm to a child, or a risk that the participant may hurt themselves or another individual, confidentiality and anonymity may have to be broken. This would be discussed with the participant first, and subsequently the research supervisor, and the participant will be made aware of this on the consent form, and be required to acknowledge and consent to it before taking part in the research.

15. What provision for post research de-brief or psychological support will be available should subjects/participants require?

> Participants will be provided with a debrief after their interviews, as displayed in Appendix D of the research proposal. I will provide participants with a sheet containing help lines and other possible services they could contact should they require further psychological support after taking part in this research. I shall also make myself available to phone the participant one week after their interview, if they should require it.

(Please append any de-brief information sheets or resource lists detailing possible support options)

> The debrief and lists of services which could offer further support is displayed in Appendix D of this research proposal.

If you have circled an item in **underlined bold** print or wish to provide additional details of the research please provide further explanation here:
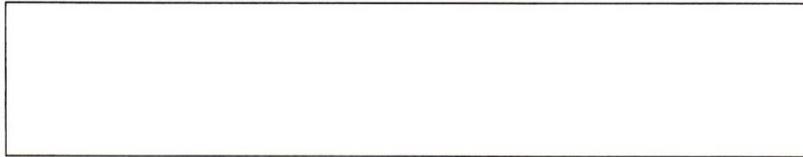
Signature of student researcher: Julia Clark   Date: 16th September 2011

CHECKLIST: the following forms should be appended unless justified otherwise

Research Proposal

Recruitment Material

Information Sheet

Consent Form

De-brief Information

Section B: Risks to the Researcher

1. Is there any risk of physical or psychological harm to yourself?   **<u>Yes</u>**   No

If yes,

a. Please detail possible harm?

Similar to that posed to the participants, the risk of harm would be a risk of psychological distress, caused by hearing sensitive issues in which the participant may speak about, and a risk this may trigger sensitive issues within myself. If I arrange to meet the participant at their home for the interview, then there may possibly be a risk to my personal safety.

b. How can this be justified?

> The risk of psychological distress is not guaranteed, only acknowledged as a possibility. It is a necessary risk to take in order for the research to be carried out. It may also be necessary to interview the participant at their home if they are unable, for any reason, to leave their home or to meet in a neutral location, so as not to discriminate against them, and to allow them to participate.

c. What precautions are to be taken to address the risks posed?

> I shall remain in personal therapy throughout the research, in order to have an avenue of support should I feel I need to address any psychological distress. I shall also be in regular contact with my research supervisor, and discuss any problems or concerns I have. To address the risk posed to my personal safety by meeting a participant at their home, I shall take a friend or colleague with me to that interview, and ask them to wait outside or nearby the address for the duration of the interview. I shall ensure the participant is in agreement with this, and ensure that the person accompanying me knows only the address at which I will be, and that I will be there for research purposes, and that they will not know any confidential or personal information about the participant or their interview, to ensure the participant's confidentiality.

Section C: To be completed by the research supervisor

(Please pay particular attention to any suggested research activity involving minors or vulnerable adults. Approval requires a currently valid CRB check to be appended to this form. If in any doubt, please refer to the Research Committee.)

Please mark the appropriate box below:

Ethical approval granted

Refer to the Department's Research and Ethics Committee

Refer to the School's Research and Ethics Committee

Signature -------------- ███████████████ -------- Date-------- 1. 10. 11

Section D: To be completed by the 2nd Departmental staff member *(Please read this ethics release form fully and pay particular attention to any answers on the form where **underlined bold** items have been circled and any relevant appendices.)*

I agree with the decision of the research supervisor as indicated above

Signature -- ███████████████ ---------- Date ---13/10/11 .

[black redaction box]

9

Blaming self?

188 be some things that I've done, erm, that have added to her phobia. You know, I've/ I   *Questioning own contribution to problem*

189 — I said to her, at one stage, "is it to do with because when you were small and you

190 fell over and I used to say (.) Well if it isn't bleeding it's not hurt. And so, so did I   *Mum's attitude.*

191 introduce the idea that blood was to be feared and that meant you were hurt?" And

192 she was saying, no it wasn't that, it was to do with, an incident, erm, where her   *Ignore ases fault?*

193 younger brother had run in the playground, erm, and completely fallen over, and put

194 his tooth through his lip, and scraped up his face. And he looked a bit like Carrie

195 when he got up, his face was just full of blood, and she as the elder sister, felt, that, it   *Pinpointing*

196 was her responsibility to help him, but couldn't, and just completely freaked out.   *Start of problem*

197 I: Wow.   *Pinpointing critical incident*

198 S: Erm, and from then on she just had a terrible thing with blood. And it was actually/

199 when I was called by the school, because it was quite a mess, erm, when I went to

200 the, the sick room they were both there. And my son was like yeah I'll go back to   *Comparison of siblings*

201 class it's not hurting so much now, and it was actually her that kept/ wanted to come   *+ how they deal with*

202 home because she felt so sick. Erm, er, but I had just been like yeah yeah, cuz I had   *things*

203 no idea, for *years* actually, that it had such an impact.   *Realization for mum.*

204 I: Yeah.

205 S: Erm, so, yeah I guess, I was just hoping, that, erm (.) she would find a way of dealing   *Hope. wanting child to find own way to cope.*

206 with it for herself, so she had, an elastic band on her li/ wrist that she would ping, to

207 distract herself. She would focus on things, she would think of pleasant events, she

208 *Therapy didn't help?* gets her own way through it now. Erm, so (.) But my overall impression of the therapy

209 (.) isn't great.   *negative experience*

210 I: Mmm, mmm.   *from mum's point of view*

211 S: Erm, so she was left with 3 techniques that she can use, and she probably uses one

212 of those.   *Something helpful from therapy.*

213   I: **Ok.**

Respected confidentiality

214   S: When I went back for the sixth session, I didn't know what had been said. Cuz I

Correction from counsellor to nurse — Shows, she did not think the nurse deserved the title of counsellor?

215   hadn't asked. Whether the counsellor, or nurse, thought that we had discussed it

Negative

216   when she went out, I don't know. But it wasn't checked. And I was invited in, and the,

Stumbling over what to call her.

217   erm, nurse, said she thought, erm, possibly we needed systemic therapy for the

218   entire family. And Keira needed additional therapy for her anxiety. (.) Keira was

Sounded like Mum was unhappy about it too.

219   incredibly unhappy at this. (.) Erm (.) And she started to tell me stuff that was

220   discussed in the sessions, and Keira completely withdrew. And, she said, she told

221   me a lot of things that Keira had said about her Dad (.) Erm, how excluded she felt by

break in confidentiality — negative important part of meaning for informant

222   her brother and sister, er, and that really I was the only one that my daughter felt that

223   she was close to in the entire family.

Mother & daughter close r'ship.

224   I: **Mmm.**

225   S: She asked if the rest of the family could be called in for a family session. And I said

this is true

226   that would not be appropriate. And she asked why, and I said because as much as I

Different views of therapy within the family.

227   embrace counselling, my husband does not, and he would see it as, erm, an affront,

228   he would feel very attacked. He would, erm, become very defensive and I can't say

worried about how it would effect Dad & Keira's r'ship.

229   that that wouldn't then follow on to how he would be with my daughter in future,

230   because he would feel that she had put him in that situation. Therefore I couldn't

Not supported by husband

Protecting family / other children

231   guarantee his support, nor would I do that to the family because the other 2 would

232   probably react in the same way. I'd asked my eldest daughter to go to counselling

other siblings have MH probs too.

233   because of depression and an/ anxiety, that she had had due to a school incident,

234   and she had out and out refused.

Quick to justify cause of def/anx. So of no blame on her?

→ How does this make Mum feel?

235   I: **Mmm.**

236   S: To then introduce her into a family session where you're looking at the way you all

Protecting 2nd daughter

237   interact, would be hugely detrimental to her. I felt. And I didn't feel that she would

238   want to be included, my son wouldn't care. He's a very open book. He'd go and he'd

Comparison of siblings.

Sari's attitude to Keira's therapy   _Comparison._

239   say what he needed to say and be lovely. But the other 2 would be very very difficult.

240   My husband, when I was in therapy, my therapist asked if my husband would go in to

241   therapy because she felt that he would benefit. I asked him then, he said "I have a

husband not willing to go to therapy with Stephanie

242   can of worms, do I want to look in my can of worms? No I do not. What is on my can

243   of worms will stay on there."

therapy described as opening up a can of worms – metaphor why? Scared of therapy/worry talking in a metaphor makes it easier to [therapy] makes you face [reality]/ reality

244   **I:**   **Mmm.**

245   S: "If you wanna look in your can, see what's wiggling around in there, that's up to you,

246   but I don't know what's at the bottom and it scares me, so I don't wanna start

247   looking." (.) So that's fair enough. Each to their own. So knowing that, there was no

accepting husband's view.

248   way he would go in to family therapy. And have been confronted, with the fact that

his kids don't think he supportive – neither does she

249   maybe his kids didn't think he was as supportive as he believes he is. And my elder

250   daughter, erm, is very unique. She's right on the outside of the autistic spectrum, er,

older daughter MH probs + learning probs.

251   and she had one incident when she was 11 that sent her in to a spiral of depression,

252   and, occasionally her depression escalates to the point where she hears voices. I

253   don't believe it's schizophrenia, I believe it's depressive psychosis. But, she is scared

Scared of diagnosis. – labelled.

254   to death that they will diagnose her as schizophrenic. And, you know, I've talked to/

Mum taking action to help.

255   gone through all the criteria and said "look you haven't got these." But there's no way

256   she would have gone into therapy.

older daughter resistant to therapy.

257   **I:**   **Yeah.**

negative emotion   _Let down? disappointed_

258   S: Erm (.) So (.) Keira felt betrayed. She felt that her confidence had been betrayed.

259   She felt that her confidenti/ the confidentiality had been breached. She felt that not

260   only had she not got the Counselling Psychologist that she had wanted, that she had

261   got somebody that didn't know how to do counselling properly, and had

262   fundamentally broken one of the golden rules. So, she also felt, that she had anxiety,

normalizing prob.

263   everybody has stress and anxiety, and that this person was giving her a mental

264   health problem that she didn't feel she had. _labelled?_

⊛ _What does it mean to be diagnosed/ labelled with a MH Problem?_

[handwritten annotation: MH problem/diagnosis = being dysfunctional?]

265   I: **Right. Yeah.**

266   S: Erm, so she was/ said "she's saying I'm dysfunctional. And I don't feel like   *[handwritten: Minimising?]*

267   dysfunctional. I came here because I couldn't cope with blood, not because I'm

268   worried about worrying." She said "people have stress, and I do worry, but I don't

269   think that makes me mentally ill."   *[handwritten: Being "mentally ill" = Stigmatised - negative. Therapy = only for mentally ill PPl?]*

270   I: **Mmm.**

[handwritten: Negative experience.]

271   S: So, erm, she was very affronted. So I said to the woman, "we need to/ I can tell you   *[handwritten: Mum directing + taking lead - Mum speaks to therapist, mum]*

272   we won't come for family therapy, but it is Keira's decision, as to whether she wishes   *[handwritten: tries to get Keira to decide.]*

273   to continue with any kind of therapy. And we will get back to you." Erm (.) So we

274   didn't, I couldn't get Keira to give me a definitive yes or no.   *[handwritten: Directive.]*

[handwritten: Child indecisive]

275   I: **Right.**

276   S: Erm, I think it's because she was frightened of letting *me* down. And, erm, I think it   *[handwritten: Mum directive - pushing for a decision.]*

277   was probably about 2 months later and I said "look we said we would get back to

278   them within 6 weeks. It's now 2 months and we really ought to tell them yes or no."

[handwritten left margin: Mum directed therapy/said for daughter to say she didn't want it anymore.] *[handwritten: Not told Mum this before]*

279   And that's when she said "they breached my confidentiality. I was so upset and   *[handwritten: important]*

280   disgusted with the fact that all these things that I thought I'd discussed in private were   *[handwritten: Negative experience]*

281   just shared with you willy nilly, and you were told how upset I was with Dad, and how,

282   erm, how he upset and how/ and all these things, and now he's made an ogre and I

283   don't/ I shouldn't be put in the position of needing to defend him." And, erm, she

[handwritten: trust important attribute]

284   was/ her/ her trust was completely blown, to the point where she said "I would never   *[handwritten: Negative experience]*

285   have counselling in the future. I don't know who I would get, if I got somebody like   *[handwritten: - put her off therapy]*

286   that again it would just blow me away. So I will just never bother."   *[handwritten: attributes of therapist   off therapy in future.]*

[handwritten: important - trust & confidentiality]

287   I: **Mmm, mmm.**

[handwritten: why negative experience? because daughter put off therapy and daughter... important]

288   S: And that hurts me. Erm (.) So, erm (.) Yeah, that's the whole experience. Eventually

289   they wrote to us and said "seeing as you didn't get back to us, we assume you don't

334 - 338

I • Background in Y
20 185/186 • Previous experience (with own counselling) (or working)

12. • Children her priority in life

19. • mentions own M.H.

25. 334-338 • Reflecting on own issues / childhood / family

26. 334 P15/16 • Own therapy enabled her to change direction in her life
4/4/16 258 • Parent helped child as much as she could
145-158 189
42 189 • Pinpointing origin of problem
177/178
43. • Parent guessing and child matching emotions - discomfort.

44 • Perceived role of parent
174 116 292
44 • Parent protecting child (+family + other children) 231/237
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47 • Mum discuss problem with child - Communication

48 • progression of prog

50/51 • probs @ school

54/55 193 • Thinking of how problem will affect child's future
55 172 232 328 • Parents decides child needs therapy
58 89 • Mum convincing child to go
124
58/59 • Personal / private nature of MH probs
135 55, 63 69 • problem takes over
60 • child's mood described e.g. grey (interview c, dark days)

65 • GP first port of call

66 • Parent knowledgeable about process of referral
72 73 91 258 260/261 356
81 85 • Expectations (of therapy process) - disappointment.
65 63 255
• Parent taking action to help
72 81/83 90 215 260/261 357
85 89 • Qualification of therapist important

88 336 • Child learns from parents experience

98 • "anxious"

100 • Not sure what to expect from the therapy
133 102 120 113 214
107 • Parents included
225
102 • Looking @ family dynamics.
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①

Parent doing all they can

113	• Child felt excluded
110/111	• Not a good therapist/client match
123-126	• Parent empathises with/mirrors child's emotions
140-142 118 214	• Respecting confidentiality
167-169	
120	• Parent "laying the ground" for the therapy
	— Prepare foundation
131	• Parent part of decision making
139 248 256	• Child apprehensive — apprehension/resistance
143	
142	• positive - progress
146 163	• Personality of child
150	• Child felt own attitude elicited change not therapist
153 211	• Good things about therapy
216 154-158	• bad '' '' ''
208/209	
160	• Parent notices child's mood after therapy
190	308 382 385 439
166	• Parent's way of dealing/[Values] 348-401 441
	• How Mum coped.
229 162/163	229 Child's bond with family/r'ships within family
177	• uncomfortable process for both child + parent.
171-174	
208	• process of the therapy for the child.
172	• knowing what to do (vs. not knowing/helpless)
188	• Blame self
186	• Helplessness
233 187	• Rationalizing — deal with guilt/helplessness?
189	• Questioning own contribution to problem.
238,239 200-202	• Comparison of siblings.
222-223	• Mum + daughter - close r'ship 468
245 726 217 465	• Qualification of therapist important
239 227-228 241-247	• Different views of therapy within family.
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231 241-243 244	• Not supported by husband (vs) good r'ship 515, 523
252 233	• Other children MH probs
241-247	• Metaphor of therapy

③②

Subtheme	
1.MASTER **The Enhancement of Relationships**	
The augmentation of closeness	"...she told me a lot of things that Keira had said about her Dad (.) Erm, how excluded she felt by her brother and sister, er, and that really I was the only one that my daughter felt that she was close to in the entire family." (220-223)
Connectedness	"Erm, so that's uncomfortable. Knowing that you've put them in a position where they're going to feel uncomfortable." (177-178)
The flow of communication	"...I've talked to/ gone through all the criteria and said 'look you haven't got these'." (254-255)
2.MASTER **Exploring the Meaning of Having a Child with Mental Health Difficulties**	
The impact of the difficulties	"...it got to the point where she was having difficulty with her periods, erm, because she would nearly faint when she went to the bathroom. And, erm, she loved Biology but she was nearly fainting when they were even discussing the circulation systems in class, let alone looking at pictures of anything... she didn't want to give up Biology and obviously she has to cope with, erm, menstruation her whole life." (48-54)
Perception of stigma from others	"…he said, 'I have a can of worms, do I want to look in my can of worms? No I do not. What is in my can of worms will stay in there. If you wanna look in your can, see what's wiggling around in there, that's up to you, but I don't know what's at the bottom and it scares me, so I don't wanna start looking.' " (241-147) "I encouraged quite a few people to go and seek help. But it is hard. And a lot of people are very very resistant. Because it is perceived as a weakness." (1163-1164)

	"…if somebody doesn't understand what counselling is about, they're probably in a greater anxiety, a greater fear, about what could happen… There is a huge stigma attached to it. So is my child always going to have mental health problems? And it's a weakness isn't it. It's always perceived as a weakness." (1111-1119)

"…you have an operation and you have something out and then it's over and done with. So on a form it would say within 5 years. Doesn't say that about depression. It says have you ever. So it is still perceived as a, as, err, as a weakness. Once you've had it, you're always susceptible." (1169-1174)
.
"…she also felt, that she had anxiety, everybody has stress and anxiety, and that this person was giving her a mental health problem that she didn't feel she had. Erm, so she was- said 'she's saying I'm dysfunctional. And I don't feel like dysfunctional… people have stress, and I do worry, but I don't think that makes me mentally ill.' So, erm, she was very affronted." (262-271) |
| A quest to make sense of the origin | "…there may be some things that I've done, erm, that have added to her phobia. You know, I've – I – I said to her, at one stage, 'is it to do with because when you were small and you fell over and I used to say (.) …well if it isn't bleeding it's not hurt. And so, so did I introduce the idea that blood was to be feared and that meant you were hurt?'" (187-191) |
| Reflection of personal attitudes | "It was, I'm putting – this is a service. It's just the same as if I was taking you to, I don't know, have a plaster cast put on a broken wrist. This is a service. And they are going to help you achieve this at the end. So a plaster cast helps your bones to stay in one place so that they can knit together. This service is going to help you get some clarity in your head, and deal with it, in a different way, so that you can be like this at the end, there will be an end point…" (1084-1089)

"Erm. I believe in the mental health continuum… it's a constant sliding up and down. And you just hit the point, because of what you're dealing with. So the people who go for counselling, do I think they're weak and do I think they're flaky and do I think that they are doomed? No, not at all. Not at all. I probably did, yeah. I used to think that if you went for counselling you had no friends to talk to." (1122-1134)

"I used to think it was the weak who went for counselling cuz they needed the support. I actually have a very different view of it now. I think it's the strong that go for counselling, because they've got the energy to see it through." (1148-1150) |

	"It was having my own therapy that made me want to go into counselling, 'cuz it had such a profound effect on my life." (22-23)
The burden of responsibility	

<table>
<tr><td colspan="2" align="center"><u>3.MASTER</u>
The Journey of Therapy</td></tr>
<tr><td>Finding the "right" therapist</td><td>"I think, personally, erm, one of the most beneficial parts of therapy is the relationship that you have between therapist and client." (868-870)</td></tr>
<tr><td>Handing my child over</td><td>"...that- that made it hard... I was disappointed she didn't, erm, get a counselling psychologist.... Erm. I was very disappointed because (.) I felt that she needed that level of expertise. And, erm, I thought it was unfair. I felt that she got second best..." (550-554)

"Erm, because, yeah, after- after her going through it for so long, and that is then my training, is that knowing the difference between a nurse practitioner, a counsellor, a counselling psychologist... And saying, this is where I position your need. I position your need over here, and actually having it two notches down I thought was kinda crap." (562-567)</td></tr>
<tr><td>Seeking own support</td><td></td></tr>
<tr><td>The balance of outcomes</td><td>"…she now copes with blood so much better that she's doing a Biology A-Level. Which is massive. And I think that was her driving force in going to therapy in the end." (872-874)

"It's good to see that she can cope with what she has now. That's very positive. I already knew that she was resourceful, and I'm glad that she hasn't- is managing it for herself now." (901-903)

"So erm, so it was good and bad. Yes she addressed what I wanted her to address, or she wanted to address, erm yes she had a successful outcome, it's completely decimated her idea of what counselling and therapy is about. That makes me sad personally." (895-898)</td></tr>
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	4.MASTER **Negotiating the Role of Parenthood**
The role of a parent	"I've always raised my children- my theory on- on- children, is that they came out of me somehow (.) erm, and, erm, (.) but then I'm just a caretaker. They are born who they are and there is a little bit of nurturing involved there where I influence them and I help them with moral issues and I give them guidance and, and teach them about respect, and tolerance and things. But they are who they are and they need to be treated who they are…So I guess it's about my whole life philosophy, it's about, you know, you are not part- I was never one of- you are part of me, you are mini me, you are- I shaped you in my own image and a bit like a God thing..." (383-399) "I think it is different for everybody, you know, I- I've deliberately not, erm (.) erm (.) encouraged a particular religion, I've not encouraged them to take any particular path. Erm, maybe that's hard for them at times, maybe it's easier to be given things and then maybe rebel against it, or maybe to be given things so that you create a comfort zone, so maybe it's made it harder for them at times. But it's always about, listen to what's inside you and then go with that." (413-418)
The origin of values	"…because my mother was so intrusive I decided not to be that intrusive." (404) "…My two brothers, erm, were always brilliant, apparently, erm, and I was always a pain in the arse… So, erm, I'd- I- I remember her telling me, err, yes but your brothers are special but I do love you. So, that's an interesting one. So I have with my own children being at pains to tell them there are no favourites, you're all very different and I love you for who you are. But it doesn't mean I love one more than the other, you're all loved equally, you're just given what you need." (446-465)

Subtheme	■■■■
	1.MASTER **The Enhancement of Relationships**
The augmentation of closeness	"I'll say again, it just got stronger, it didn't get…and I hate using that word cuz it sounds like it wasn't strong to begin with. Erm, it is strengthened even more, is how I should put it... Yeah. So it's strengthened that which was strong and made it stronger." (1012-1019) "I think, again I'm embarrassed to say but I'm going to say it, I think that a lot of families envy our family unit. I think we are very, erm, connected to one another. I think there's a lot of very equal relationships in all different directions." (1005-1007) " 'I'll do anything…and I know you're trying to help my sister and I'll do anything but, to be honest with you, I'd rather be doing sport at school and I hate sport.' " (1086-1088) "He absolutely loves her; she absolutely loves him." (1093)
Connectedness	"…it did end up being a journey with duality to it." (992) "I am so in tuned with my children that I have a certain link to them that's not real, it's almost psychic." (724-725) "…it was almost like her inner child coming to get me. I mean most people will think I'm absolutely cooked, but I actually think that happened and I'm grateful that we were that in tune, that whatever that was, I don't understand it, whatever it was, it happened." (740-744) "The pull to leave and the pull to stay, it was such a polarisation of souls that maybe one split away and came to get me." (760-762) "And so at one point I was, not anorexic, but I was struggling to swallow food..." (573)
The flow of communication	"…I don't think normally a mother gets to know all the darkest, deepest, demonic thoughts of somebody else's mind. I don't think, from my experience working with parents, I don't think other parents get to know the whole inner dialogue but she was sharing that with me and it was really upsetting." (54-59)

2.MASTER **Exploring the Meaning of Having a Child with Mental Health Difficulties**	
The impact of the difficulties	
Perception of stigma from others	"I could sense, often, an undercurrent with friends and wider family circle people, kind of like what didn't you get right? It wasn't like what did you get wrong, it was what haven't you done right with this child." (568-571) "And they'd say to me, 'Because you always look good, do you think it's because she wants to grow up and be as pretty as you?' I'd think, 'It's not about me.' " (574-576)
A quest to make sense of the origin	"We then, we left **** and we came to settle here and I think that's where she started to look for greater control because nothing made sense here. She understood life in **** and this was a grey, dark, cold, unfriendly place, by comparison. So I was watching her very carefully sink further and further into sadness that then became depression." (24-28) "We hadn't left **** yet but she had the most punitive class teacher I've ever come across. The most wicked woman. And this impacted so badly on my daughter that she became very sad. She wasn't depressed but she was sadder every day than I'd ever seen her." (178-181) "So that was the only time that I'd start to feel, have I got anything wrong? What have I done? What's it like being her mum? Having me as a mum, what does that feel like? What have I done? Have I colluded with the idealist perfectionism that she's carried from as soon as she could talk? Have I colluded with that? Have I been part of creating somebody that looks for control issues to feel better about herself?" (576-581) "That was a sort of stigma that I would have, this over processing when everything was quiet, going on in my own mind. I'd think, "Is it me? Have I done this?" (586-588)

Reflection of personal attitudes	"My mother was a counsellor. I was always surrounded by counsellors, therapists. It was just part of my world growing up. I used to say to people as a little girl, 'Why are people ashamed? If you've got an infection you go to a doctor. If there's something wrong with your mind you should go and sort it out,' and that was my very childlike view. And it was a very open platform for discussion in our lives." (146-149)

"I think that, erm, it's kind of my mission statement: if you can identify it and there's help, get the help." (166-167) |
| The burden of responsibility | "I mean although I knew I was carrying her and getting her through and holding her, it would have felt very remiss of me if I was doing that in isolation without any practitioners to back me up. And I would have felt like a bit of a charlatan and a bit deluded to think that I could do it alone." (1043-1047) |
| | |

3.MASTER
The Journey of Therapy

Finding the "right" therapist	"they just don't get me" (37)

"I can't engage with her." (381)

"The others were very, very frosty, very cold and arrogant, the first one quite rude at the door. The first one I went to the doorstep with her and she was very, very clinically cold and very unwelcoming. The other one practically was at the point of inviting us for dinner, so completely inappropriate." (381) |
| Handing my child over | "They got her a top child psychotherapist whose specialism was girls in crisis. That's why we had to wait then. I had huge trust in the whole system." (437-439)

"I'd feel so liberated when I left there because she was in safe hands. That's how it felt. And I could go off and focus on shopping or whatever I had to do without knowing the phone would ring and I'd have a tearful or hysterical or absolutely desolate child on the end of it. I knew for that hour and a half I had a breathing space. So in that sense it was hugely supportive for me too." (543-547)

"I always felt very settled when she was there." (554) |
| Seeking own support | "I realised that unless I started meeting my own needs a bit more I was going to go under with her. So I went off and got my own counselling… Because I always practiced preaching to the parents I work with: if you don't refill |

	your coffee cup, who is going to fill it up again for you? You're useless unless you meet your own needs. I started to question why I wasn't doing that for myself." (234-243)
The balance of outcomes	"I think he was superb and I think the feedback I got from Lucy each week showed me that he was doing his job so brilliantly and making her unpack the relevant things that she didn't want to revisit… I think she's not fully aware of quite how deeply he worked with her and how successful that therapy was." (64-68)
4.MASTER **Negotiating the Role of Parenthood**	
The role of a parent	"I think that as a parent, when I became a parent for the first time I…because of the constructs of my childhood and the things I remember as being important, I felt that it had always been my role to save my children from things. So therapy for me was a part of that. It was saving my child from danger and she was at danger from herself." (1034-1038)
The origin of values	

Subtheme	
1.MASTER **The Enhancement of Relationships**	
The augmentation of closeness	
Connectedness	"He was very scared, actually... I was also scared, I guess. We often, our children, I think we often mirror our children's feelings." (251-252)
The flow of communication	"...he wasn't normally communicative generally, though anyway, so it was… it was finding those moments to get through." (137-138) "...it was a definite thing about 'I can't manage this anymore', and then he told me what it was that he couldn't manage, and it was… it was the stuff that was happening at school. So, it was good that he eventually had talked about it..." (220-222)
2.MASTER **Exploring the Meaning of Having a Child with Mental Health Difficulties**	
The impact of the difficulties	"a sensitive soul." (76) "He'd become more withdrawn. His world had started shrinking, he… he was withdrawing from his friends. Not that he had many. He was morose, I suppose, a lot of the time... I suppose the most important, biggest thing was his posture. He was very hunched..." (88-92)

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	"...he did have times of, you know, rubbing his knuckles until they scraped, bled. And picking round his fingers a lot, that sort of thing... there were those little tell-tale things in hindsight." (232-234)
	"I just thought that it was part of this adolescent thing. I just thought it was part of his struggling with, as I say, all the things that adolescents sometimes do." (226-227)
	"...in the back of my head I was scared about being sectioned. His being sectioned." (416-417)
Perception of stigma from others	
A quest to make sense of the origin	
Reflection of personal attitudes	"It was positive, it was very good. It had helped me at that stage to sort out some things… But I think… I think the reason I stopped it partly then was financial, but I would have carried on… I like that process. For me." (327-335) "…perhaps it just made it easier for me to access and to trust the process." (354
The burden of responsibility	

3.MASTER
The Journey of Therapy

Finding the "right" therapist	"He was very helpful, very skilled. Connected really well with him... there was one woman that we saw before and I didn't quite get a sense that she'd got him in the same way..." (471-474) "I think one of the reasons that he didn't like her is perhaps because she was quite direct." (487-488) "...she pushed him a bit... she challenged him." (492)

	"He's what I'd call soft. A very soft, warm person... And so just the person that he needed at the time, actually... I think he did a lot of acknowledging of Luke, really. And… yeah he was quite… he was very reflective, and acknowledged and validated him. I think just identified his strengths, and the things that he did do well." (516-527)
Handing my child over	"But that was annoying, I mean it was… that, that made it scary actually..." (415) "...it was that control, yeah, yeah… That other people, yeah… could easily take control." (435-436) "So… so, yeah perhaps it was about control for me." (446)
Seeking own support	
The balance of outcomes	
4.MASTER **Negotiating the Role of Parenthood**	
The role of a parent	
The origin of values	

Subtheme	■
1.MASTER **The Enhancement of Relationships**	
The augmentation of closeness	"...even though I have a son who has been a doddle, an absolute doddle, he's never given me any trouble at all. Because it's been so easy, erm, as much as I love him in different ways, the sense of achievement and reward and pleasure for my daughter is very intense, compared with him." (226-229) "I think it's because she's a girl as well. We share all that girly stuff." (233)
Connectedness	
The flow of communication	
2.MASTER **Exploring the Meaning of Having a Child with Mental Health Difficulties**	
The impact of the difficulties	"My husband was er, extremely busy, and away from home a lot, out of the country as well, so it felt very much that I was coping on my own, and to see her so unhappy, and also missing huge chunks of school, refusing to go in, and getting threatening letters from the authorities that they would prosecute, at the point where I had the letter about prosecution, I think it even mentioned taking her into care." (50-54)

Perception of stigma from others	"[Amy's] perception of the whole process was that it was unnatural, erm… followed a format that counsellors had standard questions and responses. Erm, obviously a lot of digging into personal things, exposing of your feelings. Erm, so she hated the whole idea of it…" (35-38)
A quest to make sense of the origin	
Reflection of personal attitudes	"I'd had four years of therapy when I was in my twenties, which was wonderful really, and that's why I trained as a counsellor, and I believed basically in the process." (38-40)
The burden of responsibility	"totally responsible for solving it." (117-118) "I felt that, you know, my husband wasn't around enough, and wasn't- didn't have the space in his head, or his life, to deal with it. He would come home very late, very tired, and you know I did, I did come to try to get him to support me, but it was very difficult for him, coming home every night to me in a state, crying, erm, and having to take that on at the end of his difficult day, so that's why I felt it was much more my responsibility." (124-129) "It's just, responsibility is the word that I think of most. It is about, you know, you've brought this child into the world… I feel responsible for taking care of her, so if bad things are happening, it's up to me to make sure that it stops. It is, for me, has been the most difficult thing in my life I've ever had to do, is to- to try and protect her." (217-223) "I reached a point where I couldn't cope with it any more, didn't know what to do... I'd been asking her if she would see somebody, and she was absolutely refusing to, and, and eventually, when I realised that there wasn't anything more that I could do to help, erm, I said, well I'm sorry, it's not now a question of asking you, I'm telling you, you've got to go." (9-17)
3.MASTER **The Journey of Therapy**	
Finding the "right" therapist	"...I met this woman who I knew personally, and liked and felt very confident that she would be right for my daughter, in apart from being very local. I felt she had the right kind of approach, right sort of attitude and personality." (251-253)

	"I think the problem with all of this matching counsellors and clients, is, it is a match in a sense, you know, and I know myself, from my experience in my training, that not every counsellor is a good counsellor. Or particularly the right person, you know, personality for the client, and it's about finding the right match." (268-271)
Handing my child over	
Seeking own support	
The balance of outcomes	"...I knew that she'd started on a road to personal change that was absolutely vital for her, and would make all the difference to her life. And clearly it is. The way she goes about things now." (702-704)

4.MASTER
Negotiating the Role of Parenthood

The role of a parent	"Being a parent, well, it's really sort of the agony and the ecstasy for me… It is, for me, has been the most difficult thing in my life I've ever had to do, is to- to try and protect her. At the same time, I mean obviously things are very different now. When you've resolved it, and when you see, erm, your child growing and blossoming and everything coming good, it's the best thing that's ever happened to me. It's the most rewarding thing in my life, really." (215-226)
The origin of values	"I grew up in a situation with my parents, where my mum was very very unhappy, and er, she really used me as her counsellor as soon as I could talk, I think, so that I was given a sense of responsibility for her happiness, and always felt that I had to do something for her, to help her, which erm, I couldn't really do, apart from listen to her, you know." (125-133)

Subtheme	
	■■■■■■■
1.MASTER **The Enhancement of Relationships**	
The augmentation of closeness	"Erm, [our relationship] was good, erm, but at that point it was probably good before as well." (1841)
Connectedness	"When you've got a baby and you feel that they're unwell and a doctor tells you they're not, actually you still know that they're unwell because you know your child... I think nothing's really better than a mother's intuition." (2027-2029) "…he'd have the session where he was, you know, at the bottom of, you know, the darkest pit and then he'd go off with friends or whatever and be absolutely fine and leave me at the bottom of his pit…" (1576-1578)
The flow of communication	"…he didn't, he didn't tell me, he didn't talk to me very often about, erm, about suicide." (719-725) "I think once you've, once you've opened the lines of communication there with somebody, anybody, then that's, you know, erm, enough to just let off some steam and, and feel listened to… I think the children that, that do end up in a desperate state are ones that don't feel listened to by anybody at all." (1802-1809) "It's not useful for him to discuss it with his dad because he'll feel disloyal or I might hear about it or, you know, so to be able to moan about your parents in a safe environment is, is really useful for kids…" (1222-1224) "…it's the only time I've ever spoken to him, to Ben, about how scared I've been… afterwards I felt so guilty that I'd shared that with him… I felt guilty for having said it because I didn't want him to, didn't want to make him feel bad…" (1479-1488)
2.MASTER	

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Exploring the Meaning of Having a Child with Mental Health Difficulties	
The impact of the difficulties	"…we changed his schools, but you know, as I say, he, he then had the power to, to make that happen because he, he basically threatened to kill himself." (678-680) "You've got no choice at that point, do you really? But say it's, you know, I'm not gonna accuse him of emotional blackmail because I think he was so unhappy… But he, you know, I was powerless at that point." (685-688) "I felt very, you know, any sort of hint that he might be feeling that way and I, I, erm, was afraid to upset him or tell him off or, you know, do anything that might jeopardise stability of his mood." (618-620) "I'd be, sort of, sneaking into his bedroom after he'd gone to sleep to check that he was, you know, breathing, which is a horrible thing to, you know. It was like that for months." (511-512) "It wasn't until, as I say, I think, I think there is an element of when your child is wanting to or talking about suicide there's an element of feeling like you've, kind of, failed as a parent." (744-746) "I think a lot of children are very unaware of how their moods affect their parents… Because, you know, it almost seemed to take me longer to recover from them than it did him." (1587-1588) "But I felt like I had to be doing something at that point because I couldn't have the kids as the only thing in my life… it kind of took some of the pressure off, just giving me something else to focus on." (1548-1551) "…it means then that that becomes the entire focus of [the parents'] lives and they're absolutely drained by it and the ones that have been able to continue to work are actually much better because they have a release really, an escape." (1559-1561) "…that makes you feel guilty because you're busy, you know, studying and doing what you're doing and then your child's got… and then I'm feeling guilty about the amount of time that I'm spending studying and not, you know, like the times that he wants to chat and I've got an assignment to get finished." (1536-1540)
Perception of stigma from others	"…I do know how I would be judged or how I might be judged, erm, having two children in therapy… and, the, the way people speak about, erm, children of, of single parents as well, certainly single mothers, erm, is almost, is almost, evidence that my kids are messed up because of what I've done, erm, and my lifestyle choice. So I'm more aware of the fact that, of, of how it's viewed than how I feel about it." (1421-1431)

	"I wouldn't particularly go around boasting about the fact that I've had two children in therapy, that doesn't feel very good, really." (1412-1413)
A quest to make sense of the origin	"...it's all kind of part of the bigger picture of… sort of who he is and, and, *(clears throat)* erm, why he might have had difficulties and also he's got quite *(clears throat)* he's got quite a medical history…" (15-17) "In her, in her summary, erm, that we got, we got posted after the session, erm, it really looked like all of his issues were to do with his relationship with his dad and our break-up, erm, which I think was quite a superficial summation of what the problems were." (1132-1135)
Reflection of personal attitudes	"I've always been very for it. I actually think everyone should have counselling, even if you don't have problems 'cuz it's not gonna do any harm." (1079-1080) "I think [counselling's] quite useful just to understand yourself better." (2156) "I think, erm, certainly men are not happy to [talk to people about their issues]. I think a lot more women go to see a counsellor than men. I think men have to be, kind of, in some sort of dire situation before they go for counselling, whereas a lot of women think, you know, I should probably see a counsellor because I think it'd be useful." (1360-1365)
The burden of responsibility	"...in the same sense that when your children are physically unwell, you know, it's your responsibility to see that they get the medical help that they need." (1416-1417)
3.MASTER **The Journey of Therapy**	
Finding the "right" therapist	"I think a lot of people will go to a counsellor, not have a rapport with them and never go to counselling again because it, you know… which is a shame… it's more about the relationship than what's being offered." (Lindsey, 1087-1094) "Erm, as I say, I wasn't, the first lady, erm, I wasn't keen on at all, erm, and I don't know why. But she, erm (.) I just knew that it wasn't gonna be a useful relationship." (1125-1127)

	"And, erm, the second lady we saw, was, from the minute we met her I knew it was gonna be a productive relationship…" (1165-1166) "I'm trying to think of the differences between her and the first one, 'cuz it was nothing, erm, it was nothing I could put my finger on that wasn't, that, you know, that was wrong with the first lady we saw." (1171-1174)
Handing my child over	
Seeking own support	"I've just had to talk to friends really and I'm lucky 'cuz I've got a lot of good friends that, that are, you know, useful to talk to, but they're not trained professionals." (1448-1450) "…I remember the one time sat with [Ben's therapist] and, erm, I felt quite emotional and I actually wanted just to tell her how bad it felt for me, you know, and how scared I was, erm, and, and just offload a little bit…" (1457-1459) C - "I'm quite laid back about everything really. I'm not…I don't see it as a big…I think probably 'cuz I've had really good support, I don't see it as the big battle that I think lots of people do." (250-252)
The balance of outcomes	"…from the minute he started seeing [his therapist] certainly, erm, he felt a bit safer and calmer and erm, I think it helped him grow up a bit as well." (1844-1844)

4.MASTER
Negotiating the Role of Parenthood

The role of a parent	"I do think as a parent pretty much the only thing that's fundamentally important is to be listening to your children all the time and make sure that even if you're really busy, that they know you're available to talk to." (1782-1784) "My, my middle one since has had difficulties, erm, and with two of them, all of a sudden you do feel like, you know, I've got one with this problem and another with that problem and actually, you know… my, my parenting skills are clearly not all that because we've fallen apart slightly..." (757-769)

	"...there have been times when I've just felt, erm, quite ineffective as a parent. Erm, I know I've not ever, kind of, done anything, erm, harmful to them, but, you know, you feel, erm, perhaps that you've not been as, erm, kind of, involved in their lives as you should have been or as, as mindful of their, erm, of their issues..." (800-806)
The origin of values	"I know when I left home, you know, I was ready to be completely independent and you don't, the last thing you want is parents that aren't allowing you to be that… And I do want him to be independent, erm, and know that I'm there but I'm there when he wants to come to me rather than, you know, rather than chasing him." (1703-1710)

Subtheme	▮▮▮
1.MASTER **The Enhancement of Relationships**	
The augmentation of closeness	
Connectedness	
The flow of communication	
2.MASTER **Exploring the Meaning of Having a Child with Mental Health Difficulties**	
The impact of the difficulties	"He would sit in his room in the mornings, in the dark, on the bed, having been a really bright-eyed, bushy-tailed toddler. He would just sit and I would go in and say, 'Can I open the curtains?' 'No, don't. I'm tired, no.' You know, what's going on? 'I just want to sit in the dark and be sad.' " (202-205)
Perception of stigma from others	"Now, working in CAHMS, in the NHS, I feel reasonably certain that it would have been impossible to get a referral for a depressed three-and-a-half-year-old… as a multi-disciplinary team, our response tends to be 'send that mother to a therapist.' " (272-276) "didn't really realise the cultural, sort of, apprehensions that other people might have" (571-572)

	"…mothers would come to ask me questions and stuff, and then they wouldn't meet my eye after that because they wouldn't want to be, wouldn't want to have to acknowledge that they've had this conversation." (579-581)
A quest to make sense of the origin	
Reflection of personal attitudes	"Well, it's just that people talk about, 'when my therapist says this and my therapist says that,' and there's no stigma, particularly… Erm, if anything, it's more just a little bit of, 'oh, you're so self-involved," rather than a 'you're mad'…" (295-297) "I think I would I have had the going in position of therapists are being… people who are wise and understood things that I couldn't understand, and I wouldn't have questioned, and all of that." (305-308) "…it's, kind of, like the Wizard of Oz. There's the man behind the curtain and maybe he's just a guy…" (309-310)
The burden of responsibility	

3.MASTER
The Journey of Therapy

Finding the "right" therapist	"This woman's creating this space – although, I probably didn't use that phrase then, but I do now – creating this space, and he's…she's with him and reflecting it back to him, so that he's working it out for himself, and it was fantastic." (433-437)
Handing my child over	
Seeking own support	
The balance of outcomes	"a long, slow drip, drip" (220)

	"It felt like play therapy was the right way to start and it did make a huge difference, and there was a lot impact, but we were, by no means, all the way there at the end of his three years of play therapy. But, you know, it felt like we were moving in the right direction…" (216-220) "So it's almost as if we were working together to figure Christopher out and it felt like we were really in it together." (506-507)
4.MASTER **Negotiating the Role of Parenthood**	
The role of a parent	
The origin of values	"Erm, well, obviously, some [values came] from my own parents and then some in reaction, against them." (387-388) "…my mother-in-law, who's English and my mother, who's American, sent me parenting books and they disagreed on everything important. They disagreed on feeding, on sleeping, on all kinds of stuff, and I thought, "That's great. You know, clearly, the experts don't know as much as they think they know, and I can pick and choose and make it up, and so, maybe, it was just a continuation of that, liberating and, there's not a right way. We can find our own right way." (376-382)

Subtheme	
1.MASTER **The Enhancement of Relationships**	
The augmentation of closeness	
Connectedness	
The flow of communication	"So it gave us a vocabulary, I suppose, that…that we could communicate with. So he could say, you know, I could say to him 'Is Agent X bothering you a lot at the moment 'cause you look like you're stressed or struggling,' or, you know, 'Let's think about what…what would Bobby the Boxer do to help you at times like this?' "(639-645)
2.MASTER **Exploring the Meaning of Having a Child with Mental Health Difficulties**	
The impact of the difficulties	"He had a meltdown, which he does from time to time, but a really emotional like grief…sobbing, you know, that whole real, you know, uncontrolled sobbing over just some miscommunication. I thought that he was going a bit…getting a bit, erm, depressed again*(sighs).*" (165-168) "...he had black moods and, you know, he'd describe things like an adult would talk about if they were depressed, you know, 'there's clouds bearing down on me', you know, "if it's raining outside I can't possibly be happy'..." (445-448)
Perception of stigma from others	"Well, we've got somebody who's in school looking for children who she can work with." (174-175). "…So I don't know, you know, whether it was just to protect me from the suggestion that he might need some help or what." (186-187)

	"You could say, you know, Bobby might find this a bit difficult he is on the autistic spectrum and has Asperger's. What does that mean? He finds social communication a bit difficult. It just makes it easier than, you know, than saying, well, Bobby… It makes you sound like a fussy parent, you know? You've got to like… And…and people switch off and think, 'oh God, not another one who has parents that thinks their child is really precious!' " (2276-2288) "It's just being a bit more gentle with Bobby because he's got this diagnosis. And then people go 'oh, what does that mean? How…? What do I need to do differently?' rather than me imposing it all on them, do it this way, here's a very descriptive list of how I want you to look after my 14-year-old son. It's like, 'really?' You know, 'get over yourself!' *(laughter)*" (2292-2296) "...they're just being careful, aren't they, to not upset people and make it a…a negative thing to get the label... You know, if it's something physical, you have some tests, you get a diagnosis, that's…that's it, and then you get the treatment. But with this it was all, yeah, a lot more careful to avoid stigma and stereotypes..." (467-475)
A quest to make sense of the origin	
Reflection of personal attitudes	"I think…actually, thinking back, erm, I didn't like the idea that people could know me better than me—and that I found a bit scary. (299-300) "…maybe shame or, you know, embarrassment about going and speaking to somebody." (314-315) "a magic wand... I wanted everything to be perfect and gone away" (279-283) "I see it as kind of a toolbox really... and, you know, there's this problem or a difficulty and you just kind of have to look for things that might help, and if CBT hadn't have made any difference or changed his views on things, then I'd think, 'Well, we're wasting our time here, what else can we try?' " (269-272) "So I guess I've learnt through it as well, so I'm…I feel more empowered to help him as well by being open minded and saying, you know, it might help, it might not, as in, you know, give it a go, you've got nothing to lose, have you?" (282-285) "...through the postnatal counselling I realised that actually they don't know me better than me, they just help me see who I am more clearly." (305-306)

	"In therapy, erm, I'm thinking, you know, drug addicts and alcoholics and, you know, inpatient, really, really, intensive rehab kind of 'in therapy' rather than having a bit of counselling. It's…I suppose it's the difference between taking a couple of paracetamol and being on morphine all the time." (2128-2131) "So having a bit of counselling, that's, you know, that…that's fine, you're just chatting to somebody and getting a bit of clarity on how you're thinking. In therapy I see it as more, erm, erm... instead of me asking for help, it's more the help has been suggested that it might be beneficial... Sort of external bodies saying, you know, we really recommend that you are on this medication... Losing control over it: 'in therapy'." (2186-2203) "Bobby's finding life a bit of a challenge at the moment... we've got him some counselling to help him sort of help him through that change. It's much more positive isn't it than 'we can't cope with him, we've had to send him into therapy'." (2300-2304)
The burden of responsibility	"It doesn't matter what the label is, he's still who he is, and it's just a case of finding things to help him with his problems in the same way that Billy's got asthma and he has medication. And if that medication doesn't work we try something different and, you know, you just do what you can to help the symptoms at the time." (396-399) "I can't make him not autistic, but I can give him strategies and ways of thinking and ways of coping that he can then use to make everyday life that bit easier." (375-377)
3.MASTER **The Journey of Therapy**	
Finding the "right" therapist	
Handing my child over	
Seeking own support	"I'm quite laid back about everything really. I'm not…I don't see it as a big…I think probably 'cuz I've had really good support, I don't see it as the big battle that I think lots of people do." (250-252)
The balance of outcomes	"...between them it was really creative, really amazing the ideas that he came up with about the toolbox that Bobby the Boxer could have to fight off Agent X, and what Agent X had that Bobby felt that he couldn't fight against." (639-641)

<table>
<tr><td colspan="2">4.MASTER
Negotiating the Role of Parenthood</td></tr>
<tr><td>The role of a parent</td><td>"I try and keep everybody quite balanced 'cause I do worry about having three, having a middle child who is a typical middle child, but they're all quite unique with different skills and…you know, strengths and things... They're really quite individual children so it's nice to have their…to be able to treat them as individuals." (123-131)</td></tr>
<tr><td>The origin of values</td><td></td></tr>
</table>

Subtheme	Michelle
	1.MASTER **The Enhancement of Relationships**
The augmentation of closeness	"We've always been close, that never changed at all…" (670) "...we've never been close with like our mum or dad; close in some ways but not close like my daughter... I'm not so close with the older one. But, you know, it's never been that close relationship that I could tell my mum about boyfriends. I couldn't do that. Then that's why I want to be more close with Sofia…" (1201-1207) "[Anastasia] like looked after [Sofia] for me as well when I was working, you know after school so they've got a good bond but again it's a bit, sometimes Sofia says like 'you're not my mum you can't tell me what to do', you know, [Anastasia] tries to… take over a little bit which I think [Sofia] brought up in the therapy as well." (185-191) "...she doesn't feel that close with her dad, you know, even though I tell him what's going on but he doesn't really get involved but he knows what's going on." (271-272)
Connectedness	"Obviously I was happier that she was happy…" (980)

The flow of communication	

<table>
<tr><td colspan="2" align="center">2.MASTER
Exploring the Meaning of Having a Child with Mental Health Difficulties</td></tr>
<tr><td>The impact of the difficulties</td><td></td></tr>
<tr><td>Perception of stigma from others</td><td>"…people do think that counselling is for crazy people but no, I'm more open minded." (385)
"Erm, I had like one friend that I told, my husband obviously he knows, yes and that's it. It is, you don't feel like you can, I couldn't tell my sisters; maybe because yes like they've not had problems with their children and you feel you can't say." (1228-1233)

"I don't know maybe just, what's the word for it, pride or; maybe its pride. You don't want to say that there's something wrong, yes. I think there's fear of being judged... definitely. Yes because you do think that you're doing the right thing, you know there's, no one teaches you what to do as a parent; yes, it's hard." (1224-1250)</td></tr>
<tr><td>A quest to make sense of the origin</td><td>"I think she had a first sort of relationship with a boy as well at that stage which she got rejected so I don't know if that triggered [the depression] off." (364-3650)

"I know she had like a lot of childminders when she was young… Six or seven childminders. So I don't know whether that made her clingy to me as well, yes. She wet the bed a lot, so I don't know; all these things… I'm thinking is that why she's like she is now. From childhood she was always, yes very clingy and emotional child and then maybe she just carried on being like that. It's quite... So maybe there's a reason for her being like that and then you know, you don't realise at the time…" (744-773)</td></tr>
<tr><td>Reflection of personal attitudes</td><td>"…because I've never had to, I've never needed it before… my daughter, what happened with her." (371)</td></tr>
</table>

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	I wanted to say to them is she, because she thinks she is [bipolar]... And they said no, no she's definitely not. And...it was [reassuring] but because they said that and also the depression thing I didn't want her, I didn't want to think that she was a depressed child." (340-354) "…I said well has she got anything… because that's what you want to know; has my child got anything wrong with them." (600-601) "...then to say to her you're normal you know, that's what they're saying to her…there's nothing wrong with you, you're normal." (926-931)
The burden of responsibility	

	3.MASTER **The Journey of Therapy**
Finding the "right" therapist	"…I know she said he was very, not, he sort of like went to her perspective a lot… She could relate to him and she found it comfortable talking to him… Like I said he came across you know, went to her level… And then to say to her you're normal you know, that's what they're saying to her…" (703-927)
Handing my child over	
Seeking own support	"You can tell; like I got upset because it's still raw isn't it; it's still something that you think yes it would have been nice if that was there then." (1515-1516) "I wouldn't have gone [for my own counselling] but it would have been nice if I had gone for Sofia and it was there and it would have been easier for me to go. You know otherwise you'd have to make another, you know it's quite a big decision then to do that for yourself but if it was just there it would have been an easier step I think. [That's] quite a big decision to make but if you're going for your child and it was there it would have been easier for you to just open the door, or knock on the door if it was there. Because we're all just sort of told to just get on with it aren't we, not told but we're just expected to just get on with things and then if that was there that would be nice." (1525-1552)

	"A support thing, that's what's coming out of this, like a support thing that you're trying to do, is good. For parents." (1259-1264) "I thought maybe it would be good for me as well, saying I knew my daughter had problems and I thought well it would be nice to talk to someone. So it was like good for me as well as good for you…" (1286-1288)
The balance of outcomes	
4.MASTER **Negotiating the Role of Parenthood**	
The role of a parent	
The origin of values	

Appendix I – Vignettes of Participant Parents

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Appendix J – Journal Information and Guidelines for Submission

http://www.apa.org/pubs/journals/sah/?tab=1

Stigma and Health

The lives of people with disease and disability are worsened by stigma, thus leading to public prejudice, loss of self-worth, and negative implications for health and well-being. *Stigma and Health* serves as a venue for articles examining research representing stigma in its various guises as it impacts people living with mental and physical illness.
Stigma and Health publishes peer-reviewed, original research articles that may include tests of hypotheses about the form and impact of stigma, examination of strategies to decrease stigma's effects, and survey research capturing stigma in populations. *Stigma and Health* especially welcomes research studies on methods meant to erase the stigma of mental and physical illnesses. Theoretical reviews and pioneering reports on innovations are also welcome.
The journal publishes regular articles as well as brief reports.

Submission

Editor: Patrick W. Corrigan
Illinois Institute of Technology

Submission Portal Entrance

Manuscript Types and Length

Stigma and Health accepts both regular articles and brief reports.

Articles should not exceed 25 pages inclusive of the Introduction, Methods, Results, and Discussion. Tables, Figures and References may be outside of this page limit. Authors may request consideration of longer papers, in advance of submission, when there is clear justification for additional length

Brief reports should be a maximum 1,800 words (excluding abstract, references, and table), plus no more than 15 references and one table or figure.

Manuscripts based in the following realms are also encouraged:

- Qualitative studies
- Survey research
- Quantitative tests of hypotheses about the form and impact of stigma
- Theoretical reviews and pioneering reports on innovations
- Research studies on methods meant to erase the stigma of mental and physical illnesses
- First person essays about experience with stigma

The journal will likewise consider lengthier theory-based papers with permission from the editor.

Masked Review

This journal has adopted a policy of masked review for all submissions. The title page should include all authors' names and institutional affiliations and full contact information for the corresponding author. The first page of text should omit this information but should include the title of the manuscript and the date it is submitted. Every effort should be made to see that the manuscript itself contains no clues to the authors' identity.

Manuscript Preparation

Prepare manuscripts according to the *Publication Manual of the American Psychological Association*, 6th Edition (2010). Manuscripts may be copyedited for bias-free language (see Chapter 3 of the *Publication Manual*).

Review APA's Checklist for Manuscript Submission before submitting your article.

Formatting

Double-space all copy. Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts, appear in the *Manual*.

Below are additional instructions regarding the preparation of display equations, computer code, and tables.

Display Equations

We strongly encourage you to use MathType (third-party software) or Equation Editor 3.0 (built into pre-2007 versions of Word) to construct your equations, rather than the equation support that is built into Word 2007 and Word 2010. Equations composed with the built-in Word 2007/Word 2010 equation support are converted to low-resolution graphics when they enter the production process and must be rekeyed by the typesetter, which may introduce errors.

To construct your equations with MathType or Equation Editor 3.0:

- Go to the Text section of the Insert tab and select Object.
- Select MathType or Equation Editor 3.0 in the drop-down menu.

If you have an equation that has already been produced using Microsoft Word 2007 or 2010 and you have access to the full version of MathType 6.5 or later, you can convert this equation to MathType by clicking on MathType Insert Equation. Copy the equation from Microsoft Word and paste it into the MathType box. Verify that your equation is correct, click File, and then click Update. Your equation has now been inserted into your Word file as a MathType Equation.

Use Equation Editor 3.0 or MathType only for equations or for formulas that cannot be produced as Word text using the Times or Symbol font.

Computer Code

Because altering computer code in any way (e.g., indents, line spacing, line breaks, page breaks) during the typesetting process could alter its meaning, we treat computer code differently from the rest of your article in our production process. To that end, we request separate files for computer code.

In Online Supplemental Material

We request that runnable source code be included as supplemental material to the article. For more information, visit Supplementing Your Article With Online Material.

In the Text of the Article

If you would like to include code in the text of your published manuscript, please submit a separate file with your code exactly as you want it to appear, using Courier New font with a type size of 8 points. We will make an image

of each segment of code in your article that exceeds 40 characters in length. (Shorter snippets of code that appear in text will be typeset in Courier New and run in with the rest of the text.) If an appendix contains a mix of code and explanatory text, please submit a file that contains the entire appendix, with the code keyed in 8-point Courier New.
Tables

Use Word's Insert Table function when you create tables. Using spaces or tabs in your table will create problems when the table is typeset and may result in errors.

Submitting Supplemental Materials

APA can place supplemental materials online, available via the published article in the PsycARTICLES® database. Please see Supplementing Your Article With Online Material for more details.

Abstract and Keywords

All manuscripts must include an abstract containing a maximum of 250 words typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.

References

List references in alphabetical order. Each listed reference should be cited in text, and each text citation should be listed in the References section.
Examples of basic reference formats:

- **Journal Article:**
Hughes, G., Desantis, A., & Waszak, F. (2013). Mechanisms of intentional binding and sensory attenuation: The role of temporal prediction, temporal control, identity prediction, and motor prediction. *Psychological Bulletin, 139,* 133–151. http://dx.doi.org/10.1037/a0028566
- **Authored Book:**
Rogers, T. T., & McClelland, J. L. (2004). *Semantic cognition: A parallel distributed processing approach.* Cambridge, MA: MIT Press.
- **Chapter in an Edited Book:**
Gill, M. J., &Sypher, B. D. (2009). Workplace incivility and organizational trust. In P. Lutgen-Sandvik& B. D. Sypher (Eds.), *Destructive organizational communication: Processes, consequences, and constructive ways of organizing* (pp. 53–73). New York, NY: Taylor & Francis.

Figures

Graphics files are welcome if supplied as Tiff or EPS files. Multipanel figures (i.e., figures with parts labeled a, b, c, d, etc.) should be assembled into one file.
The minimum line weight for line art is 0.5 point for optimal printing.
For more information about acceptable resolutions, fonts, sizing, and other figure issues, please see the general guidelines.
When possible, please place symbol legends below the figure instead of to the side.
APA offers authors the option to publish their figures online in color without the costs associated with print publication of color figures.
The same caption will appear on both the online (color) and print (black and white) versions. To ensure that the figure can be understood in both formats, authors should add alternative wording (e.g., "the red (dark gray) bars represent") as needed.
For authors who prefer their figures to be published in color both in print and online, original color figures can be printed in color at the editor's and publisher's discretion provided the author agrees to pay:

- $900 for one figure
- An additional $600 for the second figure
- An additional $450 for each subsequent figure

Permissions

Authors of accepted papers must obtain and provide to the editor on final acceptance all necessary permissions to reproduce in print and electronic form any copyrighted work, including test materials (or portions thereof), photographs, and other graphic images (including those used as stimuli in experiments).
On advice of counsel, APA may decline to publish any image whose copyright status is unknown.

- Download Permissions Alert Form (PDF, 13KB)

Publication Policies

APA policy prohibits an author from submitting the same manuscript for concurrent consideration by two or more publications.
See also APA Journals® Internet Posting Guidelines.
APA requires authors to reveal any possible conflict of interest in the conduct and reporting of research (e.g., financial interests in a test or procedure, funding by pharmaceutical companies for drug research).
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Authors of accepted manuscripts are required to transfer the copyright to APA.
- For manuscripts **not** funded by the Wellcome Trust or the Research Councils UK
Publication Rights (Copyright Transfer) Form (PDF, 83KB)
- For manuscripts funded by the Wellcome Trust or the Research Councils UK
Wellcome Trust or Research Councils UK Publication Rights Form (PDF, 34KB)

Ethical Principles

It is a violation of APA Ethical Principles to publish "as original data, data that have been previously published" (Standard 8.13).
In addition, APA Ethical Principles specify that "after research results are published, psychologists do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release" (Standard 8.14).
APA expects authors to adhere to these standards. Specifically, APA expects authors to have their data available throughout the editorial review process and for at least 5 years after the date of publication.
Authors are required to state in writing that they have complied with APA ethical standards in the treatment of their sample, human or animal, or to describe the details of treatment.
- Download Certification of Compliance With APA Ethical Principles Form (PDF, 26KB)
The APA Ethics Office provides the full Ethical Principles of Psychologists and Code of Conduct electronically on its website in HTML, PDF, and Word format. You may also request a copy by emailing or calling the APA Ethics Office (202-336-5930). You may also read "Ethical Principles," December 1992, *American Psychologist*, Vol. 47, pp. 1597–1611.

The Experiences of Parents Who Have Had a Child or Children Receive Psychological Therapy:

An Exploration of the Perception of Stigma and Self-Blame

Abstract

Stigma and self-blame has been shown to play a large part of how parents make sense of having a child or children receive psychological therapy. This paper outlines how stigma and self-blame played a prevalent part in the experiences of eight mothers who had had a child or children receive psychological therapy, and how these themes contributed to the sense making process and the impacts of having a child with mental health difficulties. A qualitative study was conducted using semi-structured interviews with eight parents, who were all mothers, and who all had had a child or children, under the age of sixteen years, receive psychological therapy. The data was analysed using Interpretative Phenomenological Analysis. The results highlighted a number of themes, the most striking of which were themes of experiencing stigma and self-blame. This paper gives an account of the previous literature around stigma and self-blame within mental health, and presents data from the qualitative study that relates to the themes of parents' experiences of stigma and self-blame when having a child or children receive psychological therapy. Implications for the field of Counselling Psychology are discussed, along with ideas for future research.

Keywords: Stigma, self-blame, parents, children, therapy

The Experiences of Parents Who Have Had a Child or Children Receive Psychological Therapy:

An Exploration of the Perception of Stigma and Self-Blame

Introduction

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Rosie:

The Therapeutic Journey of an Emotionally Abused Child

By Julia Clark

Introduction and the Start of Therapy

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