Portfolio Volume 1: Major Research Project

Parents' Experiences of Their Child's Interpersonal Psychotherapy for Adolescents (IPT-A) Intervention.

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Abstract

Rationale and Aims: Interpersonal Psychotherapy for Adolescents (IPT-A) is an evidence-based intervention for treating depression in young people, with parental involvement encouraged as part of the process. While research has examined IPT-A's effectiveness, there is limited understanding of parents' experiences with this intervention. Given the important role parents play in supporting their child's mental health, this study aims to explore their lived experiences, focusing on how they interpret the intervention, their involvement, and the perceived positive and negative aspects of their child's therapy.

Method: Semi-structured interviews were conducted with seven parents whose children received IPT-A. The study employed Interpretative Phenomenological Analysis (IPA) to explore in depth how parents make sense of their lived experiences, with a focus on identifying key themes that capture the complexities of these experiences.

Findings: The analysis revealed three Group Experiential Themes and their respective subthemes, including the struggles of navigating the mental health care system, parent roles and boundaries in therapy and learning points for IPT-A. These themes reflect the complexities and emotional journeys parents undergo while supporting their child through therapy. These themes also touch upon the roles of parents in the therapeutic process and the perceived effectiveness of the IPT-A intervention.

Discussion: This study highlights the complexities of parents' experiences with their child's IPT-A intervention. Parents expressed frustration and helplessness due to long waits for therapy, negative previous experiences and difficulties in securing appropriate support, yet remained determined to do whatever it took to help their child. The study revealed mixed emotions regarding parental involvement in therapy, with some parents feeling excluded

while others valued their participation. Parents in this study also highlighted the tension between their desire to be involved and the need to respect their child's autonomy and confidentiality in therapy. Parents observed positive changes in their child and family dynamics, attributed largely to the therapist's ability to build trust and rapport. However, they also expressed concerns about ongoing challenges and the need for continued support.

Implications: The findings highlight the importance of tailoring parental support, emphasising the need for improved communication, continued post-therapy support, and a robust therapeutic alliance to enhance treatment effectiveness.

Keywords: IPT-A; adolescent depression; parental involvement; parental experiences

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1. Introduction

1.1 Chapter Overview

This thesis concerns the lived experiences of parents of their child's Interpersonal Psychotherapy for Adolescents (IPT-A) intervention. Initially, I will introduce this chapter by highlighting my personal interest in the topic, and my ontological and epistemological position. I will then provide a description of adolescent depression, including differences in gender and risk factors which contribute to the development and maintenance of depression. I will take a holistic approach by focusing on how adolescent depression impacts the entire family. Evidence-based interventions for adolescent depression will be presented, paying particular attention to IPT-A and the existing literature on IPT-A. The remaining part of this chapter focuses on parents and carers, and their role in adolescent depression. A systematic literature review will follow focusing on the current evidence base of parental experiences and their involvement in their child's psychotherapeutic intervention specifically. Finally, this chapter will provide the rationale and research aims of this thesis.

1.2 Positioning the Researcher

1.2.1 Relationship to the research topic

My interest in this topic stems from working closely with parents of young children and young adults and listening to their journeys of navigating mental health services for their children. On a professional level, I have worked extensively in the field of mental health and in particular with children, young people and their families in community services, specialist services and schools. I had been privileged to work clinically with families and become aware of the many challenges involved while navigating the mental health care system. I have witnessed directly the impact of psychotherapeutic interventions on young people and their families. These experiences enabled me to acknowledge the challenges and complexities

involved while managing child and adolescent mental health (CAMH) difficulties and the vital role that family dynamics play in the therapeutic process. After working in CAMH settings in the United Kingdom (UK), I have come to learn that there is a lack of existing research and literature exploring caregivers' understandings and experiences of CAMH difficulties and their participation in interventions.

I feel personally connected to the topic because of my inclination towards understanding and enhancing current systems available to young people with mental health issues and their families. I have witnessed how families are often provided with limited space to give qualitative feedback on their experiences of therapy, which raises important questions as to how services are run and for whom. Family members' voices are therefore often underrepresented in the literature. As a trainee Clinical Psychologist, I became actively interested in developing services 'with' families and not 'to' families (NHS, 2019) and the need to provide effective psychotherapeutic interventions pursuant to the needs of this population.

Furthermore, I come from a Greek origin in which I recognise my strong attachment and support of the institution of family. I have grown in a family-oriented and relational culture in which relationships are seen as extremely important for the individual's reputation, honour and status. Concurrent with my own values, I became particularly interested in the theoretical underpinnings and basic principles of IPT-A, which involve understanding difficulties in an interpersonal and relational context (Mufson et al., 2011). Additionally, IPT-A encourages that clinicians involve parents and carers in the therapeutic process (Mufson et al., 2011), which further increased my interest in exploring how caregivers experience and interpret their child's intervention. Consequently, I consider this topic is worth exploring and I hope that this thesis will enable me to explore parents' lived experiences in greater depth, with the goal of amplifying their voices and contributing to more effective therapies.

1.2.2 Reflexivity

Researchers have proposed that insider and outsider positionalities are not distinctly separate but rather fluid and exist along a spectrum (Eppley, 2006; Katyal & King, 2014). According to Milligan (2016), a researcher is never entirely an insider or an outsider, but assumes various positions depending on the context. The researcher's positionality involves personal characteristics and emotional reactions to participants (Bradbury-Jones, 2007). In this current research, I recognise my own assumptions and biases due to previous experiences working with families as well as personal values, ideological stance and co-constructed meanings and narratives.

Reflexivity is often seen as an ongoing internal dialogue and critical self-assessment of a researcher's positionality, along with an appreciation that this stance may influence the research process and its outcomes (Bradbury-Jones, 2007; Stronach et al., 2007). Throughout this research study, it was pertinent to acknowledge that my experiences and perspectives might impact the research process (Malterud, 2001). My experiences may occasionally affect my decisions, such as when reviewing the literature or grouping together themes during data analysis. In that respect, the concept of reflexivity questions the notion that the production of knowledge is independent of the researcher and that knowledge itself is objective (Berger, 2015). Bracketing is a method used in qualitative research to set aside the researcher's preconceptions and biases, allowing the data to speak for itself (Tufford & Newman, 2012). Writing a reflective journal as part of bracketing (Ahern, 1999) allowed me to become more aware of and reflect on my assumptions and lessen their impact on the research process (Appendix 1). Also, this method enabled me to further explore how I perceive family formation, structures and dynamics, and how my personal and professional experiences might have affected my interpretation of parental experiences.

Additionally, I engaged in taking a step back as a researcher, reflecting critically on my assumptions and initial interpretations. This practice enabled me to approach participants' narratives with a fresh perspective, ensuring that my understanding remained true to their lived experiences rather than shaped by my preconceptions. I also adopted an iterative approach, going back and forth between participants' narratives and my analysis. This process of revisiting the data allowed me to refine my interpretations and explore the deeper meanings behind participants' views. Through these strategies, I was able to co-construct meaning with participants and make sense of their narratives within a broader social context. These efforts ensured that I approached the data not just descriptively, but interpretively, acknowledging the interactive and socially constructed nature of the research process.

1.2.3 Ontological and epistemological position

My epistemological stance has shaped and influenced multiple aspects and areas of this research study; therefore, it is vital to refer to this. Ontology is concerned with the nature of existence. It can be described as a theory of being, aiming to clarify what it means for something to exist. Ontology refers to the fundamental assumptions we use to understand the world (Hussain et al., 2013). Epistemology is concerned with the study of knowledge. It addresses questions about what distinguishes actual knowledge from beliefs or ideas, what can be known, how knowledge is acquired, and the certainty of its validity or truth (Greco, 2017). My understanding of the world favours a Social Constructionism epistemology. Social Constructionism argues that there is no 'single' truth to be revealed by taking an objective stance to the world. Rather our understanding and perception of the world are shaped by how it is represented or constructed through language, and this is influenced by the culture and era in which we live (Burr & Dick, 2017).

As I begin this study, I recognise that my understanding of psychotherapeutic interventions is shaped by my previous professional experience within specific social and

cultural contexts. By exploring the subjective experiences of parents of their child's IPT-A, I can examine and critique my prior knowledge (Gergen, 1985). Adopting a social constructionist epistemology allows me to critically assess 'taken for granted' knowledge by considering cultural and historical contexts (Burr, 2003). This lens will create an opportunity for parents to share their experiences. Throughout this research, I was conscious of the tension between the social constructionist epistemology that guided my study and the more positivist framework that underpins IPT-A as an intervention. My decision to adopt a social constructionist stance stemmed from my belief that understanding parental experiences requires consideration of the subjective meanings they ascribe to their child's therapy and their own role within it. I acknowledged that IPT-A's focus on symptom reduction, diagnostic criteria, and structured treatment outcomes could sometimes conflict with the broader, relational focus of social constructionism. This led me to critically reflect on how I positioned myself as a researcher—balancing the need to remain faithful to the structured nature of IPT-A while allowing space for participants to voice their unique perspectives and lived realities. I aimed to explore not only what IPT-A 'does' for parents but also how parents construct and interpret the impact of IPT-A in the context of their wider social and cultural frameworks.

In this study, I also adopt a transdiagnostic approach to mental health, which allows me to gather novel insights into how we understand and make sense of mental health difficulties (Dalgleish et al., 2020). I recognise how traditional diagnostic approaches, predominantly developed in the West, may no longer fit for purpose, gathering support for alternative means of conceptualising mental health struggles (Dalgleish et al., 2020).

1.3 Defining adolescent depression

Depressive disorders, also known as depression, are widely defined by ongoing negative changes in mood, such as dysphoria, irritability, and apathy, as well as various

psychological and physical symptoms that lead to distress or impair functioning in important areas; for instance, school and peer relationships (APA, 2022). Depression is regarded as one of the main causes of disability and illness in adolescents aged 10-19 years (WHO, 2021), and the dominant cause of disability globally, with roughly 280 million individuals suffering from depression to date (WHO, 2023). In the UK, the prevalence of depression has been 2.7% among adolescents aged 11 to 16 years and 4.8% among adolescents aged 17 to 19 years, with women more likely to experience depression than men (NHS, 2018). Adolescent depression negatively affects social interactions, sense of self and often self-worth (Shaw et al., 2009). It is also associated with increased risk behaviours (Akil et al., 2018) and cognitive decline (Hammer-Helmich et al., 2018). In young adolescents, suicidal thoughts seem to be more strongly associated with the symptoms and severity of depression (Casey et al., 2022). It is proposed that an increase in depressive symptoms may trigger or exacerbate suicidal ideation (Casey et al., 2022). Suicide ranks as the second leading cause of death among youth, and the incidence of depression and suicide is escalating in industrialised nations (Viswanathan et al., 2022).

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) outlines diagnostic criteria for various depressive disorders based on expert consensus and current research (APA, 2022). Over the past decade, the use of discrete diagnostic categories has been criticised, with many researchers favouring a dimensional approach to understanding depression throughout life (Caspi & Moffitt, 2018; Hankin, 2019; Kotov et al., 2017; Lahey et al., 2017). Despite criticisms, this categorical approach to diagnosis remains a valuable tool for clinicians. The DSM-5 diagnostic categories of depressive disorders include major depressive disorder (MDD), persistent depressive disorder (PDD), premenstrual dysphoric disorder (PMDD) and other specified depressive disorder (Griffith et al., 2024).

Dimensional models offer an alternative conceptualisation of depression by viewing it as a spectrum, where symptom levels and severity fluctuate over time (Hankin, 2019; Kotov et al., 2017). Instead of treating depressive disorders as separate categories, these models understand depression as a continuum, with individuals placed at various points along it. Those at the more extreme ends of this spectrum are more likely to experience significant distress and impairment. Dimensional models have been suggested to exhibit high validity compared to traditional diagnostic categories, representing an area of continuing and future research (Hankin, 2019). Throughout the rest of this chapter, the term 'depression' is widely used to describe the range of symptoms that characterise depressive disorders.

The social construction of depression refers to the idea that depression is not purely a clinical entity but is also shaped by social, cultural and historical contexts (Horwitz, 2011). Diagnostic categories for depression are not fixed or universal; rather, they are constructed through societal norms, professional practices, and the broader political landscape. In the context of this thesis, this perspective sheds light on how societal and cultural influences shape the understanding, diagnosis, and treatment of depression in young people and their families.

1.3.1 Gender differences

Overall, prevalence rates of depression have greatly increased for both genders over the recent years. The majority of research on gender differences and depression, has primarily concentrated on cisgender adolescents (Griffith et al., 2024). Before adolescence, childhood depression rates seem to be equal across genders (Hankin & Abramson, 2001). During the adolescent development period, it appears that young females are more likely to experience depressive episodes compared to their male counterparts (NIMH, 2022). A meta-analysis has shown that 3.5% of young males have been given a diagnosis of depression compared to 5.8% of young females, suggesting that young females are twice as likely to experience

depression (Ferrari et al., 2013). This disparity could be explained by social role theory which suggests that social roles are the root of differences and similarities across genders (Addis, 2008). In this respect, young men are less likely to be diagnosed with internalising problems like depression, since these difficulties contradict with traditional gender stereotypes. At the same time, it is important to consider how young males might experience and express depression in a different manner from young females. Other theories mainly focus on firm risk factors like vulnerabilities and diatheses and how these interact with contextual factors like stress, especially as gender gains prominence during teenage years (Hankin & Abramson, 2001; Hyde et al., 2008; Rose & Rudolph, 2006). Irrespective of the gender differences, adolescent depressive disorders have been shown to have enduring psychological and social effects into adulthood (Steinberg, 2005). Engaging adolescents in evidence-based treatments is therefore important to addressing these symptoms.

1.3.2 Aetiologies of adolescent depression

Adolescence marks a period of 'storm and stress' (Casey et al., 2010) since developmental, psychological and social changes often take place. These changes may cause adolescents to become more vulnerable to the onset of MH difficulties (Rapee et al., 2019). A range of interrelating factors that contribute to the risk of developing and maintaining depression are presented below.

1.3.2.1 Developmental risk factors

According to Erikson's theory of psychosocial development (Erikson, 1950), adolescents between the ages of 12 and 18 years, experience the Identity versus Role Confusion stage, during which they learn to become more independent and evolve a sense of self. As they transition from adolescence to adulthood, adolescents may experience confusion or insecurity about themselves and how they fit into society, creating room for psychological

difficulties, such as anxiety or depression, to develop (Costello et al., 2011). Moreover, the period of adolescence is linked with increased levels of emotionality, with adolescents showing emotions that are often more intense, heightened and volatile compared to adults. It has been suggested that adolescents are more vulnerable to mood disorders as a result of their inability to build neural mechanisms to regulate intense and heightened emotions (Guyer et al., 2016). Research indicates that adolescence is a critical period for the development of brain regions associated with social cognition and self-awareness (Blakemore, 2012). This development is thought to result from a combination of factors, including shifts in social contexts, hormonal changes during puberty, and both structural and functional changes in the brain, along with advancements in social cognitive abilities (Andrews et al., 2021; Blackmore, 2012; Konrad et al., 2013).

1.3.2.2 Contextual risk factors

The environment in which adolescents grow up can increase their susceptibility to depression and mental health issues. Political and cultural influences can provide protective factors against mental illness, nevertheless political instability and cultural pressures can also elevate the risk of depression by exposing youth to distressing events or forcing them to manage adolescence under difficult or dangerous conditions (Griffith et al., 2024). Since the COVID-19 pandemic began, research has shown a global increase in depression among adolescents (Barendse et al., 2022; Viner et al., 2022). While the enduring impacts of the pandemic are still unknown, short-term observations by professionals and researchers indicate that adolescents have faced heightened depression, anxiety, and panic, with one study reporting a 5% rise in the incidence of clinically significant depressive symptoms among youth (Hawes et al., 2022).

Adolescents from low-income households or neighbourhoods have higher rates of depression compared to those from wealthier backgrounds, with one study indicating that low-income young people are four times more likely to experience depression than their wealthier counterparts (Glied & Pine, 2002). However, the rates of occurrence can vary depending on how both depression and income are estimated (Patil et al., 2018). Likewise, adolescents living in neighbourhoods with limited resources, substandard housing, and poor living conditions are more prone to depression compared to those living in well-appointed and safe localities (Cutrona et al., 2006; Leventhal & Brooks-Gunn, 2000). Additionally, meta-analyses show strong connections between encountering racism and other types of oppression and negative mental health outcomes, such as depression (Dürrbaum & Sattler, 2020; Paradies et al., 2015; Pellicane & Ciesla, 2022). These experiences of being treated unfairly mostly come from major factors like the broader political situation, local communities, and the social environments that young people interact with as they grow up (Griffith et al., 2024).

Parental depression is a strong indicator of adolescent depression (Goodman, 2020; Weissman, 2020). Adolescents of parents who suffer from depression are about three times as likely to develop depression compared to those with parents who do not have depression (Weissman et al., 2016). These adolescents tend to experience depression symptoms earlier and demonstrate functional difficulties and high risk of dying at middle age (Weissman et al., 2016). Furthermore, adolescents with a family history of depression covering multiple generations are at a higher risk of developing depression compared to those with less extensive family history (van Dijk et al., 2021). A number of familial factors increase the likelihood of depression in adolescents (Robertson & Simons, 1989; Sander & McCarty, 2005; Schwartz et al., 2012; Sheeber et al., 2001). Regarding parenting, a meta-analysis revealed that higher levels of negative parenting behaviours, such as parental withdrawal,

hatred, and over-parenting, and lower exposure to positive parenting behaviours, including parental affection and responsiveness, are linked to increased depressive symptoms in adolescents (McLeod et al., 2007). Furthermore, research increasingly shows that children who face early family adversity, such as maltreatment and neglect, are more prone to experiencing depression during adolescence, in terms of symptoms and diagnosis (Harkness & Lumley, 2008; Infurna et al., 2016; Lee et al., 2020; Wang et al., 2021).

Another commonly researched and thoroughly documented risk factor for adolescent depression is exposure to life stress. Stressful life events (SLEs) include a range of experiences and situations such as interpersonal conflicts, neglect, financial problems, divorce, and the death of family members/friends (Cohen et al., 2019). Research indicated that exposure to interpersonal stressors, in particular, plays a significant role in contributing to depression in adolescents (Hammen, 2009). Adolescents who face stressful interpersonal environments, such as conflicts with others, are more likely to develop depressive symptoms (Hammen, 2006). This can create a cycle where depression leads to more social problems and conflicts, a process referred to as "stress generation" (Hammen, 2006). This stress generation might be a mechanism through which depressive symptoms persist throughout adolescent growth.

Interpersonal and relational risk factors play an important role in developing and maintaining youth depression. Research has found that adolescent depression is linked to the quality of family relationships and perceived social support from family and siblings (Mason et al., 2009). Family conflicts and poor family functioning might become a stressor for young people. Moreover, depression in youth is associated with poor quality of peer relationships, lack of peer popularity and ongoing exposure of negative attitudes from peers (Allen et al, 2006; Bowes et al., 2015; Shih et al., 2006). Although peer relationships and social support serve to protect adolescents from developing MH difficulties, a number of adolescents often

experience rejection or perceived loneliness, making them more susceptible to depression (Miloseva et al., 2017). Notably, these interpersonal difficulties can persist even after depressive symptoms have subsided (O'Shea et al., 2014; Puig-Antich et al., 1985a).

1.3.3 Impact of adolescent depression on caregivers

Living with a child or adolescent with depression can be a difficult experience for the family. Previous research has identified that parents of adolescents with mental health difficulties, including depression often experience high distress and other related feelings like fear and guilt (Armitage et al., 2020; Mohr & Regan-Kubinski, 2001). In an IPA study exploring mother's experiences of having a depressed adolescent child, all eight interviewed mothers expressed fear that their child exhibited with self-harming and/or suicidal behaviours (Armitage et al., 2020). Parents of adolescents who experience depression reported feeling hopeless and referred to the change of managing their child's issues at home while also needing to work to support their family (Stapley al., 2016). With the onset of mental health struggles, the change in the child's personality and functioning may create deep feelings of loss in families (MacGregor, 1994). Many parents experience a sense of loss to their child's personality, their child's role in family and society, their child's potential, competence and future, and their child's pleasure in life (Richardson et al., 2013). Internal losses might include low self-esteem and feelings of incompetence in their role as parents, which can then lead to a change in self-perceptions, self-beliefs and family dynamics (MacGregor, 1994). The majority of parents whose children experience MH problems, reported blaming themselves for their child difficulties (Mose, 2010). Parental self-blame has been attributed to concerns about passing on genetic predispositions for mental health problems, perceived inadequacies in parenting, and a turbulent family environment (Mose, 2010). Studies have also suggested that parents of depressed young people reported reduced wellbeing compared to parents of non-depressed young people (Early et al., 2002; Perloe et al., 2014).

1.4 Interventions for adolescent depression

Given the high number of adolescents with depressive symptoms, it is paramount to explore existing treatment options for this population. In line with the NICE guidelines (2019), there are a number of psychological therapies for young people with moderate to severe depression and their families. These include individual Cognitive Behavioural Therapy (CBT), Interpersonal Psychotherapy for Adolescents (IPT-A), Family Therapy (attachment-based or systemic), Brief Psychosocial Intervention and Psychodynamic Psychotherapy.

The IMPACT trial (Goodyer et al., 2017), Europe's largest clinical study on adolescent depression, compared three therapies—CBT, Short-Term Psychoanalytic Psychotherapy (STPP), and Brief Psychosocial Intervention—among 465 adolescents aged 11-17 with moderate to severe depression. The goal was to determine the most clinically and cost-effective treatment for reducing depressive symptoms 12 months post-treatment. Results showed that all three therapies led to a 49-52% reduction in symptoms and a 78% remission rate after 86 weeks, with no significant differences in effectiveness between them (Goodyer et al., 2017).

Between 1998-2017, there have been updates on the evidence base in relation to psychotherapeutic treatments for depression in adolescent youth. In the most recent review by Weersing et al. (2017), psychotherapeutic treatments were categorised as "well-established, probably efficacious, possibly efficacious, experimental treatment and treatments with questionable efficacy" (pg. 5). Treatments were also divided by type and modality. These included CBT, IPT-A and family therapy, adopting either an individual, group, internet-delivered or bibliotherapy format. CBT and IPT-A have both stood out in examining effective therapeutic interventions for adolescents with depression. Weersing et al., (2017) found that the number of IPT-A studies conducted was significantly lower than the number conducted on CBT; with only six trials on IPT and 27 trials on CBT. Of interest, IPT-A has been found to

have positive outcomes in 83% of trials compared to 56% for CBT. Their conclusions support previous reviews, suggesting a future need for additional research to match care to the needs of young people with depression and their families, and address the long term effects of evidence based interventions for youth depression (Weersing et al., 2017). Given the promising results of IPT-A for adolescent depression, this thesis will focus specifically on this intervention and aim to add to the existing IPT-A literature.

1.4.1 History and origins of IPT

Interpersonal psychotherapy (IPT) is a time-limited, manualised psychotherapeutic intervention that was initially developed in the late 1960s for the treatment of adult depression in outpatient settings. IPT is based on the idea that the depression is inseparably connected with the individual's interpersonal relationships. IPT's aims are firstly, to reduce depressive symptoms and secondly, to enhance interpersonal functioning by building better communication within important relationships (Klerman et al., 1984). IPT is considered unique compared to other psychotherapeutic interventions because of its focus on existing interpersonal conflicts, and is one of the first therapies to be implemented in a treatment manual (Mufson et al., 2011).

IPT makes no assumptions about the cause of depression. Nevertheless, IPT supports the idea that the occurrence of clinical depression takes place within a social and relational context and that interpersonal interactions between the client and significant others significantly affect the onset, treatment response and treatment outcomes. IPT is rooted within Meyer's and Sullivan's interpersonal theories. Meyer (1957) used a psychobiological approach and proposed that psychopathology is better understood as deficits or dysfunctions in personality rather than as brain pathology. Strongly influenced by Adolf Meyer, Sullivan's (1953) concepts about the importance of interpersonal interactions and insight in the development of mental illness are foundational to interpersonal theory. Sullivan (1953)

argued that inadequate communication, rather than inherent biological factors or internal struggles, leads to mental ill health by hindering an individual's fundamental need for empathy and connection with others. Similarly, Bowlby's (1969) attachment theory, which posits that early disruptions in the caregiver context affect children's capacity to manage interpersonal relationships later in life, has influenced theories on the interpersonal roots of adolescent depression. Early disorganised and insecure attachment styles are thought to result in social deficits that may result in depressive symptoms in adulthood.

1.4.2 Interpersonal Psychotherapy for Adolescents (IPT-A)

IPT for depressed adolescents (IPT-A) is a novel adaptation of a psychotherapeutic intervention which has proved to be effective in clinical trials (Mufson et al., 1999, 2004, 2018; Roselló & Bernal, 1999). Interpersonal Psychotherapy for Adolescents (IPT-A) was adapted by Mufson and colleagues in 1991, and the rationale for adaptation is situated in the established research evidence of IPT's efficacy, the developmental appropriateness of the intervention and the existing clinical needs in the community. IPT-A specifically focuses on treating the interpersonal issues that are linked with adolescent depression. IPT-A directs predominantly towards existing interpersonal conflicts that might be of significance or cause a great deal of concern to adolescents. By modifying the treatment goals and strategies of the problem areas, Mufson et al. (1991) adapted IPT-A to prioritise key developmental challenges and thus address adolescents' needs and abilities. IPT-A is aimed at addressing problematic interpersonal relationships, especially those occurring within the family. As part of the treatment, parents and other family members are encouraged to participate in IPT-A, either in a form of offering informal support to the adolescent, or being directly involved in the intervention, causing a change in familiar interactions or intrafamilial communications.

IPT-A is a manualised evidence-based intervention adapted specifically for adolescents aged 12-18 years, who experience moderate to severe depression (Mufson et al.,

2011). IPT-A is a time-limited intervention; it is designed as a weekly intervention and aims to last for 12 weeks (Mufson et al., 2011). IPT-A's objectives are to reduce depressive symptoms and improve interpersonal relationships and dynamics within the emergence and/or maintenance of depression (Mufson et al., 2004). IPT-A argues that there is an association between the adolescent's social and interpersonal interactions and the start and/or maintenance of depression. Support networks have been found to serve as protective factors against depression; therefore, stress that arises from interactions and relationships with others can lead to depressive symptoms (Coyne, 1976). Mood and relationships can mutually influence one another; consequently, turbulent relationships can reduce mood levels and low mood can negatively affect relationships.

The treatment consists of three phases: the initial phase, the middle phase and the ending phase. The initial phase involves confirmation of depression diagnosis, psychoeducation, exploration of the important interpersonal relationships and identification of a problem area which will be the focus of the next phase of treatment. The identified problem areas include grief; struggle coping with the loss of a loved one, role disputes; adolescent and others having differing expectations about their relationship, role transitions; difficulty with adjusting and accepting a new role in life and interpersonal conflicts; limited or no attachments, social isolation and very few relationships (Weissman et al., 2000). During the middle phase, the work is focused on establishing specific strategies and thus enabling the adolescent to overcome their interpersonal difficulties, in one or two problem areas. More specifically, adolescents learn communication skills to express their emotions regarding conflicts or other adversities which take place in relationships and life events, for instance an absent parent, an inconsistent parent or conflicts with peers. At the ending phase, the goal is to pinpoint warning signs, reflect on existing strategies and emphasise application of skills to future situations.

1.4.2.1 The effectiveness of IPT-A

IPT-A is a well-established and efficacious treatment for adolescents experiencing depression and their caregivers. IPT-A has been shown to be effective in a number of clinical trials, resulting in reduced depressive symptoms (Mufson et al., 1999, 2004; Roselló & Bernal, 1999). In a systematic review for adolescent depression worldwide, IPT was shown to be as effective as CBT, with low attrition rates and long-term outcomes (Zhou et al., 2015). The authors noted that this conclusion was drawn from a limited number of trials and needs further validation. The efficacy of IPT for depressed adolescents has also been investigated in more recent meta-analyses. Pu et al. (2017) concluded that IPT was notably effective compared to control conditions in reducing depressive symptoms both at after treatment and follow-up. Mychailyszyn and Elson (2018) conducted a more comprehensive meta-analysis of 10 studies, which revealed that IPT-A was effective in alleviating depressive symptoms in youth and was more effective than control groups in addressing adolescent depression.

Some studies have also explored the effects of IPT-A on interpersonal functioning and reported long-term reduction (Mufson et al., 2004; O'Shea et al., 2015). Nevertheless, it is worth noting that IPT-A did not seem to enhance interpersonal functioning more than any other relevant intervention. Additionally, IPT for depressed adolescents has proven efficient in both high and low-middle income countries (Bolton et al., 2007; Mufson et al., 2004). Although these results serve as good evidence that IPT-A can be offered as an effective intervention for adolescent depression, it should be noted that the existing literature in IPT-A is mainly based on a large number of small studies, uncontrolled trials and studies with high risk of bias ratings (Duffy et al., 2019).

1.4.2.2 The experience of IPT-A

To date, there is a lack of qualitative research within IPT-A, and limited exploration of the experience of the intervention. This is noteworthy given IPT-A is a NICE guideline recommended therapy for adolescents with depression. Also, the existing evidence base has been predominantly generated by the developers of the intervention and the invested stakeholders. It has been argued that a variety of methods are needed to be able to generate conclusions to important and complex questions; for instance, the experiences of an intervention, highlighting the importance of incorporating qualitative research to the existing evidence base (Midgley et al., 2014).

1.5 Parents and their involvement

Several evidence-based interventions involve participation of both the child and parent to some degree (Kazdin & Weisz, 2003). According to the NICE guidelines, it is considered good practice to involve parents and family within adolescent mental health treatment (NICE, 2005). The majority of existing research is derived from CBT interventions and highlights that parents are likely to be involved in their child's treatment in many different ways, including but not limited to offering informal support, acting as co-therapists or acting as co-clients (Stallard, 2002). The level of parental involvement in their child's CBT intervention varies based on the needs of the adolescent and the family, and might alter throughout therapy (Verduyn et al., 2009).

In a systematic review (Dardas et al., 2018), research on parental involvement in CBT has suggested that the involvement of parents in the therapeutic work has been effective in reducing depressive symptoms. Dardas et al. (2018) found individual CBT along with joint parent sessions to be more successful than individual CBT with the young person alone. Moreover, they found that interventions involving joint adolescent-parent sessions were more effective than parent sessions only, by enabling positive parenting and positive interaction between the young person and family. There was evidence that joint sessions with the

adolescent and family showed a positive change on their relationship and decreased family conflict, and further improved results at a two year follow-up (Dardas et al., 2018). Similar findings have been supported by previous research on parental involvement in CBT, resulting in reduced depressive symptoms in adolescents (Gilham et al., 2006; McCarty et al., 2013). These findings highlight the importance of involving caregivers in the therapeutic work for adolescent depression and further exploring their role and experiences in other interventions.

Irrespective of parents' active involvement in CBT interventions, it has been noted that parents play a significant role in supporting their child seeking out therapy for their difficulties (Schlimm et al., 2021). Moreover, parents can ensure continued attendance, suggesting that their views of their child's therapy might influence their child's engagement in therapy. This is supported by an empirical review which found that parents had a key role in enabling their child's adherence and participation to treatment (Nock & Ferriter, 2005). Disengagement from therapy is a common issue among depressed adolescents, potentially stemming from feelings of amotivation and hopelessness (O'Keeffe et al., 2019). For instance, the IMPACT trial reported a relatively high dropout rate of 37% (O'Keeffe et al., 2019). Consequently, these findings highlight the importance of capturing parental views of their child's therapy to ensure increased treatment engagement and continuation of therapy.

Parental involvement in CAMH treatment has gained particular attention in the recent years (Mackova et al., 2022). Although there is evidence of the impact of adolescent depression on family members and the role of parents in child and adolescent mental health interventions, there is a lack of research exploring the experiences of caregivers of their child's intervention. This highlights the need to enhance our understanding on parental experiences specifically, by summarising and critically appraising what is currently known about parents' experiences of being involved in their child's intervention. The next section explores existing literature on this topic.

1.6 Systematic Literature Review

1.6.1 Overview and initial search

Systematic literature reviews aim to identify, critically evaluate, and synthesise findings from multiple studies to better determine the reliability and validity of the evidence base (Boland et al., 2017). They are considered the gold standard of literature reviews and offer a number of benefits (Boland et al., 2017). Firstly, they provide a detailed and comprehensive summary of existing evidence on a specific topic and help identify the gaps in the literature. Additionally, systematic reviews can highlight methodological issues in research studies that can be used to ameliorate forthcoming work in the topic field (Eagly & Wood, 1994). They also identify questions that have been conclusively answered, indicating areas where further research is unnecessary (Chalmers & Glasziou, 2009).

An initial scoping search was conducted in January 2024. Initially, preliminary searches included a focus on adolescent depression and parental experiences of being involved in their child's intervention for depression. Given the scarcity of results on parents' experiences of their child's intervention for depression, it was decided in consultation with the research team, to broaden up the topic of this current systematic review to include a wide range of mental health (MH) difficulties in children and young people. MH difficulties in children and young people were in line with WHO (2021) and included depressive disorders, anxiety disorders, emotional and behavioural disorders, mood disorders and psychotic disorders. It was hoped that looking at a variety of MH difficulties in children and young people and their relevant interventions would provide a more robust and wider understanding of parental experiences. Additionally, children and young people with neurodevelopmental conditions (NDC) were included, as mental health difficulties are more prevalent among youth with NDC compared to those without these conditions (Boulton et al., 2023; Hansen et al., 2018). Specifically, children with ASD accessing CAMHS constitute a high proportion in

the general population; one in ten children who access CAMHS have autism, and this proportion becomes even higher when looking at emergency departments where children with NDCs account for 25% of all paediatric mental health cases (Bourke et al., 2021). It is also worth noting that 91% of parents of children with NDCs reported that their children's MH difficulties had a negative impact on the entire family (NAS, 2014). An examination of Prospero and Cochrane Library revealed no active reviews in this topic area, providing a rationale to conduct the current systematic review.

This systematic review aimed to identify and critically examine the existing knowledge regarding parental experiences of their child's intervention. More specifically, this systematic review aimed to answer the following question: 'What does the current literature say about the experiences of parents/carers of being involved in their child's psychotherapeutic intervention?'.

1.6.2 Method

A SPIDER approach, as shown in Table 1, was used as a method for qualitative and mixed methods search (Methley et al., 2014). Using this framework enabled me to structure key search terms and develop appropriate inclusion and exclusion criteria.

Table 1

Overview of SPIDER approach

SPIDER Criteria	
Sample	Biological or birth parents, adoptive or foster parents, step-parents, carers
Phenomenon of Interest	Being involved in child's psychotherapeutic intervention
Design	Qualitative data collection and analysis, mixed methods data collection and analysis
Evaluation	Experiences, perceptions, attitudes, beliefs

Research type	Any qualitative or mixed methods research design

It is important to mention that caregivers of children and young people who were aged 0-25 years were included. The decision to use this specified age range is in line with the age range of service users currently seen in CAMHS and the Long Term NHS Plan (2019) to include support for children and young people that is embedded in various settings including schools and colleges. Additionally, it is important to clarify what is meant by parental involvement in the context of this systematic review. The literature employs numerous concepts to describe different types of involvement, including participation, engagement, inclusion, and collaboration (Jerofke-Owen et al., 2023). In this review, the term involvement was used to encompass all these concepts. However, it is important to specify the exclusion criteria related to this term. For example, interventions were excluded if they were directed solely at parents without directly supporting the child's intervention.

A thorough search was conducted to explore how caregivers have been involved in/ supported their child's intervention. Although some therapies involve a direct parental component as part of their process, e.g., family therapy, parent-led CBT, parents as co-therapists, others include more psychoeducational and informative aspects. Different types of therapy or components within therapy in which parents might participate in their child's intervention were identified and considered within the existing literature (Dardas et al., 2018; Haine-Schlagel & Walsh, 2015; Kurzweil, 2023; Weisz & Kazdin, 2017), thus informing relevant search terms. Examples included informal support, information, psychoeducation, shared decision making, treatment decision making, decision on care planning, joint therapy, co-therapy and/or co-client and family therapy.

All studies were evaluated based on the eligibility criteria outlined in Table 2.

Table 2

Overview of inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
Participants are parents or carers involved in their child's mental health intervention	Studies in which parent involvement in their child's mental health intervention is limited
Studies focusing specifically on the experiences of parents or carers. If multiple perspectives were included, studies are included if it is clearly indicated that the parent's perspective was clearly expressed	Studies focusing on parents or carers receiving their own psychotherapeutic intervention, or with a main focus on parental mental illness
Studies reporting on some form of parental involvement in their child's mental health intervention.	Studies focusing solely on help-seeking behaviours, accessing mental health services or accessing treatment experiences
Different types of therapy or components within therapy where parents could be involved might include but are not limited to informal support, information, psychoeducation, shared decision making, treatment decision making, decision on care planning, joint therapy, co-therapy and/or co-client, family therapy	Studies published in a non-English language
The child is receiving care from a mental health team	Studies only using quantitative approaches
Studies may use qualitative, or mixed-methods approaches	

1.6.3 Search strategy

The searches took place between January and May 2024, enhancing the likelihood of capturing a significant portion of the current evidence base and identifying gaps in the literature. The electronic databases searched were Scopus, PubMed, Medline and Cinahl Plus. These databases were selected to encompass the evidence base across various disciplines pertinent to the research question, such as medicine, nursing, and applied social sciences. Each database had specific search parameters tailored to focus on research relevant to the systematic review question. Google scholar was also utilised to supplement the search and

revealed 380k results. The first 30 pages were reviewed after being sorted by relevance due to resource constraints. Grey literature including ProQuest Dissertation & Theses Global, University of Hertfordshire Archive and Grey Net were scanned for relevant articles. Other search strategies included screening citations and reference lists of the papers included.

Search strategies were constructed to find keywords and synonyms anticipated to retrieve eligible studies. Databases were used to identify subject headings and thesaurus terms, broadening my search terms (see Table 3). Additional terms were found though literature obtained from the scoping search. Key terms were refined using quotation marks and truncation to capture all relevant literature. Boolean operators AND/OR were combined with the search terms to yield appropriate papers for addressing the research question. Searches were restricted to English, with no chronological limitations on the papers during the literature search.

Table 3

Overview of search terms

Key search terms			
Concept 1	Parent*	OR	caregiver* OR carer* OR guardian* OR mother* OR father*
		AND	
Concept 2	Experience*	OR	perspective* OR perception* OR belief* OR view* OR attitude*
		AND	
Concept 3	Involvement	OR	participation OR engagement OR inclusion OR collaboration
		AND	
Concept 4	Child*	OR	adolescent* OR "young person" OR "young people" OR "young adult*" OR teen* OR youth*

	AND	
Concept 5	"Psychotherapeutic intervention*"	treatment* OR intervention* OR therap* OR psychotherap* OR care OR support OR psychoeducation OR information OR "decision making" OR "shared decision making" OR "treatment decision" OR co-therap* OR co-client* OR "care plan*" OR "family therapy" OR "family focused" OR "family oriented"
	AND	
Concept 6	"Mental health"	"mental illness" OR "mental disorder" OR "mental health difficult*" OR anxiety OR depression

1.6.4 Screening process

I individually reviewed all titles and abstracts to determine their eligibility according to inclusion/exclusion criteria. Titles/abstracts were reviewed by one reviewer due to resource constraints. Full text articles were then retrieved and independently assessed by two reviewers for inclusion based on the eligibility criteria, documenting the reasons for excluding articles. Any disagreements were resolved through discussion. Out of the total number of papers reviewed (n=32), 3 disagreements were identified, resulting in an inter-rater reliability rate of 90.6% (29/32).

1.6.5 Quality assessment

This review includes studies utilising qualitative and mixed-methods designs, which are well-suited for exploring and understanding the nuanced experiences of caregivers. Qualitative studies were assessed using the Critical Appraisal Skills Programme (CASP) Qualitative Studies Checklist (CASP, 2018). This widely accepted tool, recommended by the

Cochrane Qualitative and Implementation Methods Group and the World Health Organisation, is suitable for novice qualitative researchers and is designed for health-related research, making it appropriate for the current review (Long et al., 2020). Moreover, the Mixed Methods Appraisal Tool (MMAT) was utilised to evaluate the quality of mixed methods studies (Hong et al., 2018). Although it is not considered rigorous enough for separately assessing qualitative studies, it was deemed suitable for mixed-methods research. The results of each quality assessment tool are outlined in Appendix 2.

1.6.6 Synthesis method

To synthesise the findings, a 'thematic synthesis' approach (Thomas & Harden, 2008) was used alongside core standards and principles for systematic reviews (Siddaway et al., 2019). The process involved thoroughly reading the studies and identifying key concepts (Campbell et al., 2003), which were considered the main themes. These concepts formed the primary data for synthesis. Descriptive themes were formed by comparing data and then transformed into analytical themes by relating them to the systematic review question. By adopting a thematic synthesis, I was able to closely align with the results of the selected studies, ensuring transparency in synthesis and enabling the clear development of new concepts and hypotheses. The detailed process is outlined in Appendix 3.

1.6.7 Results

1.6.7.1 Study selection

In total, 1190 studies were initially identified for screening through database searches. All identified citations were imported into Covidence, a software designed to facilitate the screening and data extraction processes in healthcare research. Covidence has been recognised as an effective, user-friendly, and suitable tool for research collaboration (Harrison et al., 2020). After removing duplicates, 529 studies were screened by title and

abstract based on the eligibility criteria, resulting in 27 studies selected for full-text review. Fifteen of these studies met the inclusion criteria and were included in the review. An additional of four studies were identified through reference and citation checks, leading to a total of 19 studies included in the review. The PRISMA flow diagram (Moher et al., 2009) in Figure 1 provides an overview of the study selection process.

1.6.7.2 Study characteristics

A summary of the study characteristics, methodology, reported findings as well as strengths and limitations can be found in Table 4. The selected studies were conducted in various locations, with the majority in the US (n=7) and Australia (n=5). Other locations included the UK (n=4), Sweden (n=1), Denmark (n=1) and Canada (n=1). Studies mostly employed a qualitative research design (n=14), while the rest employed a mixed-methods research design (n=5). The studies employed various sampling strategies, including purposive sampling (n=10), convenience sampling (n=4), stratified sampling (n=1), self-selection sampling (n=1), and a combination of sampling strategies (n=3). Data collection methods differed based on the methodology used, including individual interviews (n=12), focus groups (n=1), survey (n=1), or a combination of methods (n=5). Similarly, the analyses varied according to the chosen methods and research aims, and included thematic analysis (n=9), content analysis (n=2), grounded theory (n=2), constant comparative method (n=1) and a combination of analytic methods (n=5).

Figure 1

Prisma flow diagram (Moher et al., 2009)

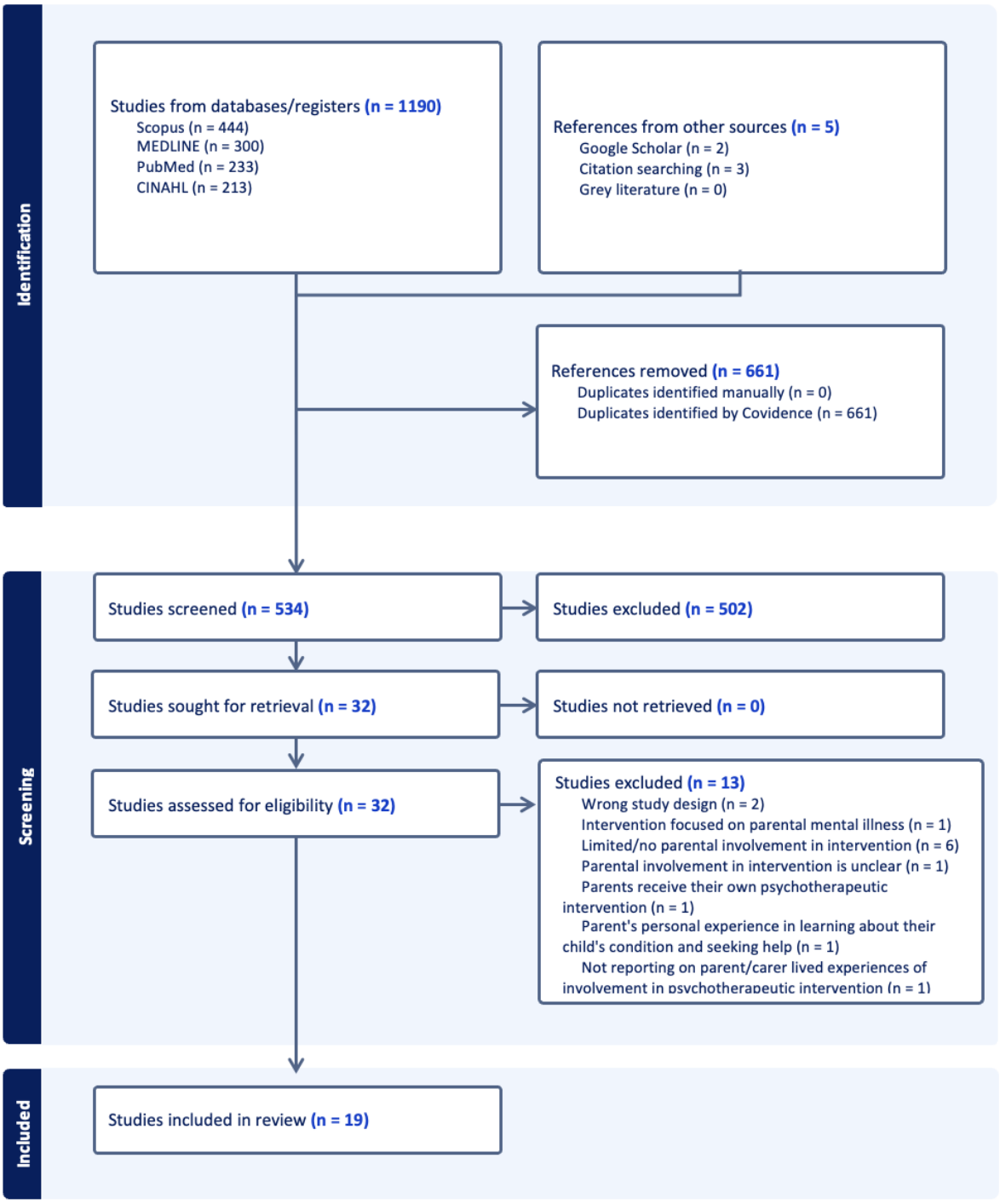


Table 4

Summary of the study characteristics

Author and Title	Study aims	Sample characteristics	Methodology	Reported findings	Strengths and Limitations
Brown (2018) Parents' experiences of their adolescent's mental health treatment: Helplessness or agency-based hope Australia	To explore parents' experiences of their adolescent child's treatment. Specifically, it sought to understand how parents' involvement in their child's treatment influenced their perception of their ability to be helpful in their child's recovery	17 parents interviewed, whose children admitted to tertiary unit: 11 mothers and 6 fathers 6 pairs of biological parents, 3 pairs of biological mother and stepfathers, 4 single mothers, 1 foster/adoptive parent pair Sample included: 2 culturally and linguistically diverse (CALD) parents (with English as second language), 2 immigrant families, 1 Indigenous mother Broad spectrum of economic class: 4 households' middle	Qualitative research design Purposive sampling Thematic analysis Semi-structured interviews, with data collected at three different times: admission, discharge, and six months post-discharge.	The study found that parents' levels of hope and their sense of agency played significant roles in their perception of their ability to contribute to their child's recovery. Parents who were more actively involved in changing their interactions with their child reported higher levels of sustained hope and self-efficacy. Conversely, parents who relied more on expert intervention and remained passive experienced lower levels of hope.	+Longitudinal design captures changes over time. +The focus on parents' perceptions and involvement is relatively novel and fills a gap in the literature. -Small sample size -Potential bias due to the researcher's prior role with the treatment unit. -Findings are specific to one treatment setting and may not be applicable to all mental health services.

		class, 8 lower middle/working class, 2 solely receiving benefits			
Chan et al. (2023) Parent Involvement in Mental Health Treatment for Autistic Children: A Grounded Theory-Informed Qualitative Analysis Canada	To explore the experiences and perspectives of parents regarding their involvement in a cognitive-behavioural therapy (CBT) program for their children with autism spectrum disorder (ASD) and anxiety	11 parents (100% mothers) of children with ASD 17 therapists Parents' mean age: 43.27 years Ethnicity: Majority were White (73%), with some representation from Southeast Asian (18%) and West Asian (9%) backgrounds Marital Status: 82% were married Education: 91% had graduated from college Family Income: varied	Qualitative research design Purposive sampling Grounded theory methodology Semi-structured interviews	Their involvement was crucial in supporting their children's learning and practice of CBT skills The study identified the need for parent support in therapy sessions and highlighted the challenges they faced	+Detailed and rich qualitative data providing deep insights into parents' experiences +Use of grounded theory allowed for the development of a comprehensive understanding of parental roles in CBT for children with ASD -Small and homogenous sample (majority were mothers and from similar ethnic backgrounds), limiting transferability -The study focused solely on CBT, so findings may not generalise to other therapeutic modalities

Chlebowski et al. (2018) Implementing an intervention to address challenging behaviors for autism spectrum disorder in publicly-funded mental health services: Therapist and parent perceptions of delivery with Latinx families USA	To explore therapist and Latinx parent perceptions of interactions and the intervention process when therapists deliver AIM HI, a structured, parent-mediated intervention for ASD	29 parents: 93% female, 100% Latinx, and 66% preferred Spanish Average age: 40 years Maternal level of education primarily less than high school (42%) 62% mothers were homemakers, 28% full time workers, 10% unemployed Household income fell below federal poverty level for 52% of sample 17 therapists: 94% female, 35% Latinx, and 47% fluent in Spanish	Qualitative research design Purposive sampling Focus groups with therapists Combination of analysis: a rapid assessment process (RAP) as qualitative enquiry and a consensus coding process, allowing the researchers to identify key themes and insights. Semi-structured interviews with parents	Themes emerged: Limited parental knowledge about ASD: parents exhibited gaps in their understanding of ASD, which needed addressing to improve engagement and intervention outcomes Differing perceptions on parental participation: there were notable differences in perceptions regarding the level and nature of parental involvement in the treatment process Influences on parent-therapist interaction: the cultural value of respeto, (meaning deference) was emphasised by therapists, whereas parents highlighted the importance of personalismo,(meaning personal) connection	**+** The study provides valuable insights into the cultural considerations necessary for effective intervention delivery to Latinx families + The use of focus groups and interviews allowed for a rich, detailed understanding of the perceptions and experiences of both therapists and parents -Sample size was small -The study focused exclusively on Latinx families, which may not capture the nuances required for interventions in other cultural contexts
Eadie et al. (2022) Carer perceptions of a specialist mental health service for	To analyse carer perceptions of a specialist mental health service for children and young people in	21 carers Out of 231 eligible carers, 21 completed the survey, resulting in	Qualitative research design Convenience sampling Thematic analysis	Themes identified: Support for carers: carers appreciated the emotional support and practical guidance provided by the service.	+Comprehensive ethical considerations ensured the ethical integrity of the study +Robust data collection: use of

children and young people in care Australia	care, identifying strengths and limitations of the service from the carers' perspectives	a response rate of approximately 9% Carers who responded in open-ended questions: 65% foster carers, 17% kinship carers, 13% residential workers and 5% biological parents No further specific demographics	Survey approach with open-ended questions	Communication: effective communication between carers and staff was highlighted as a key strength. Personal attributes of staff: carers valued the empathy, professionalism, and dedication of the staff members. Collaboration: working collaboratively with the service to support the children was seen as beneficial. Accessibility: issues with accessing the service, such as long waiting times, were noted as areas for improvement. Training: carers expressed a need for more training to better support the children in their care.	open-ended survey questions allowed for in-depth, qualitative insights +The findings offer actionable insights for improving the mental health service -Low response rate may limit the generalisability of the findings. -The study does not provide detailed demographic information, which could have added depth to the analysis -Limited discussion on how the researchers' presence and potential biases might have influenced the responses
Frauenholtz & Mendenhall (2020) "They'll Give You a Second Chance":	To evaluate the implementation and effectiveness of a child and family-centered approach within a children's mental	6 caregivers 2 children Age range of parents: 25-54y; average age: 39y	Qualitative research design Convenience sampling Three-step content analysis	Themes identified: Importance of relationships: positive therapeutic outcomes were strongly associated with the quality of relationships	+ The mixed-methods design provided a well-rounded understanding of both quantitative outcomes and

Perceptions of Youth and Caregivers Regarding Their Experiences in a Community-Based Mental Health System of Care USA	health system, focusing on improving treatment outcomes and satisfaction through personalised services and family empowerment	Age children: 16-18y 4 were African American and 3 were Caucasian. 6 female and 2 male	Individual interviews with children, youth, and their caregivers	between service providers, children, and their caregivers Family empowerment: families felt more self-efficacious and knowledgeable about their children's situations, contributing to better clinical outcomes Personalized services: tailoring services to individual family needs significantly enhanced satisfaction and engagement in the treatment process Parallel process: Healthy relational attributes modelled by service providers were mirrored in the interactions between children and their caregivers, improving family dynamics	qualitative experiences +Emphasizing the perspectives of children, youth, and their caregivers ensured that the findings were relevant and actionable. -The study's findings may not be applicable to all geographic regions or service settings beyond the context of the program -Results may reflect the views of those who agreed to participate, potentially overlooking the perspectives of those who declined -While primary themes were identified, the study did not exhaustively explore all potential topics, indicating the need for further

					research in specific areas
Goodkind et al. (2012) Involving parents in a community-based, culturally grounded mental health intervention for American Indian Youth: parent perspectives, challenges, and results USA; Arizona	To examine the impact of involving American Indian (AI) parents in a community-based, culturally grounded mental health intervention for youth	10 mothers American Indian Age range: 29-51y (Mean=41.4) All lived on the tribal reservation at the time of the study 70% were married 70% were employed All had graduated from high school or earned their GED Half reported speaking their tribal language "moderately" or "very well." Other life stressors e.g., 30% reported food insecurity, 30% reported inadequate healthcare	Mixed-methods research design Purposive sampling Combinations of methods and analysis. Five interviews with parents, combining quantitative measures and open-ended questions. Repeated-measures ANOVA and paired t-tests	Changes over time in thoughts about historical loss, enculturation, parenting practices, and parent-child communication were examined. Key themes: understanding tribal culture in new ways, increase in warmth and encouragement for children, decrease in less effective parenting practices, increased parent-child communication, observed positive changes in children, increased involvement in community and barriers to participation due to family stressors.	+Culturally grounded approach addressing historical trauma +Mixed-method design providing both quantitative and qualitative insights +Focus on a vulnerable and under-researched population (AI parents and youth) -Small sample size -Lack of control group, making it difficult to attribute changes solely to the intervention -Potential biases due to self-reported measures and the involvement of student interviewers from the same tribe
Green et al. (2023)	To evaluate the effectiveness and	Children (8-9 years old), their parents,	Mixed-methods research design	The study found significant improvements in children's	+Innovative approach, online

Increasing access to evidence-based treatment for child anxiety problems: online parent-led CBT for children identified via schools UK	acceptability of Online Support and Intervention (OSI), a therapist-guided, parent-led CBT program delivered online for children identified with anxiety problems through school-based screening	and class teachers from nine mainstream primary schools in England 131 children completed screening questionnaires, and 50 children screened positive for anxiety problems Parents of 42 children took part in OSI 14 parents interviewed Age range: 35-49y Out of 14 parents, 2 were males. Rest female Most were White British, 2 White Other, 1 not stated All had higher education Housing: majority were on mortgage, others on rent	Two phase sampling: targeted sampling and self-selection Combination of methods: An uncontrolled case series using a repeated measures design to evaluate child outcomes from OSI, following school-based screening for child anxiety problems Template analysis Qualitative interviews	anxiety symptoms and high levels of parent engagement and satisfaction with the OSI program Quantitative results: Session-by-session improvements were noted, with substantial changes by the final module (e.g., Child Outcome Rating Scale d = 0.84; Goal Based Outcomes d = 1.52) Qualitative results: Parents reported positive experiences and found the intervention acceptable and engaging	parent led-CBT program addressing accessibility issues in traditional mental health services +Combination of quantitative and qualitative methods provides a thorough evaluation of the intervention's effectiveness and acceptability +High engagement and satisfaction support the feasibility of the intervention -Uncontrolled design, as lack of a control group limits the ability to attribute improvements solely to the intervention -Small sample size -Short-term evaluation, focusing on immediate outcomes without long-term follow-up data

Grudin et al. (2024) "Therapy without a therapist? "The experiences of adolescents and their parents of online behavioural activation for depression with and without therapist support Sweden	To explore adolescents' experiences of receiving online Behavioural Activation (BA) and the experiences of parents supporting their adolescents throughout the intervention Also, to explore the experiences of guided BA versus self-guided BA	9 parents; all mothers 8 adolescents Two types of therapy 5 families participated in self-guided online BA 6 families participated in guided online BA	Qualitative research design Stratified purposive sampling Reflexive thematic analysis Semi-structured interviews; two conducted at the clinic and the rest online or via telephone	Themes included: Engagement with Online BA: -Mixed levels of acceptance of the BA model among adolescents -Understanding the connection between activities and mood was beneficial for some Parental Involvement: -Crucial for skill acquisition, improving parent-child relationships, and providing emotional support -Parents appreciated the guidance provided by therapists Therapist Support: -Essential for maintaining motivation and engagement. -Self-guided BA participants desired more therapist interaction Self-Guided vs. Therapist-Guided BA: -Some adolescents found self-guided BA empowering, while others felt it lacked engagement and support -Preferences for self-guided BA might stem from previous face-to-face therapy experiences	+ Inclusion of both adolescents and parents + Consideration of different responder statuses -Small sample size -Focus on mild to moderate depression -Inclusion of multiple participant groups complicating data analysis

				Therapist Role: Important for guidance and emotional support for both adolescents and parents	
Hart et al. (2005) Attuned practice: a service user study of specialist child and adolescent mental health, UK UK	To explore the views of teenage clients and their parents on the service delivery in a specialist Child and Adolescent Mental Health Service (CAMHS)	30 parents 27 teenage clients (aged 11-18) Majority of parents were poorly paid or in irregular jobs, unemployed. Only 9 parents were in professional occupations Participants were White British or White European, from a range of socioeconomic backgrounds.	Qualitative research design Purposive sampling Standard qualitative data analysis; thematic Initial home interviews were conducted followed by focus discussion groups using structured participatory techniques	Themes identified: Therapeutic Alliance: identified core values crucial for establishing a therapeutic alliance Therapeutic Practice: explored the style of therapy and its inclusiveness of different family members Service User Involvement: supplemented a model of organizational user involvement with a model of therapeutic user involvement to help negotiate the mode of practice Outcomes: the process of eliciting views was found to be therapeutic, leading to the formation of a parent-led self-help group	+User Involvement: a genuine collaboration between service users and professionals, reflecting UK policy +Ethical approval was obtained, and participants were recruited through their therapists to ensure psychological robustness +The findings can be applied to achieve attuned practice in other specialist CAMHS -Small Sample Size -Only included White British participants, which may not reflect the experiences of more diverse populations -As an exploratory study, the findings

					may not provide definitive conclusions but rather insights for further research
Hurley et al. (2020) Achieving Therapeutic Gains for Regional Youth with Emergent Mental Health Issues: The Role and Experience of Parents Following Participation in a Nurse-Led Therapeutic Group Australia	To explore the experiences of parents and their children with emergent mental health challenges following the parents' participation in a nurse-led therapeutic group called "Parentspace."	21 parents; 17 female, 4 male, ages: 37-69y 4 identified as Indigenous 7 youth; 5 female, 2 male, ages: 13-24y Parents and their children from a regional area	Qualitative research design Purposive sampling Thematic analysis In-depth interviews	Themes identified: -Parents reported enhanced relationship dynamics with their children, characterized by increased empathy and understanding. -Children noted improvements in their parents' behaviour, including more calmness and positive interactions. -The program fostered empathic communication within families, reducing conflict and promoting mutual understanding. -Parents and children reported better understanding of each other, with parents becoming more reflective and children feeling more understood. -The program addressed intergenerational psychological trauma, helping parents understand the impact of their family systems on current dynamics.	+Focused on a practical, scalable intervention that can be implemented in similar settings, addressing the gap in mental health services in regional areas. +Family-centered approach, focusing on family systems and addressing the interconnectedness of family dynamics and mental health. -Small sample size -Single-site study, findings might not be applicable to other regions with different demographic and socio-economic profiles. -Lack of long-term follow-Up to assess the sustainability of the reported

				-This understanding led to improved emotional regulation and coping strategies among parents, positively influencing their children's mental health.	improvements in family dynamics and mental health.
Kingston et al. (2013) Parent experiences of a specialist intervention service for mental health difficulties in children with autistic spectrum disorder UK	To assess parents' satisfaction with various aspects of the specialist intervention service for mental health difficulties in children with autism spectrum disorder (ASD)	49 parents Most respondents were mothers (96%)	Mixed-methods research design Convenience sampling Combination of methods: Content analysis Quantitative data analysed descriptively Telephone interviews Likert scale and open-ended questions	-High Levels of Satisfaction: Parents reported high levels of satisfaction with the service Specific aspects valued included therapy that improved understanding and awareness, provided strategies and techniques, and offered school liaison -Therapy Targets: Main targets included anxiety (47%), challenging behaviour (25%), depression (8%), anger (8%), and low self-esteem (6%) -Advantages of Specialist Services: Parents valued the specialist knowledge, experience, and understanding of ASD that the service provided. They also appreciated ASD-specific interventions and coordinated access to other staff groups. -Most Useful Aspects: Parents highlighted the importance of feeling understood and supported, being involved in	+High response rate with a clear representation of parents of children with various ASD diagnoses. +Comprehensive assessment of parental satisfaction and valuable qualitative insights. +Practical recommendations for service improvement based on parental feedback. -Potential bias due to the self-selected nature of respondents. -Limited to parents' perspectives, without direct input from the children themselves. -Generalisability might be constrained by the specific

				therapy, and having liaison with schools as particularly beneficial	demographic and geographic characteristics of the sample
Lundkvist-Houndoumadi et al. (2016) Parents' difficulties as co-therapists in CBT among non-responding youths with anxiety disorders: Parent and therapist experiences Denmark	To explore the difficulties parents face when acting as co-therapists in Cognitive Behavioural Therapy (CBT) for their children who do not initially respond to the therapy for anxiety disorders	Parents of children who were non-responders to CBT for anxiety disorders 34 parents; 21 mothers, 13 fathers Danish ethnic background	Qualitative research design Self-selection sampling Thematic analysis to identify common themes and patterns in the parents' experiences Semi-structured interviews	Key themes identified: -Parents often struggled with understanding their role as co-therapists and balancing this with their parental responsibilities -The process was emotionally taxing for parents, as they dealt with their own anxiety and stress in addition to their child's condition -Parents felt they needed more guidance and support from professionals to effectively fulfil the co-therapist role -Practical difficulties in applying CBT techniques at home were commonly reported -The dual role sometimes strained the parent-child relationship, creating additional stress within the family	+The use of semi-structured interviews allowed for a detailed understanding of parents' experiences and challenges +The findings provide valuable insights that can inform clinical practice, highlighting the need for better support and training for parents acting as co-therapists +Focusing on non-responders to CBT helps address a gap in the existing literature and offers targeted insights for improving treatment efficacy -Small sample size and lack diversity, which can affect the generalisability of the findings.

					-Recruitment bias: the method of recruiting parents through therapists might introduce bias, as those who agreed to participate could have different experiences compared to those who did not -Retrospective reporting: parents' recollections of their experiences may be influenced by memory biases, potentially affecting the accuracy of the reported challenges
Macdonald et al. (2023) Parents' Perspectives of an Arts Engagement Program Supporting Children with Anxiety Australia	To understand parents' perspectives on the acceptability, feasibility, and effectiveness of an arts engagement program (AEP) called Culture Dose for Kids (CDK) designed to	19 families from the Sydney metropolitan region 21 children (10 girls and 11 boys), aged 9-12 years, experiencing mild anxiety as identified by their parents	Mixed-methods research design Purposive sampling Combination of methods: Quantitative measures: RCADS-P25 to assess children's anxiety from the parents' perspective, along with evaluation forms filled out by parents	-Effectiveness: The program had a positive and significant impact on parental perceptions of their child's anxiety. Parents reported improvements in their children's mood, confidence, and sense of empowerment, all of which are associated with resilience and mental well-being. -Acceptability: The program was well-received by parents, who appreciated the opportunity for their children to engage in open-	+Combining qualitative and quantitative measures provided a robust assessment of the program's impact. +Actively engaging parents in the evaluation process provided valuable insights into the program's

	support children with anxiety		Thematic analysis Qualitative Measures: interviews	ended activities that fostered connection, creativity, and experimentation -Feasibility: The study demonstrated that the CDK program is a viable and practical approach to supporting children with anxiety, showing that structured arts engagement in a gallery setting is both acceptable and effective	effectiveness from the perspective of those closest to the children. +The use of a non-clinical, arts-based approach represents a novel intervention in the field of child mental health. -Small sample size and specific regional focus -The reliance on parents' self-reported data may introduce bias and affect the objectivity of the findings -The COVID-19 pandemic affected session attendance, which may have influenced the overall program outcomes and data completeness
Mirzadegan et al. (2024) Perceived acceptability and	To evaluate the usability, acceptability, and appropriateness of the "Making	Families from active treatment conditions of a large RCT	Mixed-methods research design Random, convenience and strategic sampling	-High acceptability and appropriateness: both parents and children generally found the program acceptable and appropriate	+Combining quantitative and qualitative data provided a comprehensive

appropriateness of a web-based program targeting risk for anxiety in young children and their parents USA	Mistakes" web-based program designed to address error sensitivity in parent-child dyads To understand participant perceptions and gather feedback for improvement	18 parent-child dyads (18 parents, 14 children) were interviewed Parent age range: 22-61y Predominantly college-educated, White/non-Hispanic, multi-parent families above the poverty line	Descriptive statistics and reliability of variables calculated and Pearson's correlations for degree of relation among variables Standardized measures Thematic analysis Semi-structured interviews via Zoom or face-to-face	-Participants provided varied feedback on program format and dose, with some preferring shorter, more engaging sessions. Suggestions included making the program more interactive and tailored to individual needs -Identified barriers to engagement such as lack of time and complexity of content. Recommendations for improvement focused on increasing reminders, simplifying content, and making sessions more engaging	understanding of participant experiences and program effectiveness +Thematic analysis and use of standardized measures ensured rigorous data analysis +Study provided actionable recommendations for improving the program, which can enhance its effectiveness and usability -Homogenous sample: predominantly college-educated, White/non-Hispanic, and from multi-parent families above the poverty line, which may limit the generalisability of the findings -Potential selection bias: Participants who agreed to be

					interviewed might have been more engaged or had more positive views of the program, skewing the findings
Muller et al. (2024) Understanding parent perspectives on engagement with online youth-focused mental health programs Australia	To understand parents' perspectives on their engagement with the BRAVE Self-Help program, an online mental health intervention for children and adolescents with anxiety	14 parents (13 female, 1 male) Average Age: 44 years (SD = 4) Participants were located throughout Australia All participants had registered for the BRAVE Self-Help program within six months prior to the study	Qualitative research design Purposive sampling Reflexive thematic analysis Semi-structured interviews	-Parents cited lack of time, program complexity, and perceived ineffectiveness as major barriers -Recommendations for Improvement: Parents suggested simplifying the program, providing more reminders and support, and making the content more engaging and interactive	+Study provided valuable qualitative insights from an under-researched group (parents of children using online mental health programs) +The use of a well-defined and systematic reflexive analysis approach added rigour to the findings -Small sample size and potential selection bias, as participants were already engaged with the program to some extent -Findings may not be generalisable to all parents or other online mental health programs

Schlimm et al. (2021) 'It's always difficult when it's family... whereas when you're talking to a therapist...': Parents' views of cognitive-behaviour therapy for depressed adolescents UK	To explore parents' experiences and perceptions of their adolescent child's cognitive-behavioural therapy (CBT) for depression	16 parents (14 mothers and 2 fathers) of adolescents who had undergone CBT for depression Adolescent Mean Age: 15.6 years (SD = 1.27). Context: parents were part of the IMPACT-ME study, a qualitative sub-study nested within the larger IMPACT trial; multi-center RCT comparing different psychological therapies for adolescent depression	Qualitative research design Purposive sampling Thematic Analysis In-depth interviews conducted at the end of the treatment.	Key themes identified: -Importance of the adolescent's readiness for therapy -The adolescent-therapist relationship was crucial for progress -Variability in the level of parental involvement in therapy -Recognition that therapy must be tailored to the individual adolescent -setting and process of therapy were important factors -parents valued the structured approach of CBT -therapy provided a safe space for adolescents to express themselves.	+Provided rich, detailed accounts of parents' experiences +Addressed a gap in understanding parents' perspectives on their child's therapy +Confirmed known factors for effective CBT, such as the need for a strong therapist-adolescent relationship -Small sample size -Differences in how much parents were involved in therapy were not thoroughly examined -Only included participants from the North London arm of the IMPACT study, which may limit the applicability of findings to other regions
Sheridan et al. (2010)	To investigate and describe the experiences of parents of	15 parents from 11 families, primarily Caucasian, aged between 40 and 59	Qualitative research design Purposive sampling	Four key themes identified: -Parents often felt confused, angry, and out of control before therapy, dealing with adolescent	+Allowed for an in-depth exploration of parents' subjective experiences,

The experiences of parents of adolescents in family therapy: A qualitative investigation USA; Virginia	adolescents who are participating in family therapy	Nine had adolescent sons aged 14-17, and two had 19-year-old daughters Most families reported high socioeconomic status Nine were two-parent families, three of which were remarried; one parent was divorced, and one was widowed 12 parents were White, one was African American, one Asian, and one Hispanic	Constant comparative method Semi-structured interviews conducted in two phases	behaviours that introduced new challenges into the family dynamic -A positive therapeutic environment was crucial. Parents appreciated therapists who understood the presenting problem, demonstrated competence, and maintained a balanced alliance with both the parent and adolescent -Effective family therapy required addressing both the child's and the parents' perspectives, which was challenging due to differing views on the problems and goals of therapy. Parents valued feeling heard and involved in the process -Post-therapy, parents reflected on the process, highlighting the importance of a collaborative approach and the critical role of their involvement in achieving positive outcomes	providing rich, detailed data +Used constructivist framework; elevated the clients' perspectives and meanings, fostering a collaborative and client-driven therapeutic process +Offers valuable insights for clinicians to better engage parents in the therapeutic process, enhancing treatment efficacy -Small sample size and lack of diversity; predominantly Caucasian -Parents were selected by therapists, which may have introduced recruitment bias
Thompson et al. (2007) Treatment Engagement: Building	To understand parents' and youth's perceptions of their engagement in treatment	19 families were interviewed Families participating in a larger family	Qualitative research design Convenience sampling Content analysis	-relationship building with therapist, positive connection, and collaborative relationship -relationship within family also primary source of engagement in therapy	+Important step in providing information to develop family therapy interventions +Evidence on the importance of

Therapeutic Alliance in Home-Based Treatment with Adolescents and their Families USA		therapy intervention study 12 mothers, 3 fathers, 4 other family members Majority Latino (52.6%), rest White (31.5%) and Black (15.8%) Age range: 29-61y	Semi-structured interviews	-increased understanding of self and others	therapist's connection with client +Exploratory study in understanding the process of engagement in family therapy -Small sample -Addressed only perceptions of treatment process among youth and parents; future research requires evaluation of other factors
Weaver et al. (2019) "Not Just One, It's Both of Us": Low-Income Mothers' Perceptions of Structural Family Therapy Delivered in a Semi-rural Community Mental Health Center	To explore low-income mothers' perceptions and experiences of Structural Family Therapy (SFT)	16 mothers Age range: 26-64y Majority identified as non-Hispanic White Half were graduates 56% married or living with partner Majority poor Semi-rural community	Qualitative research design Combination of purposive and random sampling Thematic analysis In-depth semi-structured interviews	Mothers found SFT acceptable and valuable in managing their children's behavioural issues and their own stress They reported that SFT strategies helped them regain parental authority, which in turn improved their ability to manage their children's needs Some mothers became more receptive to individual treatment after participating in SFT	+Focuses on low-income mothers in a semi-rural setting +Provides valuable insights into a specific and often under-researched demographic -Small sample size -Only included the perspectives of mothers -Did not follow participants over

USA				Challenges included the low dose of treatment received and lack of father involvement, raising concerns about the sustainability of the intervention	time to assess the long-term impact -Receiving a low dose of treatment, which might affect the overall outcomes and perceived effectiveness of the therapy

1.6.7.3 Quality of the studies

All included studies clearly identified a clear research question and aims. The quality of the included studies demonstrates a high level of methodological rigor across most studies. Each study employed appropriate qualitative or mixed methods designs, ensuring alignment with their objectives. One mixed-methods study however (Green et al., 2023), utilised a uncontrolled case series design, suggesting that a lack of control group limited the ability to attribute improvements solely to the intervention. Despite this limitation, the uncontrolled design was deemed appropriate for a preliminary evaluation of a new intervention. Data collection techniques, predominantly in-depth interviews, were robust and yielded rich, detailed data, which were systematically analysed using appropriate chosen methods. Whilst some studies provided comprehensive insights (Brown, 2018; Hurley et al., 2020), others faced limitations regarding sample size and diversity, which might affect the transferability of the findings.

A range of sampling strategies was employed across the studies. While some studies made use of a combination of sampling strategies to enhance diversity in their samples (Green et al., 2023; Mirzadegan et al., 2024; Weaver et al., 2019), most of the studies utilised some form of non-probability sampling strategy to recruit participants. Such recruitment strategies are common in research, especially in qualitative studies (Lyon, 2015). Nonetheless, selection bias was common in some studies (Chlebowski et al., 2018; Frauenholtz & Mendenhall, 2020; Goodkind et al., 2012; Sheridan et al., 2010). For instance, in a study by Sheridan et al. (2010), parents were recruited through family therapists, which ensured relevance but may have introduced selection bias as therapists might have chosen parents that they anticipated would provide positive feedback. Moreover, in another study by Frauenholtz and Mendenhall (2020), while researchers describe the recruitment process, the

study does not detail how participants were selected or approached to ensure a representative and unbiased sample.

Many of the included studies either failed to adequately address the relationship between the researchers and participants or did not provide sufficient details to allow for an assessment of these relationships (Brown, 2018; Chlebowski et al., 2018; Frauenholtz & Mendenhall, 2020; Goodkind et al., 2012; Green et al., 2023; Grudin et al., 2024; Hurley et al., 2020; Kingston et al., 2013; Macdonald et al., 2023; Sheridan, 2010; Weaver et al., 2019). For example, while Grudin et al.'s (2024) study mentions regular contact with a clinical psychologist for the guided group, it does not provide detailed information on how the researchers managed their relationship with participants to minimise bias and influence. Similarly, Weaver et al.'s (2019) study provides limited discussion on how the researchers addressed potential biases or power dynamics, such as their relationship with participants and how this might have influenced the data collection and interpretation. Despite these limitations, many of the studies (Chlebowski et al., 2018; Eadie et al., 2022; Frauenholtz & Mendenhall, 2020; Goodkind et al., 2012; Green et al., 2023; Hurley et al., 2020; Kingston et al., 2013; Weaver et al., 2019) endeavoured to carry out their research in a culturally sensitive way by acknowledging the unique cultural, regional and community contexts of participants, tailoring interventions to be relevant and accessible to diverse populations, including rural and urban settings, and engaging with community members and stakeholders to ensure cultural appropriateness.

All studies adequately addressed ethical considerations. However, it is important to note that in some studies (Chlebowski et al., 2018; Goodkind et al., 2012; Grudin et al., 2024; Weaver et al., 2019), although ethical considerations were considered, there is a lack of explicit information and specifics on how ethical issues such as informed consent, confidentiality, and potential risks to participants were addressed. For example, in Grudin et

al. (2024), ethical issues were considered, though more detail on consent and participant relationships would strengthen the quality of the study.

Potential biases, such as interviewer or subjective interpretation biases, were acknowledged, and efforts were made to mitigate them through rigorous coding processes and triangulation (Brown, 2018; Chlebowski et al., 2018; Eadie et al., 2022; Green et al, 2023; Hurley et al., 2020; Lundkvist-Houndoumadi et al., 2016; Sheridan, 2010). The study by Hurley et al. (2020) acknowledged the possibility of interviewer bias and subjective interpretation. To mitigate these biases, the researchers employed a rigorous coding process, involving multiple coders to ensure consistency. They also used triangulation by comparing findings across different data sources to enhance the credibility of the results. Similarly, in another study by Brown (2018), researchers highlighted the risk of subjective interpretation bias. Mitigation efforts included using a detailed coding framework and involving multiple researchers in the analysis process. Additionally, member checking was used to verify the accuracy of the findings with the participants. Studies with mixed methods, like those by Eadie et al. (2022) and Green et al. (2023), effectively integrated qualitative and quantitative data, though the complexity of this integration sometimes posed challenges. These studies collectively demonstrated a strong awareness of potential biases and implemented robust methodological strategies to minimise their impact, thereby enhancing the credibility and reliability of their findings.

All studies, except one (Goodkind et al., 2012) were able to offer a clear statement of findings in relation to their research aims and objectives. While the methodology for analysing data was clear, the specific findings were not clearly detailed. However, the study does outline the key areas of focus, such as historical trauma, parenting practices, and parent-child relationships. Overall, the studies are of high quality, providing valuable insights into

parents' and carers' experiences in their child's psychotherapeutic interventions, despite some common limitations to the quality of the studies.

1.6.7.4 Synthesis of findings

Four themes were constructed from the thematic synthesis and included: 1) Experience of therapy, 2) Strengthening relationships, 3) Therapist is key and 4) Navigating obstacles. Themes are described below using participant quotes to substantiate the findings. The recurrence of themes across studies is provided in the supplementary materials (Appendix 4).

Theme 1: Experience of therapy

This theme captures parents/carer's holistic experiences of being involved in their child's intervention. Parents often enter their child's psychotherapeutic process with a history of previous treatment experiences and interactions with mental health services (Brown, 2018; Chan et al., 2023; Frauenholtz & Mendenhall, 2020; Hurley et al., 2020; Sheridan et al., 2010). Whilst making reference to previous experiences, parents reported difficult emotions such as frustration, confusion, guilt and self-blame. Several parents came to therapy "in a state of panic" and "out of desperation" and others considered therapy as their "last straw and only choice" (Sheridan et al., 2010). One parent reflected on her daughter's journey from admission to the commencement of treatment:

> *"I see Redbank as an oasis in the middle of the dessert, the last resort of us getting some sort of help for our daughter" (Brown, 2018, p.650).*

In Frauenholtz and Mendenhall (2020), parents described past treatment experiences as "negative" and "inadequate" to meet their own and their child's needs. Another caregiver

shared a similar experience with previous treatment, describing it as disjointed and impersonal:

> *"Before she [daughter of caregiver and CEP child client] would be in different treatments three or four times per year. They tried, but nothing was working. It felt like we were in a revolving door. Nobody took the time to really get to know [child client]" (Frauenholtz & Mendenhall, 2020, pg. 481).*

These past experiences shape parents' expectations and their trust in the current therapeutic interventions. Many parents expressed scepticism on past encounters. For instance, a parent shared concerns about past interventions indicating a need for improved communication and outcomes this time around (Hurley et al., 2020). Such views highlight the importance of acknowledging and addressing these prior experiences to build a positive and trusting therapeutic environment (Chan et al., 2023).

Involvement in their child's therapy frequently led to parents gaining new insights and knowledge (Chan et al., 2023; Chlebowski et al., 2018; Goodkind et al., 2014; Kingston et al., 2013; Thompson et al., 2007; Weaver et al., 2019). This educational aspect was highly valued, as it empowered them to better support their children. As a parent noted:

> *"We don't have to have that sense of urgency to find the cause anymore. Just having that knowledge I suppose stops you feeling: "Gosh, I've been a bad parent." . . . You've just gotcaught up and in something and not realising you're adding to it or making it harder to get out of . . . Having that knowledge . . . helps you to move on" (Brown, 2018, pg. 652).*

Another parent also shared:

> *"I've found it really enlightening and it's nice to have the encouragement from [the CWP] as well to know that you are not the only one, there are lots of things that you are doing right and there are other ways that you could do things where perhaps you're not getting the results you want. So it's been encouraging and really helpful" (Green et al., 2023, pg.48, table S10).*

Parents were able to enhance their understanding of their child's needs and adjust their expectations regarding their children's reactions to issues (Thompson et al., 2007). After participating in therapy, parents were able to respond with warmth and compassion to their child's difficulties (Chan et al., 2023; Goodkind et al., 2014) and thus encourage their child to develop their self-confidence and self-accomplishment as well as grow their independence (Brown, 2018; Chan et al., 2023; Macdonald et al., 2023; Schlimm et al., 2021). Acquiring knowledge and understanding, not only improved their ability to manage their child's difficulties but also enhanced their overall confidence as caregivers (Frauenholtz & Mendenhall, 2020; Green et al., 2023; Kingston et al., 2013). For instance, parents indicated how they were able to take more control, renew their confidence and grow agency in relating with their child:

> *"gave me a lot more confidence because I was becoming too manipulated- me learning to take more control" (Kingston et al., 2013, pg. 112).*

> *"we've encountered bumps along the way but now I just know how to deal with things that we didn't have before" (Brown, 2018, pg. 651).*

Others reported how they build personal growth and gained awareness and greater insight. Parents observed changes in their perceptions and behaviours, often using phrases like *"I learned", "I began to see"* and *"I think differently"* to express these shifts (Sheridan et al.,

2010). Additionally, parents felt better equipped to navigate the system (Frauenholtz & Mendenhall, 2020) and developed greater appreciation and understanding of other family member's perspectives (Weaver et al., 2019).

In most of the studies, parents reported being given strategies and gaining tools for use in everyday life (Brown, 2018; Chlebowski et al., 2018; Grudin et al., 2024; Hurley et al., 2020; Kingston et al., 2013; Mirzadegan et al., 2024; Muller et al., 2024; Thompson et al., 2007). Parents managed to learn how to use coping skills and regulate their emotions independently (Chan et al, 2023). They were able to make changes to their parenting style or invite new ideas about managing their child's difficulties (Sheridan et al., 2010). Empowerment through the acquisition of parenting skills was critical. Many parents reported feeling more competent and confident in their parenting abilities after participating in their child's therapeutic interventions. As a parent stated:

> *"It has helped me to think a lot more, to take into consideration of how I can improve my parenting skills. How I can deal with my children and who can provide me with some assistance" (Goodkind et al., 2012, pg.7).*

Other parents reported how they were able to up-skill themselves and have additional strategies to try out:

> *"Our main goal was to up-skill ourselves as parents. We know it was about how we were managing our child's needs. For our purpose, the parenting program was perfect because we wanted some additional strategies to try as parents" (Muller et al., 2024, pg. 622).*

This empowerment was crucial for fostering a sense of control and effectiveness in dealing with their child's mental health issues.

Observed positive changes in their child's wellbeing and behaviour directly reflects the impact of the psychotherapeutic interventions from the perspective of the parents. Parents often reported noticeable improvements in their child's emotional and psychological wellbeing as a result of therapeutic interventions (Goodkind et al., 2014; Macdonald et al., 2023; Sheridan et al., 2010). These changes were a primary indicator of the therapy's effectiveness and provided a sense of relief and hope to parents (Brown, 2018). A parent expressed:

> *"Once she started this treatment, she became incredibly active and did things. /.../ Every time I came home from work, the kitchen bench was clean. She felt that she was succeeding. And without me having to say anything. /.../ This meant she made it out of that very dark space where she only wanted to stay in bed" (Grudin et al., 2024, pg. 109).*

Behavioural improvements were frequently cited by parents as a key outcome of their child's participation in therapy. These changes included better adaptive skills, reduced disruptive behaviour, and improved social interactions (Schlimm et al., 2021). A parent spoke about her daughter's school performance:

> *"Her improvement in her [daughter's] grades... and she's actually stayed in school. In the past she had problems in school, and she would be suspended or something like that. This is the longest she's been in school, and she likes it. She likes going to school. Actually, before that, she didn't like going to school, and I was having problems with her with the principal or the police always calling. I haven't had any problems like that since January after the program ended. She's really improved since the program. She was kind of sad that the program had ended" (Goodkind et al., 2012, pg. 7-8).*

Parents frequently commented on the overall improvement in their child's quality of life, which was attributed to the therapeutic interventions. These holistic improvements were crucial for the child's development and the family's overall wellbeing. Sheridan et al. (2018) included a quote from a parent who said:

> *"And [the therapy] went on, I started seeing concrete results in my son's behavior that I had never seen before. Then I started really getting into therapy… I got real excited…He started talking to me; I started talking to him" (Sheridan et al., pg. 152).*

In Schlimm et al. (2021), a parent reflected:

> *"he can make decisions now. . . he used to have them made for him. . . through his therapy he's learnt the ways of thinking about things" (Schlimm et al., pg. 1024).*

Theme 2: Strengthening relationships

This theme highlights the impact of therapy on family relationships. One of the most significant benefits of involving parents in their child's therapy was the strengthening of the parent-child bond (Goodkind et al., 2014; Grudin et al., 2024; Macdonald et al., 2023). Many parents reported that being involved in treatment strengthened the parent–child relationship and brought them closer together. Therapeutic interventions often provided a framework for improved understanding and communication between parents and their children. For instance, a parent in Goodkind et al., (2012) reflected:

> "*I've learned that we have to work together. We have to communicate and communication is the main thing. We have a lot of difficulty in that because we think that we know what the other is talking about but we really don't and then we do the wrong thing. Here [in the Our Life program] we communicate and I'm trying to do that and then to work at that because that's the main thing for us. The family meetings*

> *was good too because we worked on that. Like you can't read the mind of what the other person's thinking. You've got to sit down and talk*" *(Goodkind et al., 2012, pg. 7).*

This improved bond was seen as a critical outcome of the therapeutic process. Similar views were shared in other studies, in which parents reported that being involved in their child's therapy further deepen their relationship with their child as well as enabled parents and children to interact more authentically with one another (Chan et al., 2023; Thompson et al., 2007).

Beyond the individual parent-child relationship, therapy also had a positive impact on overall family dynamics (Hurley et al., 2020; Sheridan et al., 2010; Thompson et al., 2007; Weaver et al., 2019). Many parents noted that family relationships appear stronger and more harmonious. Enhanced communication and reduced tension within the family were common outcomes. A parent noted:

> *"I think we're closer. I think we're a little bit more focused on each other's, um, things that we're all going through separately, so that has helped. We've gotten a little closer" (Weaver et al., 2019, pg. 1158).*

This indicates that involving parents in therapy can lead to broader improvements in family relationships and functioning.

The collaborative nature of the therapeutic process was emphasised by many parents (Eadie et al., 2022; Frauenholtz & Mendenhall, 2020; Weaver et al., 2019). Being treated as valued partners in their child's therapy, rather than passive observers, significantly impacted their experience. A parent in Eadie et al. (2022) emphasised:

> *"Everyone works as a team and communicates information appropriately to best meet the needs of the child, everyone is calm, happy and understanding" (Eadie et al., 2022, pg. 210).*

This collaborative approach not only validated parents' insights but also fostered a more cohesive and supportive therapeutic environment. Parents felt deeply satisfied when their voices were included and found it beneficial when therapists prioritised family needs or showed interest in understanding both their own and their child's needs. Parents frequently emphasised the importance of an individualised approach that focuses on the needs of the entire family (Eadie et al., 2022; Frauenholtz & Mendenhall, 2020). For some parents, collaborating with the therapist meant sharing the responsibility for recovery or the burden of treatment (Grudin et al, 2024). This, in turn, made parents feel relieved for not carrying the responsibility alone. Nevertheless, some parents experienced a lack of communication from the therapist (Schlimm et al., 2021). Others noted that the support provided to them was insufficient, highlighting the need for more adult-focused attention and greater involvement (Hart et al., 2004; Weaver et al., 2019).

Theme 3: Therapist is key

This theme emphasises the importance of the therapist's role in the therapeutic process. The personal qualities of therapists, such as empathy, patience, and understanding, were highly valued by parents (Chan et al., 2023; Chlebowski et al., 2018; Eadie et al., 2022; Sheridan et al., 2010). These qualities were seen as essential for building trust and rapport. One parent noted:

> *"I think that human quality, knowing that [the therapist] understands, give us the confidence to feel comfortable in asking [questions], knowing that he [therapist] as a*

> *professional also is sympathetic to what you are going through, that would help a lot" (Chlebowski et al., 2018, pg.12).*

Other parents highlighted the importance of a therapist adopting a non-judgmental approach and respond to the family needs with openness and honesty (Hart et al., 2004). As a result, parental confidence would grow, making parents feel more empowered. This emphasises the importance of therapists' interpersonal skills in creating a supportive therapeutic environment.

Professional competence and expertise were also crucial factors influencing parents' experiences (Eadie et al., 2022; Kingston et al., 2013). Knowing that the therapist was well-trained and knowledgeable gave parents confidence in the therapeutic process. A foster carer appreciated,

> *"The professionalism of staff, their approachability and flexibility to accommodate the young persons and carers hectic schedules." (Eadie et al., 2022, pg. 209).*

This highlights the importance of therapists' professional qualities in reassuring parents and fostering trust. In some studies, parents viewed therapists as role models and found their professional support invaluable. Some parents felt it challenging to work with their youth without the therapist's assistance and regarded them as experts in addressing their family's issues (Lundkvist-Houndoumadi et al., 2016). Overall, the presence of the therapist was highly valued (Grudin et al., 2024; Muller et al., 2024). The overall relationship between the therapist and the family was a central factor in the success of the therapy (Frauenholtz & Mendenhall, 2020; Sheridan et al., 2010; Thompson et al., 2007; Weaver et al., 2019). A strong, trusting relationship was seen as essential for progress. In Chlebowski et al. (2018), a parent said:

> *"We had a relationship of trust, it is as if I was talking with a friend, she made me feel as a friend, as someone who I could trust, as someone who listens to me and is not criticizing or watching to see what I'm going to say wrong or what I do wrong" (Chlebowski et al., 2018, pg.12).*

Other parents pinpointed that they were able to build trust and security in their therapist and the process (Chlebowski et al., 2018; Sheridan et al., 2010). This highlights the need for building strong therapeutic alliances to facilitate effective interventions. A few parents considered that the relationship between therapist and adolescent is key, thus allowing them to develop trust and mutual respect in the therapeutic process (Schlimm et al., 2021).

Theme 4: Navigating obstacles

This theme addresses the practical and emotional challenges parents face during therapy. Parents often faced practical challenges that affected their ability to participate in their child's therapy, such as scheduling conflicts, financial constraints, and logistical issues (Green et al., 2023; Lundkvist-Houndoumadi et al., 2016). Some parents mentioned,

> *"[we] didn't always live here...and I was bouncing around...So there were a lot of appointments that I had to cancel. And I couldn't attend or make up" (Weaver et al., 2019, pg.1159).*

Other parents reported facing numerous stressors and pressing priorities (Goodkind et al., 2014; Muller et al., 2024). While they appreciated the accessibility of online therapies, they also pinpointed several challenges related to technical difficulties. Addressing these practical barriers is crucial for improving access to and participation in therapy. The emotional burden on parents was another significant factor. Many parents experienced stress, anxiety, and

emotional exhaustion as a result of their involvement in their child's therapy. In Chan et al. (2023), a parent expressed:

> *"I wanted to be a part of [therapy] so I could really capture what they were doing and what was helpful. If I'd been sitting in the waiting room, I wouldn't have gotten that full effect, which I think is really good. But I did find it, to be honest, exhausting, just because it was a long drive there and because he was a bit resistant to go. We really want to help our kids too but there's also never time for us either, and then we get burnt out".*

In some studies where parents had co-therapy roles, additional challenges emerged regarding the application of therapy materials (Lundkvist-Houndoumadi et al., 2016). An important quote from a parent included:

> *"In order to practice, it gets to be invasive not only for the youth's life, but also for the one that needs to practice with the youth . . . Now someone needs to talk to my child, so we can just be mum and dad. Having to be a therapist for your child—I think for some it is easy and for others very hard, depending on the child". (Lundkvist-Houndoumadi et al., 2016, pg. 483).*

This highlights the need for additional support to help parents manage their own emotional well-being.

1.6.7.5 Conclusions

The synthesis of findings from the reviewed articles highlights the multifaceted nature of parents' and carers' experiences in their child's psychotherapeutic interventions. Four main themes were identified in this systematic review. The first theme was 'experience of therapy', which captured parents/carer's holistic experiences of being involved in their child's

intervention. Their experiences involved previous experiences of accessing services and treatment for their child and how these might affect their current participation in their child's intervention, increased knowledge and understanding of their child's difficulties, acquirement of parenting skills and empowerment as well as observed changes in their child's behaviour and wellbeing. The second theme, 'strengthening relationships', described the impact of therapy on family relationships. More specifically, significant benefits of involving parents in their child's therapy included the strengthening of the parent-child bond and family dynamics. The third theme included 'therapist is key' and emphasised the importance of the therapist's role in the therapeutic process, including the personal and professional qualities of the therapist and the relationship between the therapist and the parent. The final theme was 'navigating obstacles' which addressed the practical and emotional challenges parents face during therapy. By recognising and addressing these themes, mental health professionals can better support parents and carers. This, in turn, can lead to more effective and holistic therapeutic outcomes for children and young people.

1.7 Possible clinical implications

The findings from this review highlight important clinical implications when working with parents/carers of children and young people and considering their participation in their child's psychotherapeutic intervention. Mental health professionals should consider adopting a holistic approach that considers the entire family, not just the child. This may involve acknowledging and addressing parents' previous experiences with mental health services and/or past treatment experiences alongside their child. Historically, Children's and Young People's services in the UK have been seen as underfunded and characterised by long waiting times for referrals (The Health Foundation, 2022). As a result, many families may have encountered numerous frustrating experiences when engaging with services, and their

recurring stories highlight a journey filled with confusion about the available treatment options and 'dead ends' (Brown, 2018). Also, previous research has highlighted that parents often experience increased guilt and tend to feel responsible for their child's mental health difficulties, while navigating services (Richardson et al., 2013). Offering parents a reflective space to talk about previous experiences and gain a deeper understanding of their impact on their participation in their child's current intervention could be beneficial. Professionals may also consider tailoring interventions to avoid negative previous experiences, thus instilling hope and optimism for parents and meeting family needs.

Another important aspect of the above mentioned findings is to adopt interventions which include components that educate and empower parents, equipping them with the skills and confidence to support their child's mental health. The findings of this review suggest that empowering parents with knowledge and skills during sessions may enable them to apply these techniques outside of therapy to support their child's progress. Moreover, clinicians can emphasise the parents' role in the therapeutic process to foster a sense of competence and confidence. Actively involving parents in their child's psychotherapeutic intervention could potentially foster collaboration and allow for their perspectives and preferences to be incorporated. Given the significant role caregivers play in securing and facilitating attendance at treatment (Haine-Schlagel & Walsh, 2015), services should consider encouraging parental participation and incorporating the family's perspective in the treatment process. Practitioners might also benefit from considering parents' observations as valuable feedback for evaluating the success of therapeutic interventions. Their insights can help tailor therapy to meet the child's specific needs. Nevertheless, it is important to be cautious about the level of parental involvement in their child's intervention, as some studies have found that parental involvement in therapy can sometimes feel overly intrusive, preventing both young people and their parents from speaking openly in each other's presence (Gondek et al., 2017).

Building strong, trusting relationships between therapists and families is an important consideration. Therapists could benefit from focusing on developing their interpersonal and professional skills to foster these relationships. Clinicians who demonstrate interpersonal skills such as empathy, patience, respect, warmth, eagerness and flexibility are in a better position of fostering trusting and supportive relationships with parents, who are involved in their child's therapy (Browne et al., 2021). Encouraging open and transparent communication with parents can also strengthen the therapeutic alliance (Eadie et al., 2022). In a wider level, services might consider maintaining high standards of professional practice and continuous professional development for therapists.

Addressing practical barriers to participation, such as scheduling and financial constraints, may also help improve participation in therapeutic interventions. Developing strategies to overcome logistical and emotional barriers to participation in therapy should be seen as priority in services. In line with the last updated statutory guidance developed by NHS England and relevant partners (NHS England & DHSC, 2022), services and policy makers should consider focusing on collaborating and working together with families and communities to better customise services to meet their needs and preferences. Services should aim to ensure that psychotherapeutic interventions are delivered in a way that works for children, young people and their families, and are appropriate for the communities they serve. Furthermore, services might consider providing parents with additional support systems, such as peer groups and educational resources which can help parents manage the practical and emotional challenges of their involvement in their child's therapy.

1.8 Gaps in existing literature

The existing literature on parents' and carers' experiences with their child's psychotherapeutic interventions offers valuable insights, however several gaps remain that

are crucial for guiding future research and improving clinical practices. Many studies have concentrated on specific populations, particularly from Western, high-income countries. There is a clear need for research that includes diverse cultural, ethnic, and socioeconomic groups to gain a broader understanding of different perspectives and challenges. Investigating how cultural beliefs and practices affect parents' involvement in their child's therapy is essential for a more comprehensive view.

Furthermore, much of the existing research is cross-sectional or short-term. Longitudinal studies are needed to examine how parents' experiences and perceptions change over time and how ongoing involvement influences long-term outcomes for children. Current studies predominantly focus on mothers, with limited attention given to fathers' roles and experiences. Additional research is required to better understand fathers' perspectives and their contributions to their child's psychotherapeutic process.

Although some studies address the emotional burden on parents, more in-depth research is necessary to explore how involvement in therapy impacts parents' mental health and well-being. Identifying and addressing both practical barriers (such as time constraints and financial issues) and structural barriers (such as access to services and systemic biases) that affect parents' participation is crucial.

Moreover, research often generalises psychotherapeutic interventions without examining the specifics. There is a need for studies that investigate parents' experiences with various types of therapy (e.g., CBT, IPT-A, play therapy, psychodynamic therapy, family therapy) and how these experiences differ.

With the growing use of online therapy, it is important to research parents' experiences with digital and remote interventions, including their effectiveness and accessibility. Finally,

exploring the types of support systems and resources most beneficial for parents, such as peer support groups, educational materials, and professional guidance, is vital.

1.9 Reflection on the review process

To the best of my knowledge, this is the first systematic review to thoroughly examine the experiences of parents/carers of being involved in their child's psychotherapeutic intervention, making a significant contribution to the existing body of evidence. A particular strength of the studies included was their focus on children's psychotherapeutic interventions from a parental perspective. Since family voices are often overlooked, it is crucial to explore and incorporate their perspectives into the literature. A comprehensive search strategy was employed, including studies from grey literature, which broadened the range of information sources and helped mitigate potential publication bias (Boland et al., 2017).

However, the review has some limitations, and the findings should be interpreted with these in mind. The quality assessment revealed selection biases in several studies, and potential biases, such as those arising from the interviewer or subjective interpretations, were acknowledged. Although efforts were made to address these issues in the included studies, they should still be considered. Due to time and resource constraints, the title and abstract screening of the retrieved articles was performed by a single reviewer, which may have increased the risk of error. According to the Cochrane guidance, involving two or three reviewers at this stage would provide more thorough scrutiny and ensure more rigorous conduct (Tawfik et al., 2019). Additionally, the review was limited to studies published in English and focused exclusively on qualitative research, which means that the effectiveness of parental/caregiver involvement on outcomes cannot be determined.

1.10 Rationale and aims of the current project

The systematic review offered insights that are invaluable for improving therapeutic practices and supporting families more effectively. The gaps in the literature highlight a need for studies that investigate parents' experiences with various types of therapy. More importantly, there is an identified gap in the current literature on the experiences of parents of their child's IPT-A intervention specifically. I therefore aimed to fill this gap by qualitatively exploring parents' lived experiences of their adolescent child's IPT-A for depression. Exploring parents' experiences of their child's IPT-A could offer new perspectives that help clinicians adjust therapy to better meet adolescents' needs, potentially improving treatment outcomes and increasing parents' sense of involvement and support.

The aim of this study was to explore the following research question: ***What are parents' experiences of their child's IPT-A intervention?*** Further sub-questions will be explored:

1. How do parents make sense of their child's IPT-A intervention?
2. How do parents perceive their involvement in their child's IPT-A intervention?
3. What are the perceived positive and negative aspects of the IPT-A intervention as experienced by parents?

2. Method

2.1 Chapter Overview

This chapter outlines the methodology used to explore the research aim and questions. It begins with a rationale for my chosen qualitative research design. Next, it details the involvement of consultants including 'IPT-A practitioners' and 'Experts by Experience', who were crucial to the study. It then covers the participant sample, recruitment process and challenges, and key ethical considerations. Finally, it discusses the data collection and analysis process and evaluates the study's quality in relation to the chosen methodology.

2.2 Qualitative Research Design

As highlighted by the systematic review, there is a scarcity of research exploring the experiences of parents of their child's IPT-A intervention. Given the promising results of IPT-A and this existing gap in IPT-A literature, a qualitative methodology was employed. A qualitative research design was considered the most appropriate approach to address some of these gaps, since it captured the richness and depth of complex phenomena, which might not be apparent through quantitative methods (McEvoy & Richards, 2006; Sullivan & Sargeant, 2011; Teherani et al., 2015). Qualitative methodology is well suited for studies with limited existing research (Barker et al., 2015) and therefore was deemed appropriate for this novel study to further understand how parents give meaning to their experiences. Last but not least, it is fundamentally conscious of the context in which experiences occur (Korstjens & Moser, 2017), thus enabling me to consider a variety of contextual factors, including family dynamics, cultural backgrounds and past experiences of mental health services, which determine how parents experience and interpret IPT-A.

2.3 Methodology

2.3.1 Interpretative Phenomenological Analysis (IPA)

Interpretative phenomenological analysis (IPA) was deemed the most appropriate methodology to use for this study as it is committed to understanding how individuals make sense of their personal lived experiences (Smith et al., 2022). IPA enabled me to focus on how parents interpret the lived experience of a given phenomenon; in this study, their child's IPT-A intervention. Additionally, I was able to examine my participants' interpretation and my interpretation as a researcher in this study. This helped me to learn from my participants and further explore how they made sense of their experiences (Smith, 2011). Below, I will briefly discuss IPA's theoretical underpinnings, which include phenomenology, hermeneutics and idiography, providing a rationale for choosing this methodology.

2.3.2 Phenomenology

Phenomenology is a philosophical approach to the exploration of human experience. Phenomenologists adopt different perspectives and emphases, nevertheless they all share a common interest in exploring the human experience, particularly emphasising on significant things that matter to humans and represent how humans live (Smith et al., 2022). A key element of phenomenological approaches is that researchers are provided with a reservoir of ideas to investigate and understand lived experience (Smith et al., 2022, p.7). Because of phenomenology's emphasis on the lived experience, this approach is relevant to the context of this research, allowing for a rich and detailed exploration of how parents interpret and make sense of their child's IPT-A intervention.

Smith et al. (2022) refer to the influential work of four phenomenological philosophers; Husserl, Heidegger, Merleau-Ponty and Sartre. Their contributions allow the conceptualisation of the theoretical underpinnings of IPA. Husserl was interested in discovering a method for someone to precisely understand their own experience of a

particular phenomenon, and to do so with sufficient depth and rigour to pinpoint 'the essential qualities' of that experience. He argues that individuals need to 'bracket' or set aside their preconceived notions of the world to focus on how they perceive it. Heidegger focused more on the fundamental question of existence and the practical activities and relationships that engage us, through which the world becomes meaningful to us. He addressed the issue by emphasising the 'worldliness' of our existence. Moreover, Merleau-Ponty engaged with both Husserl's and Heidegger's commitments, yet took a slightly different direction towards describing how our embodied nature of our engagement with the world shapes our unique, individual perspective on it. Finally, Sartre further extended the significant concept of 'worldliness' of our experience in the context of individual and social connections; he argued that we are more likely to understand our experiences dependent on the presence and absence of our relationships with others.

2.3.2 Hermeneutics

IPA is phenomenological as it wishes to explore an individual's experience in its own terms. Although 'experience' is a complex phenomenon, IPA is concerned with what happens when individuals become deeply immersed in their lived experiences, thus creating room to become more aware of their experiences and reflecting on the significance of what is happening to them. This individual's endeavour to make sense of what is happening to them reflects the second theoretical underpinning of IPA. It concerns an interpretative attempt informed by hermeneutics, 'the theory of interpretation' (Smith et al., 2002, pg. 17). IPA conceptualises that humans are sense-making beings and thus their accounts will demonstrate their efforts to understand their own experiences. At the same time, IPA acknowledges that accessing participants' experience depends on what the participant shares, emphasising that the researcher needs to make interpretations of the participants' accounts to make sense of their experience. In that respect, it can be argued that the researcher adopts a dual role by

engaging in a double hermeneutic in their attempt to understand how participants make sense of their experience. In this current research, this involved me as a researcher making sense of the participants' experiences, who are making sense of their experiences of their child's intervention.

2.3.3 Idiography

IPA's idiographic focus is concerned with the 'particular', positioning participants in their particular contexts and exploring their unique perspectives (Smith et al. 2022, p. 24). In turn, the researcher adopts a detailed examination of participants' particular experiences and focuses on understanding how certain individuals make sense of certain experiential phenomena. Consequently, IPA is better suited to small sample sizes with a purposively-selected sample of participants, which is relevant for this study. Moreover, by adopting and becoming committed to a thorough and systematic analytic approach, I was able to deeply engage with each of my participants' viewpoints.

2.3.4 Limitations of IPA

IPA has been critiqued for capturing participants' lived experiences without always offering explanations for them (Willig, 2008). However, it can be argued that before attempting to explain an experience, it is essential to deeply understand how individuals perceive and interpret it (Macran & Shapiro, 1998). Another limitation of IPA is its reliance on language, as participants describe their experiences through words (Willig, 2008). This means that they may present a particular version of their experience. IPA recognises this issue and highlights the researcher's role in understanding and interpreting the participant's narrative (Larkin, Watts, & Clifton, 2006). Despite recent critiques questioning its phenomenology (Van Manen, 2017), IPA is still considered a strong method for combining psychology and phenomenology (Smith, 2018), which is important for this study. I have been

aware of these limitations throughout the analysis, trying to minimise their influence on how the data is interpreted and remaining conscious of the limits of interpretation.

2.4 Consideration of other methodologies

Other methods of analysis were considered during the design of the study. These are listed in Table 5 below, along with the reasons for excluding.

Table 5

Overview of other methodologies

Qualitative Methods	Philosophy	Goal	Methodology	Rationale for rejection
Thematic Analysis (Braun & Clarke, 2006)	Thematic analysis is a flexible method, which can be used with various theoretical frameworks	Identify, analyse and report patterns or themes within the data. It aims to provide a detailed understanding of the data by systematically organising and describing the features of the data set	Familiarising with data Identifying, assessing and documenting themes or patterns within the data Extracting units of meaning from the data	Less emphasis on exploring the phenomenological world of participants compared to IPA Less acknowledgment of the researcher's interpretive role
Grounded Theory (Glaser & Strauss, 1967).	Interactionist approach Individuals who share a culturally oriented understanding of their world, exhibiting similar attitudes and values. Concerned with generation of theory which is 'grounded' in the data.	Create an explanatory level account, including factors, impacts, influences, social processes, and context. The analysis produces a new theory by examining concepts directly grounded in the data.	Systematic data collection and analysis to build theory inductively Symbolic interactionism involves understanding meanings in interactions, actions, and their consequences. Both objectivist and constructivist perspectives (Charmaz, 2011). Questions how the process unfolds within a specific setting or environment.	Used for creating explanatory accounts. Depends on larger and more diverse samples, with less emphasis on individual experiences. The aims of this thesis are focused on the meaning and sense making of parents' experiences rather than the processes.

Narrative Inquiry (Connelly & Clandinin, 1990)	Narrative frameworks that people use to recount events	Emphasis on how narratives are connected to the process of making sense of and interpreting the world	Essentially a hermeneutic effort; data collected from the contextualised narratives that individuals share to make sense of their actions and identities.	There is a considerable overlap with IPA (Eatough & Smith, 2008) however IPA places more emphasis on capturing internal, authentic subjective experiences rather than the broader interpretive process of narratives While Narrative Inquiry provides deep insights into how people make sense of their experiences through stories, the focus of this thesis is more aligned with examining subjective experiences and the detailed meaning-making process, which IPA handles more directly
Discourse Analysis (Kaplan & Grabe, 2002)	How is something constructed Knowledge is built through interactions and various discourses	Emphasising the need to understand concept according to the conventions of a specific context Involves examining how people use language to create and engage in processes and phenomena	Utilising a variety of data sources This approach looks at the discourse in play and how they influence relationships, activities, and identities	There is less focus on individual lived experiences, making it harder to draw out a participant's narrative Focused more on how language constructs meaning rather than assuming that words inherently convey meaning, which can be less suited for in-depth exploration of personal experiences compared to methods like IPA

2.5 Consultation with IPT-A Trained Practitioners

Consultation was sought by a team of IPT-A practitioners during the initial stages of the project. The primary researcher was invited to attend monthly supervisory IPT-A meetings, which took place online via Microsoft Teams. These meetings were attended by practitioners; mainly with a psychology background, who were trained in IPT-A therapy, as part of standard practice in CAMHS. These meetings involved consultation, case discussions and informal support. Feedback was sought from IPT-A practitioners on the interview schedule, and amendments were made as advised. Practitioners' contributions had been significant, especially due to the lack of my professional knowledge and expertise on the IPT-A intervention. Interview questions were updated to match practitioners' requests. Overall, consultation with practitioners offered a professional insight and further enhanced my understanding of IPT-A processes and the role of parents in this particular therapy.

2.6 Consultation with Experts by Experience

Since the 1990s, public involvement in health research has been encouraged in the UK (DoH, 1999). Ethically, engaging Experts by Experience (EbE) in research would not only allow people with lived experiences to have a voice in relation to their care and treatment, but also ensure that research studies are carried out thoughtfully and in an ethical manner. There are a number of advantages of engaging EbE in research, including enhanced recruitment and retention, and improved communication of findings to participants (Domecq et al., 2014). Additionally, by involving people with lived experiences, research projects can benefit from establishing trustworthiness and accuracy (Lindenmeyer et al., 2007; Thompson et al., 2009). For EbE, the process can enable individuals to make better sense of their experiences and feel more empowered (Patterson et al., 2014).

The Patient and Public Involvement (PPI) and the Service User and Carer Involvement teams were contacted to identify EbE; parents with lived experience of their child's mental health journey and mental health intervention. The present study was advertised by both teams, detailing how EbE would be involved in the consultation of the research project. A parent with lived experience of their child's mental health journey, expressed interest in supporting this research study and was consulted as an EbE advisor. While she was not a participant in the study, she contributed as an EbE, providing valuable insights and input during various stages of the project. She was paid for all meetings attended in acknowledgment for her time and support. Appendix 5 includes an overview of her involvement.

2.7 Participants

2.7.1 Sampling

To be consistent with the qualitative approach and IPA's conceptual framework, samples are selected purposively to offer insight into a particular experience in a particular context (Smith et al., 2022). In IPA studies, participants are selected on the basis that they can provide a specific viewpoint on the phenomenon being examined. In essence, participants are chosen to represent a particular perspective on the phenomenon, rather than to reflect the experiences of a broader population. Additionally, researchers in IPA studies attempt to find homogenous samples, for whom the research question would be meaningful. Instead of treating samples as identical, researchers can scrutinise other forms of variation between participants; which in IPA studies is done by examining the convergence and divergence within the data and consider the context and the experiences of the participants. IPA is concerned with the in depth accounts of personal experience, thus studies include relatively small sample sizes. According to Smith et al. (2022), a sample between 6 and 10 participants is considered suitable for professional doctorates.

This study included parents/carers aged 18 years and above, in line with the 'Adult' definition set by NHS (2021). Parents/Carers were included if they were deemed to have capacity to consent and be suitable to recruitment by their care team. Parents/Carers were recruited if they had undergone an IPT-A intervention alongside their child within the last twelve months. A time period of twelve months was deemed appropriate to capture a pool of participants. Moreover, parents/carers were included if they were involved in a minimum of two sessions of the intervention, in accordance with the IPT-A manual which invites parental participation of 1-3 sessions as needed (Mufson et al., 2004). Nevertheless, following consultation with the IPT-A supervisory team and the research team, it was deemed appropriate to consider caregivers who have had less participation in sessions but enough involvement to provide feedback on their experiences. Those who have had very limited involvement in the intervention or have been identified as current risk to self and or others were excluded from the study. A detailed overview of the study's inclusion and exclusion criteria is listed in Table 6.

Table 6

Overview of the study's eligibility criteria

Inclusion criteria	Exclusion criteria
Aged 18 years or over	Parents/Carers who have had very limited involvement for an IPT-A intervention
Deemed to have the capacity to consent by their care team	Identified current risk to self and/or others
Deemed to be suitable for recruitment by the care team	
Able to read, speak and comprehend English	
Parents/Carers who have undergone an IPT-A intervention within the last 12 months	
Parents/Carers who have been involved in a minimum of 2 sessions of IPT-A, in accordance with IPT-A manual, or may be considered if they	

had less participation but enough involvement
to provide feedback on their experiences

2.7.2 Recruitment strategy and challenges

Participants were recruited between January and June 2024. Correspondence with a number of recruitment sites across the UK (CAMHS, Local authorities, Charities) had taken place to make links with local collaborators[1]. Further correspondence had been made with the national IPT-A courses for Children and Young People (CYP) and the IPT UK network to recruit potential participants. A research advert (Appendix 6) was provided to local collaborators, to gather initial interest. During initial contact, local collaborators were informed about the research study and were provided with the research protocol (e.g., relating to obtaining consent from carers to be contacted). It was hoped that local collaborators would identify parents/carers who have undergone an IPT-A intervention alongside their child and provide them with the Participant Information Sheet (PIS, see Appendix 7), either via email or following a therapeutic session. The PIS included detailed information about the purpose of the research study, to enable parents/carers make an informed decision about their participation. Moreover, local collaborators were advised to provide participants with an Expression of Interest form (Appendix 8), either via email or following a therapeutic session, should they wish to take part. Expressions of interest forms were then passed on and shared with myself, before directly contacting eligible participants.

Identifying and thus linking up with local collaborators had been an initial challenge in the recruitment phase. I made multiple attempts to locate trained or trainee practitioners via IPT-A courses, IPT UK network or supervisors in teams. This two-way communication

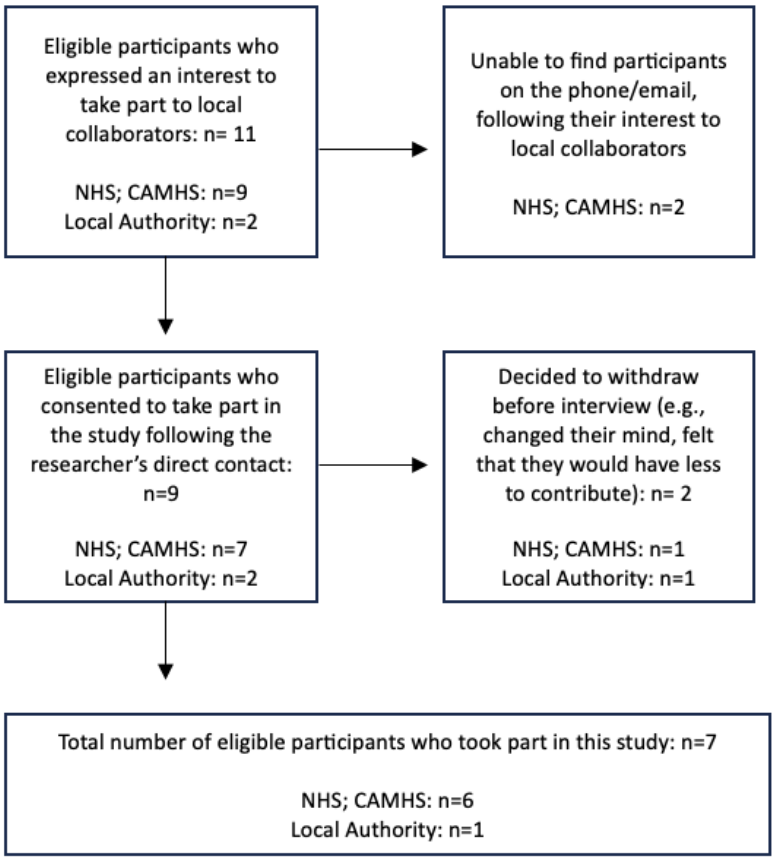
[1] A local collaborator is the contact person who either works directly with eligible participants or supervises a practitioner who works directly with eligible participants. Local collaborators are trained IPT-A practitioners themselves or supervise a team of trained practitioners or trainee practitioners who apply IPT-A therapy with families.

process would often prove time consuming; requiring chasing up emails and maintaining communication to reach my ultimate goal of reaching out to practitioners. Consequently, I experienced increased delays in the commencement of recruitment. Despite successful direct contact with practitioners, interest to this research study varied; approximately half of local collaborators expressed an interest to support with the recruitment. These challenges potentially reflect the paucity of existing qualitative research on IPT-A intervention. It has been suggested that recruitment cannot commence without the explicit approval of gatekeepers; individuals who control access to potential participants (Lysaght et al., 2016). In this current research, local collaborators acted as gatekeepers who could either hinder or facilitate the research (Namageyo-Funa et al., 2014). This initial challenge enabled me to learn how supportive local collaborators significantly can enhance recruitment efforts, as highlighted in previous research (Thomas et al., 2007).

Participants' motivations to take part in the study also influenced recruitment. Some participants may have been more likely to participate as a way to help the researcher in advancing knowledge and influencing practice (Clark, 2010; Coyne et al., 2016). Additionally, participants who are interested in the research topic or find the research question important are more likely to take part (Clark, 2010; Keightley et al., 2014). On the other hand, people are less likely to participate if they feel overwhelmed by their schedule or believe they have little to contribute (Coyne et al., 2016; Kristensen & Ravn, 2015). Overall, 11 participants were identified to be eligible for this study, of which 7 were interviewed (Figure 2).

Figure 2

An overview of the recruitment process



2.7.3 Participant characteristics

The sample consisted of 7 parents. Two participants were male and five were female. All participants identified as White British. The participants were aged between 43 and 63 years, while their children were between 15 and 17 years old during therapy. To protect the anonymity of the participants, these age ranges are presented in a generalised format. Parental involvement in therapy varied, ranging from participation in a minimum of one therapeutic session to a maximum of three sessions. Additionally, some parents were involved in brief check-ins or debriefs at beginning or end of each session. All parents were involved in the sessions with the consent and presence of their child and therapist. Additionally, to ensure that participants' confidentiality and anonymity were protected, participants were given the

opportunity to choose their own pseudonym. A pseudonym was given if one was not provided. Table 7 below provides an overview of participants' characteristics.

Table 7

Overview of participants' characteristics

Participant	Gender	Ethnicity	Number of involved sessions
Fran	Female	White British	2
Gigi	Female	White British	3
Jacob	Male	White British	3
Kali	Female	White British	2
Talia	Female	White British	3
Kevin	Male	White British	1
Faye	Female	White British	2

2.8 Ethical Considerations

Ethical approval for this study was granted by the Health Research Authority (HRA) and Research Ethics Committee (REC); IRAS project ID 330849. The University of Hertfordshire also granted sponsorship approval and provided a protocol number (LMS/PGT/NHS/02999). Copies of the approvals are in Appendix 9. A non-substantial amendment was made to include new NHS sites after additional local collaborators expressed interest. The Research and Development (R&D) teams at each site were consulted to follow their internal procedures.

2.8.1 Informed consent

Consent was obtained through two stages: 1) Consent to be contacted, and 2) Consent to participate in the research. Initially, local collaborators provided participants with a PIS and

recorded their contact details securely before sharing them with the researcher via NHS mail. This initial process indicated that participants were interested in being contacted and that the expression of interest forms have been shared with the researcher. The researcher then contacted eligible participants to arrange interviews and ensure they had reviewed the PIS. Informed consent (Appendix 10) was obtained electronically via Qualtrics on the day of the interview, allowing participants to ask questions and affirm their understanding. Participants were reminded that consent was ongoing and that they could withdraw at any time without affecting their care.

2.8.2 Participant wellbeing

It was not anticipated that this research will cause significant distress. However, the research team was aware that participants may find talking about their experiences of their child's therapeutic intervention difficult. The interviewer and members of the research team all had experience of managing distress through their training as psychologists and work with both clients and staff in the NHS. Participants were reminded that they only need to talk about what they felt able and willing to talk about, at a level of detail and in a way that they felt comfortable with. Participants were also reminded that they could take breaks if they needed, or they could withdraw their participation at the end of the interview, without having to provide a reason. Participants were given the opportunity for debriefing upon completion of their interview and were provided with a debrief sheet (Appendix 11).

2.8.3 Confidentiality

Participants were informed about confidentiality and anonymity principles, and data sharing protocols. All relevant information was kept stored and secured on a password protected file within an NHS secure system and was only accessed by myself, as the primary researcher. Where identifying information, such as an email address, was required—for example, to follow-up with participants at a later stage or to send a summary of the research

findings—I stored these details separately from the actual study responses. I used randomly generated unique identifiers to link names and data sets, ensuring that only the primary researcher had access to the code system. The codes were carefully protected and will be deleted after the study is completed to maintain confidentiality.

Data collected from interviews was anonymised and kept confidential in compliance with the Data Protection Act 2018. Personal identifiable information about the participant and all third parties was removed from the transcribed interview. Participants were given the right to choose their own pseudonyms to ensure anonymity. All information and audio/video recordings were stored on an encrypted and password protected NHS system and were kept secured for the duration of the study. These recordings were accessible only by myself and were permanently deleted at the end of the study. Written transcripts will be kept anonymised and stored on an encrypted University hard drive (128 bt encryption) for five years, in line with the University of Hertfordshire guidelines. After this time, data will be destroyed permanently. Information regarding risk-related issues was addressed according to a clear procedure involving the research team and the local service's policies, with participants informed if confidentiality needed to be breached.

2.9 Data Collection

2.9.1 Interview schedule

A semi-structured interview schedule was developed to allow participants to share their experiences in depth (Appendix 12). The design of the interview schedule was guided by the research aims and the willingness to gain a comprehensive understanding of the participant's experiences, in line with the principles of IPA and social constructionism. The semi-structured interview schedule was developed in consultation with the research team, IPT-A practitioners, and a parent with lived experience of CAMHS and psychotherapeutic interventions, ensuring that the questions were both relevant and sensitive to the participants'

perspectives. Semi-structured interviews were conducted since they were regarded the most suitable way of collecting data for IPA studies (Smith & Obsorn, 2008).

A pilot interview was conducted with a parent as the expert by experience. To ease the interview process, I shared the questions with the parent beforehand and provided her with an overview of what will be discussed as part of the pilot interview. Overall, she reported a positive experience. This was an opportunity to reflect on my questioning style, how it felt to pose the questions, and the parent's experience in hearing and responding to them. It is noted that relatively inexperienced qualitative researchers often use rigid questions in initial interviews (McNair et al., 2008), highlighting the importance of reflexivity in this context. Following the pilot interview, the interview schedule was reviewed and minor amendments were made to provide further clarity to some questions.

I began the interview process by providing an introduction to this research, followed by background demographic questions to enable participants ease into the research (Ranney et al., 2015). Establishing rapport at the start of the interview is key (Smith et al., 2022). While conducting interviews, I ensured that participants were offered a reflective space where they felt able to talk about their experiences, by active listening, allowing time for responses and using the interview guide flexibly. The interview schedule invited participants to share their experiences by using generalised questions first, and then moving more to specific processes involved in IPT-A. The interview schedule also involved suggestions for general prompts and follow-up questions, to enable exploration of additional ideas and responses. The interview schedule questions aimed to explore the lived experiences of parents of their child's IPT-A intervention.

2.9.2 Interview procedure

Interviews were conducted and recorded online and consent for this was obtained prior to commencing the interview. Since the interview took place over remote technology, it was recorded from the point that consent was obtained until the end of the interview. Participants were given the option to choose their preferred interview platform. Three interviews were conducted on Zoom and four on Microsoft Teams. There have been mixed results on the effectiveness of remote interviews, suggesting that rapport can be negatively impacted due to technical difficulties (Roberts et al., 2021). On the other hand, other studies have highlighted that video interviewing can be beneficial for building rapport between the interviewer and the interviewee (Sy et al., 2020), and increase accessibility for participants (Gray et al., 2020; Irani, 2019). In line with previous literature (Salmons, 2016), I ensured that virtual qualitative research was conducted ethically and important steps were followed to reduce any potential issues that may arise. The British Psychological Society guidelines on online research (BPS, 2021) were consulted and adhered to before and while conducting the remote interviews (see Table 8).

Table 8

Consultation of BPS guidelines on online research (BPS, 2021)

Managing confidentiality and openness in a remote set up
• Clearly communicate to participants about the importance of maintaining confidentiality during the online sessions and encourage them to find a private space within the home where they would participate in the Teams session without interruptions.
• Suggest the use of headphones to manage the privacy of the questions and follow-up prompts.
• Maintain their right to withdraw or skip over questions without the need to explain or be penalised for doing so.
• Ensure that all participants are aware of the purpose of the online sessions and have given informed consent for their involvement, only after confirming they have received enough information and had chance to ask questions.

• Remind all participants to be mindful of their surroundings and adjust Teams settings to blur backgrounds or use virtual backgrounds to maintain privacy.
• Offer a pre-research briefing/check-in to help participants be informed about what to expect.
• Establish a safe research space; e.g., asking participants on the day of their interview if they are comfortable in the space they have chosen to interview, ensuring they can speak openly in the room they have chosen, establishing how to manage any background noise.
• Stop the interview to manage unexpected interruptions, for instance someone getting in the room.

All interviews were conducted in the English language, and no interpreters were required. Interviews lasted between 45 to 60 minutes, with an additional 10-15 minutes offered for any preliminary issues, including consent. Following completion of the interview, participants were debriefed and reminded that they can raise any questions or concerns with the research team. They were also provided with a list of contact details for extra support in writing, as stated on the PIS. Participants were offered a £10 voucher as a gesture for their time and participation in this research study.

2.10 Data Analysis

By using Smith et al.'s (2022) framework, the analysis involved a set of common processes and principles which can be applied in a flexible and iterative manner. The initial phase involved listening to the audio-recordings and reading each transcript multiple times to fully immerse myself in the data. This allowed me to gain a holistic understanding of each parent's account and to start noting my initial thoughts and observations. Documenting my own impactful recollections from the interview experience allowed me to capture these moments and remain aware of their potential influence on my subsequent observations. As I familiarised myself more with the data, I made detailed exploratory notes on each transcript focusing on the language used, the context of what was said and more abstract concepts which provided a deeper level of interpretation and reflection. These exploratory notes were

documented on the right hand side of the transcript page. From the exploratory notes, experiential themes were identified. This next step involved reducing the volume of detail while maintaining the complexity of the participants' experiences. Experiential statements were written on the left side of the transcript (see Appendix 13 for an extract).

The next stage of the data analysis involved the development of mapping of how statements fit together. I used a manual and creative method to examine experiential statements for patterns and connections (Smith et al., 2022). This involved printing a copy of the original annotated transcript and cutting up the set of experiential statements so that each appeared on a separate piece of paper. By spreading these statements on a desk, I could rearrange them to explore different possible connections. Experiential statements were clustered together based on conceptual similarities, resulting in a coherent thematic structure (Appendix 14). This process involved iterative reviewing and refining to ensure statements accurately represented the parents' experiences. These clusters were then identified as participants' Personal Experiential Themes (PETs). For each transcript, a master table of PETs and their subthemes was created, listing the set of emergent statements and illustrative quotes used to develop them. This table helped in organising the data and provided a clear overview of the PETs, their sub-themes and the set of experiential statements that emerged from the analysis.

After analysing individual transcripts, a cross-case analysis (Appendix 15) was conducted to identify convergences and divergences across different participants' experiences, which helped in drawing out Group Experiential Themes (GETs). This process highlighted commonalities and unique aspects of the parents' experiences of their child's IPT-A.

2.11 Quality Assurance

In conducting this research, I adhered to Yardley's (2000) four broad principles of qualitative research: sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance. These principles guided each stage of the research process, ensuring the credibility, validity, and relevance of the study, as shown in Table 9.

Table 9

Yardley's (2000) four broad principles of qualitative research

Principles	Relevance to this study
Sensitive to context	According to Smith et al., (2022), sensitivity to context is evident in the early stages of the IPA research process, such as the careful comparison of other methodologies and the justification for choosing an IPA methodology. This sensitivity is reflected in IPA's detailed and idiographic approach. I demonstrated sensitivity to context by consulting with experts in the field, thoroughly reviewing literature on parental experiences of their child's intervention, and drawing on the philosophical framework of social constructionism in relation to my own personal and professional experiences (Yardley, 2000). During data collection, I was acutely aware of the sensitive nature of the topic. I conducted interviews with empathy and respect, recognising the emotional burden parents might carry. In interpreting the data, I remained mindful of the socio-cultural contexts that may influence the participants' experiences, as well as the power dynamics inherent in the researcher-participant relationship. This awareness helped me to present a nuanced analysis that accurately reflects the participants' voices (Smith et al., 2022).
Commitment and rigour	Commitment is closely linked to sensitivity to context and involves a deep and sustained engagement with the topic, as well as the development of research skills suited to the methodology and immersion in the participants' stories (Smith et al., 2022, pg. 221). Commitment to the research topic was demonstrated through my sustained engagement with the subject matter. I invested significant time in building rapport with participants at the start of the interviews, ensuring they felt comfortable sharing their experiences. The rigour of the study was ensured through the careful design of the research process, from the selection of participants to the detailed analysis of the data using IPA, by fully adhering to the IPA framework (Smith et al., 2022). To ensure the robustness of my findings, I engaged in reflexivity throughout the research process, constantly reflecting on my own potential biases and how these might influence the research. I also employed a systematic approach to coding and theme development, allowing for a deep and thorough exploration of the data. Regular supervision and peer debriefing were also utilised to maintain the analytical rigor and integrity of the study.

Transparency and coherence	Transparency was maintained through detailed documentation of each step of the research process. I provided a clear and comprehensive account of how the data was collected, analysed, and interpreted. The research process, from the formulation of the research question to the final analysis, was guided by a coherent epistemological framework grounded in social constructionism, which aligns with the principles of IPA. I have also demonstrated transparency through my personal relevance to the topic, as discussed in chapter 1, and my reflective diary extracts. The coherence of the research was evident in the coherent structure from the research question to the methodological approach and the resulting analysis. Each stage of the research process was connected to ensure that the final conclusions were well-supported by the data. With guidance from my supervisors, I thoroughly drafted and revised sections of the thesis, making necessary adjustments to enhance coherence of the information both within and across chapters. In presenting the findings, I aimed to create a coherent narrative that effectively communicated the complex experiences of the participants.
Impact and importance	The impact and importance of this research are significant in both academic and clinical contexts, particularly regarding the implementation and refinement of IPT-A interventions. This study contributes to the understanding of how parents perceive their involvement and experience during their child's IPT-A treatment. By highlighting these lived experiences, the research provides insights that can inform the enhancement of IPT-A protocols, ensuring they are more responsive to the needs and concerns of parents as well as the adolescents undergoing treatment. The research emphasises the importance of considering parents as partners in the therapeutic process, which could lead to more effective and holistic approaches to treatment. Effective dissemination strategies could involve sharing a summary of the findings with participants, presenting the results to local CAMHS teams and the broader IPT UK network, and engaging with parent support networks. Additional ideas will be explored with the research team to ensure the findings are accessible to both academic and non-academic audiences.

3. Results

3.1 Chapter overview

In this chapter, I present the findings obtained through an IPA framework (Smith et al., 2022). I present a range of shared experiences related to parental experiences of their child's IPT-A and highlight "areas of convergence and divergence across the individual cases" (Smith et al., 2022, p.110) to ensure a balanced representation of both common experiences and individual perspectives. My interpretation of the participants' accounts is influenced by the social constructionist epistemology guiding this research, as well as by my own personal and professional contexts. I provide a summary of the themes, highlighting four GETs and their subthemes (see Table 10). The findings are then discussed in more detail, where I aim to convey my interpretative understanding while staying rooted in the participants' narratives. Lastly, the recurrence of themes across participants is detailed in Appendix 16.

Table 10

Summary of GETs and their subthemes

GETs and subthemes
1. The struggles of navigating the mental health care system
2. Parental roles and boundaries in therapy 2.1. The extent of parent involvement in therapy evokes varied emotional responses 2.2. Acknowledgement of boundaries in therapy and appreciation of confidentiality
3. Learning points for IPT-A 3.1. Perceived benefits for the child alleviating concerns 3.2. Expressing profound changes in the family dynamic beyond the therapy encounter 3.3. Moving beyond therapy with new knowledge but caution 3.4. The vital role of the therapist

3.2 GET 1: The struggles of navigating the mental health care system

The experience of parenting a child with depression is accompanied by emotional strain, frustration, and a continuous struggle to secure adequate support. This theme outlines the challenges parents face within the context of parenting a child with depression. Across the narratives of all seven parents, a common thread emerged: the persistent challenge of navigating a mental health care system that often feels inadequate and unresponsive to their needs.

All parents reported significant struggles related to accessing support for their child. A common struggle for parents included long waiting times. Kevin elaborated on the inadequacies of previous therapy, describing it as *"awful"*, with his teenage child being unwell for a prolonged period. As a father, Kevin saw his role as a constant source of support, feeling responsible for checking in on his child's emotional state and pushing hard for assistance. His protective attitude is evident in his belief that it was his responsibility to *"sort out things for her"*, saying *"that's my job. I'm her dad".* This sense of duty intensified the emotional burden he experienced, particularly as he found himself *"stuck"* in a system that failed to provide timely care. Kevin's frustration with the long waiting times and his belief in his responsibility to 'sort things out' for his daughter illustrate the deep sense of obligation he felt as a parent. His role as a protector seemed to heighten the stress of navigating a mental health system that felt unresponsive. The struggle to fulfil this parental duty was compounded by a system that left him feeling powerless, further intensifying his frustration and emotional strain.

Similarly, Jacob focused on the stress and worry associated with his child's prolonged wait for therapy. He noted that *"the only downside was the wait"* and used a metaphor to highlight the difficulty of the long wait for his daughter to receive therapy:

"It was a bit like falling off a cliff". - Jacob

His narrative reflected a broader theme of anxiety and concern over the impact of *"long waiting"* on his child's varied mental health journey. The ongoing stress of waiting for treatment highlights the constant state of worry that these parents endure, exacerbated by the uncertainty and unpredictability of their child's mental health needs.

Kali also reflected on the mixed emotions of being on a waiting list, nevertheless she described herself feeling fortunate that her child had been offered IPT-A. Her awareness of long waiting times and the anxiety of trying anything shows the constant stress that comes with looking for effective treatment. Using Kali's words:

"I think at that stage we were willing to give anything a go. And I think the fact that you know I think she called us and we could see her like within a matter of like 2 weeks so yeah it was just we thought we'd give it a go we have nothing to lose." - Kali

The sentiment of having *"nothing to lose"* reflects the desperation felt by these parents in similar situations. Kali compared the current experience with previous difficulties in determining what works for her child, highlighting the stress that comes with the uncertainty of mental health interventions. Specifically, Kali noted: *"before we didn't know what works for him and you know, trying to sort of work that out was really stressful".*

Another common issue reported by several parents included previous negative experiences with therapy. Fran reported the struggle to secure appropriate support, reflecting a history of previous involvement in the mental health care system. Talia also recounted previous negative experiences with counselling, where a therapist's inappropriate behaviour—laughing at her child—left her child reluctant to start IPT-A. Despite this reluctance, Talia encouraged her child to *"give it a go and see"*, demonstrating her hope and

determination to find something that works. The urgency of her situation was evident, as she described a period before therapy when the struggles were so intense:

> *"cause it was getting to the point where, you know. This is awful to say, but I couldn't stand it. You know, and I think she felt like that as well."* - Talia

This narrative reflects the critical role that therapeutic support plays in alleviating both the child's and the parent's distress.

A particularly traumatic experience was shared by Gigi, where her child *"was left with so much"* after a negative encounter in an assessment session, ending up in a suicide attempt. She noted:

> *"They spent an hour talking together. I wasn't there. And then, yeah, she spiralled because she was left in amongst everything." – Gigi*

Faye also described a long and difficult journey through her child's mental health struggles, characterised by repeated attempts to find effective treatments; *"we've tried a lot of other things"*. The exhaustion felt by both parent and child from *"starting again and telling my story all over again"* is noticeable. For instance, Faye shared hers and her child's experience:

> *"You're having to lay all your feelings, or she's having to, and us to an extent, having to explain all, like some of the scenarios and the situations we've been through, and it's really mentally exhausting for her to go through that and then build up that relationship or so you do it with the doctor, and then you get somebody contact you from the crisis team. Then you've got to go through it all again."* - Faye

The emotional burden and sense of helplessness were noted among several parents. According to Kevin, the *"weight and frustrations"* of watching his child struggle, combined with a sense of helplessness, underscores the profound impact of his experiences. As Kevin noted:

> *"So, I think just for me, it's the weight and the frustrations of watching your child. You know, if she had a broken leg, I wouldn't leave her laying there for a week before I took her to A&E, you know? And you know, and she wouldn't be sent home with a broken leg. Now I totally get waiting lists. I totally get that. Just to sum up with one word, I find the whole thing really frustrating. However, once she's in, it's been really good. But that three, it was a long three years".* - *Kevin*

Adding to that, Gigi explained how her daughter *"was just stuck in this cycle"* and that *"even I couldn't see a way out of it".* Her statement suggests that she felt just as trapped as her daughter, recognising the challenges and sense of powerlessness that accompany such experiences. Despite these adversities, there was a sense of gratitude for receiving IPT-A quickly, as Kali also reported, though the emotional toll of past experiences continued to weigh heavily on her.

Similarly, Fran's emphasis on the word "hard" and repetition of similar phrases *"hard to say"*, *"hard to gauge"*, *"it's hard as a parent"* and *"it's very hard"* highlights the difficulty she experienced while parenting a child with depression. The phrase *"it's hard as a parent"* captures the emotional burden this journey has taken, underlining the ongoing difficulty in balancing hope with the reality of limited support.

Together with the emotional burden and sense of helplessness, some parents also expressed a willingness to try out any intervention to help their child, demonstrating a deep

commitment despite the challenges. For Kevin, the desperation to prevent his child from becoming ill again was noticeable, and his determination to do anything for his child illustrates the deep emotional burden he carries. Kevin highlighted in his own words: *"I'll do anything for my children"*. He also shared:

> *"I don't care what she has as long as it is the right thing and she gets better from it 'cause I'm desperate for her not to be ill."*

Fran echoes Kevin's view. Her willingness to *"try anything"* highlights the desperation and determination that often accompany parenting a child with depression. Fran shared:

> *"It's very hard because I think when you're a parent of somebody who's going through trauma, you are willing to try anything. In my mind. So, it wasn't a hard sell. If you see what I mean". - Fran*

Faye explained how *"we were just happy at that time to get any help from anybody who was going to sit down and invest the time with [young person]".* Faye's account was filled with apprehension about whether any therapy will be successful, given their history of unsuccessful interventions and her perception that mental health runs in her family. The feeling of being unsupported over the years, coupled with a sense of isolation due to the lack of a community of parents and adolescents facing similar challenges, adds to the emotional burden. Faye shared her reflections:

> *"I mean nobody's been able to share that. So as a carer for a young person, nobody… any of the therapies that she's had. Nobody's really been able to share from a family perspective what the learnings are, how you can, and I don't know if anybody has displayed the same things that [young person] has displayed. So, in a way, I feel a*

little bit like we're on our own, or she's on her own, or I don't know whether there's a community of people that are very similar to her, and how their families have, and they have managed to deal with it." - Faye

3.3 GET 2: Parental roles and boundaries in therapy

The second theme explores the varying levels of involvement parents experienced during their child's IPT-A and their emotional responses to this involvement. It also highlights parents' perspectives on therapeutic boundaries and confidentiality in therapy. This theme is divided into the following subthemes.

3.3.1 Subtheme 2.1: The extent of parent involvement in therapy evokes varied emotional responses

Parents expressed a range of emotions regarding their level of involvement in their child's therapy. This subtheme reflects the diverse ways in which parents navigated their involvement in the therapeutic process, revealing both the challenges and the positive outcomes of their participation.

Some parents felt excluded or frustrated by the limited involvement, leading to feelings of being left out of the therapeutic process and unsure about how to best support their child. For instance, Fran expressed a profound sense of disappointment and exclusion, articulating that the limited involvement left her uncertain about how to effectively support her teenage child. Her quote reflects a back and forth uncertainty, highlighting her frustration and confusion:

"Hmm I was advised by the practitioner that this was going to be used. Hmm and that I would be brought in at the middle and the end of the sessions to hmm to participate and for us hmm to be shown how to deal with [young person] and his… How I could

> *almost carry it on afterwards? However, at the end of the sessions, that didn't happen so hmmm. I suppose in one way I felt let down by that because it wasn't actually shown to me. [young person] is an older you know, he's 17 now hmm and doesn't communicate openly hmm about the sessions, so it was quite hard for me to gauge hmm how…What was happening in them, I suppose? hmmm He would share with me things like they discussed."* - Fran

The repeated use of phrases like *"hmm"* and *"I suppose"* in Fran's response highlights her uncertainty and the struggle to make sense of the situation, revealing the emotional impact of not being properly informed or involved. Fran seemed to have high expectations for her involvement in therapy, as evidenced by her repeated phrases like *"I was expecting to be called in"* and *"I didn't get the kind of final part I was expecting"*. The sentiment of *"expecting"* more but ultimately feeling *"let down"* underscores the emotional toll of being unable to gauge the progress or content of the therapy sessions. Her efforts to gauge what was happening in her son's sessions demonstrate her eagerness and willingness to be involved. Fran's experience highlights a common struggle among participants—an unmet desire to be more actively engaged, which in turn fosters feelings of inadequacy and helplessness. Fran's disappointment at not being more involved in her child's therapy highlighted the emotional complexity of parenting an adolescent in treatment. Her sense of frustration and confusion stemmed not only from the lack of involvement but also from her expectations of what her role as a parent should be. The tension she experienced—between wanting to be more actively engaged and respecting her child's growing independence—underscored the difficult balance parents must navigate as their children mature.

Similarly, Kevin voiced frustration over his limited role in the therapy, expressing his disappointment regarding the lack of communication and transparency from the therapist. His

statements reflect a deep sense of confusion and the frustration that comes from being left in the dark:

"I think for me it's just the frustration of not knowing a lot of things". - *Kevin*

"So I came out from therapy still not knowing and she never addressed it". - *Kevin*

The recurring theme of *"not knowing"* what's going on led to a deep sense of being unheard and left unsure. The uncertainty and confusion experienced by both Fran and Kevin illustrate the emotional toll of their limited involvement in the therapeutic process. Kevin's account illustrates the emotional burden of being kept on the periphery, where the lack of understanding about the therapy's focal points intensified feelings of confusion and disconnect within the family dynamic. Kevin reflected on the difficulty of sharing his perspective, either out of respect for the differing perceptions between him and his daughter or due to the limited opportunity he had to express his views. As Kevin put it in his own words *"you don't get your chance to say back"*. His inability to speak his truth during the sessions reflects a strong desire for greater involvement and clarity, which was met with disappointment and frustration. Kevin's respect for his daughter's privacy highlights a deep trust in the therapeutic process. However, the uncertainty about whether his approach was right reveals a tension between supporting the child's need for privacy and his own feelings of doubt about not knowing more details. This internal conflict, of wanting to do more while respecting boundaries, reflects the broader emotional complexity many parents face when balancing their role as caregivers with their adolescent's growing independence. Kevin's experience points to the challenges of navigating these ambiguous boundaries between being supportive and giving space, often leaving parents feeling unsure about the most appropriate way to engage in their child's therapy.

In contrast, Kali and Jacob experienced a more positive involvement in therapy. Kali was *"pleased with the experience"* and found that the level of parental engagement met her expectations. Kali seemed to be involved in conversations around *"what we want the outcome to be"* and *"the whole process was then reviewed at the end"*, emphasising that she felt included and heard. Kali's experience differs from those of Fran and Kevin, highlighting how different levels of involvement can either alleviate or increase parental anxiety.

Jacob articulated clear expectations for his involvement, with a routine presence at sessions and a debrief at the end. Although he noted that sometimes the handover was brief, *"sometimes there wasn't enough time to sit down and talk. But there was a brief handover, if you like"*, the overall perception of involvement was positive. Jacob's experience underscores the importance of consistent communication and the value placed on being informed, even if time constraints occasionally limited the depth of discussion.

Faye also expressed a good understanding of involvement, indicating that meeting with the therapist was a factor in her positive experience; *"it was good as a parent to meet [therapist]"*. These accounts suggest that when parents perceive their involvement as adequate and meaningful, it can enhance their satisfaction with the therapeutic process.

Talia experienced a complex emotional response to her involvement, finding it *"hard sitting there and listening to what [young person] and [therapist] had written and obviously getting the feedback"* and upsetting to witness her child's struggles. Despite the emotional difficulty, Talia remained committed to the process, recognising the importance of being there to listen and support her child. Specifically, she shared:

> *"as hard as it was for me to sit there and listen. You know, I did and it was hard and sometimes did get upset, but it was like, okay, yeah, I'm listening".* - Talia

Talia's statement seems to reflect how these parents feel a deep sense of responsibility for their child, leading them to care for and respect their child's needs, even when it is difficult for them as parents. She also described what it was like for her to be directly involved in some of the therapy sessions:

> *I was quite stressed. I think I sort of when I did come home, I did cry. Because it's you know these problems today but having it in front of you. And having to sit there and listen. I suppose I was a bit heartbroken. Maybe not heartbroken, this is a harsh word, but you know, I was very emotional about it. I probably did, you know, I felt to blame for everything, but obviously I wasn't. I think it affected me for a good few days because I couldn't stop thinking about it again. I was like, you've got to get over there. You've got to move forward. Otherwise that would have, I think, affected my mind and [young person]'s relationship even more". - Talia*

Talia's journey from initially feeling emotional and blamed to eventually seeing the benefits of her involvement mirrors an emotional growth. This transformation seems to involve an identity shift, where she moves from feeling overwhelmed and self-blaming to developing a stronger determination to improve her relationship with her daughter. It is though as she is reflecting on her past emotions and experiences, realising how far she has come, and using that understanding to drive her forward. This determination to *"move forward"* shows how Talia's discomfort with being involved in therapy turned into a stronger sense of purpose, leading to a positive change in her relationship with her daughter.

For Gigi, the involvement was seen as both relevant and necessary, matching other parents' narratives. She acknowledged that while these are ultimately the child's sessions, parental involvement added *"another layer of support for the child and reassurance for the parents"*. Gigi's perspective highlights the dual role of being supportive while respecting the

boundaries of the child's therapeutic space, a perception that resonates with the concept of balanced involvement.

3.3.2 Subtheme 2.2: Acknowledgment of boundaries in therapy and appreciation of confidentiality

For the second subtheme, the parents' responses reflect a range of perspectives on the importance of maintaining the child's privacy within the therapeutic process. Parents expressed an understanding of the importance of boundaries within the therapeutic relationship between their child and the therapist. This acknowledgment often came with a sense of respect for the child's need for privacy and autonomy in the therapeutic process, which in turn influenced how parents perceived their own role.

Many parents recognised the necessity for their child to have private, one-to-one time with the therapist to foster a sense of independence and ownership over their therapeutic journey. Both Fran and Kali respected the need for their child to have space without parental involvement, understanding that this autonomy was crucial for the child's development. Specifically, Fran reflected on her experience:

> *"[young person] is happy for me to normally be there, at the start of the session but doesn't you know he wants his independence now he wants to be able to have that open dialogue, I suppose, without me being there and I want him to have the space to do that". - Fran*

Fran's acknowledgment of her child's need for space reveals an emotional transition. Her struggle with letting go highlights a deeper sense of loss and adaptation. While she understands the importance of her child's independence, her willingness to step back likely involves a painful process of accepting her reduced role in the therapeutic journey.

Similarly, Kali's approach emphasised the core therapeutic relationship between the therapist and the child, while also recognising her supportive role:

> *"Yep, apart from that. We, my husband and I were not involved in it. It was purely between the therapist and [young person] which we felt was much better because [young person] got more out of it. Yeah. So we. We were there outside if he needed us or on the end of the phone if [therapist] wanted to talk to us about anything but it was between [therapist] and [young person]".* - Kali

Kali's experience suggests a different quality in how boundaries and independence are considered compared to Fran. Her approach reflects having faith in the process which itself might influence possible stress.

Kevin's experience further illustrates this theme:

> *"but she never goes into that detail and I never and I've always respected that. And I don't know if it's the right thing to do. So I don't know if she's annoyed that I never ask her more detail, but I see that as her safe space and her private space".* - Kevin

Kevin's respect for his child's privacy highlights a deep trust in the therapeutic process. However, his uncertainty about whether his approach is correct reflects a tension between supporting the child's need for privacy and his own feelings of doubt about not knowing more details.

Faye emphasised the importance of her child handling therapy independently, particularly given her child's teenage years. Faye acted as a support figure but consciously allowed her child to determine the extent of parental involvement:

> *"she wanted to have those sessions on her own. She knew that I would be happy if she wanted me or [father] in all of those sessions, but she was happy to have lots of those sessions on her own". - Faye*

Although not everything from the sessions was shared with her, she appreciated the importance of providing her child with a private space and felt content with the level of her involvement. She added:

> *"I don't in any way feel like we were left out the loop or kept in the dark, and as I say. It's really difficult when they're that they're almost on the cusp of being considered an adult. So you're not kept in the loop all the way through. But, [young person] you know we talk to her every week, but we wouldn't necessarily get a download on everything that they've done throughout that session". - Faye*

This acceptance highlights a nuanced understanding of the developmental needs of a teenager, where independence and privacy become more critical. The parents are not only coming to terms with their child becoming an adult but also dealing with this transition within the context of a therapeutic encounter. This situation may make these parents are more acutely aware of their child's independence, which is particularly challenging when the child is depressed. There is a noticeable tension between the need to let go and the uncertainty about the outcome of the therapy.

Many parents respected the boundaries of confidentiality, recognising that some matters would remain between the child and the therapist. Talia commented on her boundaries in therapy and confidentiality:

> *"So you know, and I was always kept informed of obviously what and the other thing was, you know, it was what [young person] said yes to, you know, so there was obviously there must have been things they spoke about which [therapist] was lovely*

> *and didn't tell me about. Which was obviously confidential to [young person]. You know, and I think that was another thing that made a big difference as well. Obviously if there were major concerns then she would have to say, but apart from the things that I was told, you know, everything else was confidential, which I think, helped [young person]". - Talia*

Talia respected her child's consent on what information could be shared. This respect for the child's autonomy in deciding what to disclose suggests a mutual trust and an understanding of the importance of preserving the child's agency in therapy.

In a similar respect, Gigi was very clear about the boundaries, reiterating that the therapy was for the child and that maintaining confidentiality was essential. She clarified, *"While I was involved, there was a very clear boundary as there should be of they were my daughter's sessions and so it was always, as it exactly as it should be, so yeah".* This clarity reflects a strong belief in the therapeutic process and the role of confidentiality in ensuring that the child feels safe and secure in their therapeutic environment.

Finally, Jacob understood that while he had some insight into the therapy, the primary focus of the sessions remained a private matter between the child and the therapist. In his own words, Jacob expressed his understanding that certain things were not meant to be shared, *"I think because of confidentiality between [therapist] and [young person], I think some things probably weren't shared".* His perspective reinforces the theme that confidentiality is not only respected but is also seen as a vital component of the therapy's success.

3.4 GET 3: Learning points for IPT-A

This theme encapsulates the insights and outcomes parents observed in their children, themselves, and their families as a result of the IPT-A intervention. This theme consists of the following subthemes.

3.4.1 Subtheme 3.1: Perceiving benefits for the child alleviating concerns

The first subtheme encapsulates the parents' observations and reflections on the positive changes their children experienced through IPT-A. These perceived benefits are central to understanding how parents gauge the effectiveness of the intervention and how it aligns with their hopes for their child's progress.

Parents observed a variety of positive changes in their child's emotional wellbeing, coping skills and overall behaviour. Kevin observed progressive improvements in their child, emphasising that the therapy allowed the child to *"get a lot of her chest that she wouldn't have done"*. This unburdening is framed as a significant breakthrough, resulting in a noticeable shift where good days outnumber the bad. Kevin referred to the positive changes in his child as *"the real highs and lows have disappeared"*. Kevin's narrative shows how much he valued the emotional relief his child has felt, while also being careful in celebrating the progress made.

In similar grounds, Kali highlighted the relaxed environment of therapy as a key factor in her child's ability to express themselves and develop coping skills. Kali noted a visible increase in the child's self-esteem and independence, crediting the therapy with equipping the child with tools that are actively used in daily life.

> *"So, he's now got the tools and techniques almost to, to deal with that. He's even in a much better place now. And if something tips the scales he knows what he needs to*

> *do. Yeah, so he, lacked like no self-esteem, no confidence. So all those sort of things were worked on and yeah, he just took it all on board". - Kali*

Kali used terms like *"equipped"* and *"positive change"* suggesting a sense of empowerment both for the child and for the parent, who sees these outcomes as a direct result of the therapeutic process.

Like Kali, Fran noted that her child has gained understanding and tools from therapy and discussed the *"repair and growth*" she had witnessed in her child. A recurring metaphor across narratives is that of tools or toolkit. Kali and Fran both referred to the therapy as providing valuable tools for coping and self-improvement. Nevertheless, Fran remained uncertain about whether learnt tools are consistently put into practice. This uncertainty highlights a common concern among participants about whether the progress made in therapy will last. It reflects their cautious hope, mixed with the anxiety of wanting the best for their child.

Faye also expressed uncertainty, but in a different way. Although Faye recognised improvements in her child, she expressed uncertainty about whether these changes can be attributed solely to IPT-A or to a combination of therapy and other life factors. This ambivalence highlights an understanding that therapy is not separate from external events or influences and that its benefits might be intertwined with other aspects of the child's life. Yet, Faye's acknowledgment of the child becoming *"much more reflective"* suggests an appreciation for the introspective skills the child may have developed through therapy.

Talia spoke to the *"big impact"* therapy has had on her child, particularly in terms of increased confidence and the ability to express emotions. She noted:

> *"it has a big impact on her changing and I think it's given her more confidence to you know getting over all the issues that she did have, you know, in a way that wasn't sort of, that's sort of easier for her to deal with". - Talia*

She valued the structured nature of IPT-A, which she believed has helped her child actively resolve issues and engage in goal-oriented behaviour. Talia's emphasis on the child having *"a more active role"* suggests a shift in the child's agency, which in turn has fostered a more open and relaxed demeanour. This narrative reflects a parent's satisfaction with the tangible outcomes of therapy, particularly in fostering a sense of empowerment in their child.

Gigi observed that the child still refers back to the therapy and therapist, indicating that the impact of IPT-A has been enduring. Gigi noted that the action-oriented steps of the therapy were particularly beneficial, contrasting this with more traditional "listening therapies". The ongoing references to therapy in the child's life suggest that the skills and strategies learned have been integrated into the child's day-to-day experience, which Gigi viewed as a key success of the intervention.

Similar to other parents, Jacob described the child's progress by using particular life examples and noted significant changes in the child's outlook, aspirations, and social interactions. He uses a metaphor to describe the feeling of moving up and making progress, suggesting that therapy has been important in improving the child's mood and creating new opportunities.

> *"It was the kind of start of, you know, the bottom of the hill when she's, you know, still climbing it. But if she hadn't had that to start with, you know, it would have been a much longer journey". - Jacob*

Jacob's story is full of hope, showing that therapy has been a life-changing experience that has helped the child re-engage with life. There seems to be a shift in the meaning ascribed to

Jacob's child's mental health. While the journey is still ongoing, it appears less stuck and moving, which can be alleviating in its own right.

3.4.2 Subtheme 3.2: Experiencing profound changes in the family dynamic beyond the therapy encounter

The second subtheme emerges as parents reflect on how their child's participation in IPT-A not only influenced the child but also brought significant changes to the family dynamic. The parents' experiences reveal how the therapeutic process extends beyond the individual, shaping family interactions, communication, and overall well-being.

Parents reported gaining insights into their child's experiences and learning how to better support them. For example, Kali described how the therapy equipped the family with the tools to better meet their child's needs. She noted the importance of prioritising her child's needs, which had a profound impact on family life.

> *Yeah, so I think, you know. If he still gets angry, like, you know, I want to go out and meet family, like on Sunday, he had a blow up. He didn't want to do it. He wants to sit at home on his gadgets and things. So, it's just giving him that time to calm down. So, I guess that and I know that he has to go and have his 5 min of calm time. And then you try again. I think that's the benefit really is that I recognise that he's got to do what he needs to do to then have the outcome that we all want".* - *Kali*

This view was shared by Gigi who focused on the importance of having the right tools to "*bring awareness in a productive way"*. This suggests that the therapy provided practical strategies that Gigi could apply in daily life, leading to more effective parenting and a more supportive environment for the child.

Kali also mentioned that the changes in her child had a significant impact, improving the overall family dynamic; *"Now, he knows what works for him. It makes it much better for*

the rest of us". This highlights how therapeutic progress in the child can lead to a more harmonious family environment, reducing stress and enhancing familial relationships.

The improvement in the child's mental health created a better atmosphere at Jacob's family home, demonstrating how a child's well-being was closely connected to the family's overall mood. In his narrative, Jacob highlighted the positive emotional impact on the parent, noting that seeing his child improve reduced his own stress and worry, which in turn benefited the entire family. As Jacob shared:

> *"It's the thing when your daughter seems to be improving or is improving. It makes a difference to you because you become happier as well. You're not kind of as stressed and as worried. You will still be stressed and worried, but it wouldn't be as stressed and worried, I suppose. And it had a whole impact on the whole family. What she does and how her behaviour is kind of affects us all in some way. So, when we see improvements, I think everybody, I think the whole atmosphere in the house is better, you know generally". - Jacob*

Talia shared a profound impact on the mother-daughter relationship, with therapy creating a space for understanding and connection. Talia learned to give the child more independence and responsibility, recognising the need to step back and allow the child to express herself. This shift in parenting style led to a calmer household, as the parent became more attuned to listening rather than controlling. The therapy, in this case, seems to have facilitated a mutual understanding that strengthened their bond.

> *"I think that's the biggest thing is me and her. Spending time together, you know, and going forward is making that time". - Talia*

> *"Just listen, you know, that is a big thing for me is listening and spending time with [young person], you know, just for me and [young person], you know, because*

> *sometimes you just get lost in everyday life, don't you and you know [other son] is so hyper, one that doesn't stop, he gets everything and then it's like, well, you know, this is for me and [young person]. We do enjoy having that time together". - Talia*

For other parents, therapy provided a space for better communication and understanding. Kevin emphasised the importance of creating space for open communication, allowing him to *"get across things"* and enabling his child to *"hear a lot more from our perspectives"*. He described learning to *"pick our battles"*, indicating a shift in their approach to parenting—choosing when to intervene and when to allow the child to navigate challenges independently. This reflects a deeper understanding of their child's needs and the importance of supportive involvement.

Faye also spoke to the increased communication facilitated by the therapy, which made her "*more accommodating"* to the child's needs. However, she attributed much of her learning to personal experience rather than the therapy itself, suggesting that while therapy provided a framework, real growth came through lived experience and ongoing family adjustments.

Finally, Fran discussed the indirect benefits she experienced, expressing that while the primary focus was on their child, she gained a full understanding of what their child was going through. This suggests that Fran felt more connected to their child's emotional world, which may have fostered a sense of empathy and alignment with her child's needs.

3.4.3 Subtheme 3.3: Moving beyond therapy with new knowledge but caution

Despite the positive outcomes, parents also reflected on the ongoing journey after IPT-A. The final subtheme delves into the parents' perspectives on their journey beyond the structured intervention of IPT-A, revealing a mix of satisfaction, existing concerns, and hopes for continued progress.

Some parents felt unequipped for the future following the end of the intervention. Fran expressed a sense of incompleteness, feeling that the therapy ended too suddenly without a clear plan for what to do next. She didn't have the opportunity for final reflection and closure, leaving her unsure about how to support her child in the future.

> *"I mean he had the last session and I was expecting to be called in. And then it's kind of like well hmmm it just, the time was up. That was it. Thank you very much. It's very nice to meet you type of thing. And I was a bit like and I'm probably not pushy enough to say, oh, I thought I was going to be called in or offered something. Hmm, so yeah I'm not sure if it was the therapist was moving on as well".* - Fran

The absence of a final session left her uncertain about how to support her child moving forward, with Fran noting, *"I didn't feel better equipped, but my child did"*, showing a split between the child's perceived progress and the parent's ongoing uncertainty. This suggests that while the therapy may have offered tools to the child, the parent's need for closure and guidance on future steps was unmet, leaving her with unanswered questions.

Kevin articulated a similar struggle, emphasising that his learning primarily stemmed from lived experiences rather than the intervention itself. Kevin voiced a desire for more education and understanding, particularly in identifying the root causes of his child's issues. The ongoing challenge of supporting his child, together with the pressure it places on him as a parent, highlights the need for more comprehensive post-therapy resources. Kevin clearly stated that although *"progress was made, we've still got some rough times ahead. I'm sure we have"*. His acknowledgement captures how many parents in this sample felt both hopeful about the progress and worried about the future. Yet, Kevin recognised that *"rough times are few and far between compared to what they were before she saw [therapist]"*. A key moment

for Kevin was when he questioned his own knowledge and expressed a strong desire to learn more. At the same time, he acknowledged that it's not always possible to know everything.

> *"Sometimes I do think like how much do I know? Do I need to know more? You know? But, you know, I do sometimes think, oh, I wish I knew more. But you can't sometimes, can you?". - Kevin*

His words reveal a combination of self-doubt and an urge for greater knowledge, along with a recognition of the limits of what one can know.

For Kali, the situation appears more optimistic. She felt adequately equipped to continue using the tools and skills learned during the intervention, attributing her confidence to both the therapy and her prior understanding of the problem. Her experience suggests that when therapy aligns well with a parent's pre-existing knowledge and coping strategies, it can reinforce their confidence in managing their child's condition after therapy.

Faye expressed a more cautious outlook, questioning whether the therapy had fully addressed her child's depression or if other underlying issues remained unresolved.

> *"it's not really changed the fact that she still gets depressed. I'm not really sure whether that therapy has necessarily worked for [young person], but it may just have been that it was medication that she did need all along to change the brain pattern. We don't really know, and it's almost difficult to say right now whether that has had an impact, we probably need to see how the medication works. We possibly need to see over the next couple of years when her brain continues to mature into an adult, and she looks back historically and then goes actually, some of that, I do think now on reflection, was really helpful. So it's almost difficult to say. - Faye*

Faye also highlighted the importance of continuity in therapy, suggesting that the benefits observed might require ongoing support to be fully comprehended.

On the other hand, Gigi acknowledged that while the therapy *"didn't fix everything"* both her and her child were happy with the clarity provided by the therapist regarding the goals and structure of the sessions. As Gigi said:

> *Did it fix everything? No. But then [therapist] was very clear from the start, that wasn't going to be the case. And she was also very clear that it was only for that period of time. And I think that was incredibly important for my daughter because she knew from the start that. I said to her, you're likely to feel very attached to this practitioner, because when somebody's helping you with something, you've struggled so much with, you feel that connection. But it was really cleverly done".* - *Gigi*

Gigi and her teenage child continued to make reference to the therapist and therapy in family conversations post-intervention, which indicates that the therapeutic relationship left a lasting impact, providing a sense of ongoing support even after the sessions ended.

Talia's narrative matches Kali's optimism, expressing deep gratitude and satisfaction with the intervention. She shared, *"it really was such a big thing and I can't thank them enough for helping both of us really, you know"*. She noted that her child had learned how to deal with situations better, which in turn helped her cope more effectively. This positive reflection indicates a strong belief in the efficacy of the therapy, suggesting that for some families, IPT-A can lead to significant, lasting improvements in both child and parent well-being.

Finally, Jacob recognised that while progress had been made, there were still steps to take forward. He used a metaphor to describe her daughter's journey to recovery.

> *"Obviously, as I say it was, it was only the start and you know, she's still on that road at the moment, but hopefully it's higher up the hill".* - *Jacob*

I interpreted his metaphor as indicating that the journey towards improvement or recovery has just begun. While there is still progress to be made, there is hope that she has already made significant progress. The *"hill"* potentially represents the challenges she is facing, and being *"higher up"* suggests that she is in a better position now than before, even though the journey is not yet finished.

3.4.4 Subtheme 3.4: The vital role of the therapist

In this subtheme, parents consistently emphasised the pivotal role that the therapist played in their child's experience with IPT-A. Across parents' narratives, the therapist emerged not only as a facilitator of the therapeutic process but also as a key figure whose personal qualities and approach deeply impacted both the child and the parents.

Several parents reported initial trepidation and caution regarding therapy, which was addressed by the therapist. Kali highlighted how the immediate connection between the therapist and her child fostered a sense of trust in the therapeutic process itself, which in turn reassured her. Although Kali felt limited in discussing her child's communication with the therapist because she wasn't involved in every session, she was still able to comment on the therapeutic relationship and share her perspective:

> *"You know, he did get on very… very good rapport with her and he was able to open up. Which is obviously a really big hurdle in the first instance to actually find a therapist that you get on with. You're able to see a good rapport with the therapist. Yeah, it was pretty good. Yeah, definitely because that was, that's always a concern".*
> *- Kali*

This sentiment was echoed by Kevin, who praised the therapist for being *"brilliant"* and for developing a strong, child-centred approach that respected the child's autonomy. The trust that developed between the therapist and the child was seen as a foundation for the

entire therapeutic journey, influencing the parents' perception of the therapy's effectiveness. This was evidenced by Kevin's words,

> *"I probably walked in there a bit grumpy and a bit sceptical. I won't lie. I walked out of there really happy with this. This lady had looked after my daughter, had got her totally and had done a tremendous job with her. It appeared and they had a real, you could tell they had a really good rapport that you could tell. [young person] really trusted her".* - *Kevin*

Similarly, Talia reflected on how her daughter's ability to build trust with the therapist was crucial, especially given her prior negative experience. The trust established with the new therapist represented a significant positive shift:

> *"Because whatever [therapist] did, [young person] was happy to go with it. And I think that was a big thing for [young person], especially after last time you know, and I think the biggest thing was that she trusted her. Yeah, [young person] trusted [therapist]. I think, having that trust was the biggest thing".* - *Talia*

The therapist's ability to address initial concerns and foster a strong, trusting relationship was a source of reassurance and relief for these parents. This trust and the therapist's qualities played a crucial role in overcoming initial apprehensions and appeared to contribute to the perceived effectiveness of therapy.

Jacob described how the therapist's *"engaging and approachable"* manner helped their child bond well with the therapist, noting the importance of this relationship in the overall success of the therapy. This bond was further reinforced by shared characteristics, such as similar age, which Jacob felt contributed to their child's comfort and connection with the therapist.

> *"I'd say [therapist] was very good, very patient with [young person]. I think as well they kind of bonded very well together. So, I think that's the main thing I think it's very important, for the therapist and the patient to kind of bond. Because you, you know, there's a lot of stuff, personal stuff that you have to cover. I think if it had been, I don't know, I have this feeling that if it had been say for example maybe an older person doing the therapy, that might not be the case. I think because she was kind of young in her outlook, it fitted well with [young person], it was really quite good and she certainly came across as quite confident". - Jacob*

The personal qualities of the therapist were frequently mentioned as contributing to the parents' confidence in the therapy. Faye appreciated the therapist's *"softly spoken"* manner, which made her feel comfortable leaving her child *"in good hands"*. This sense of security was important for the parents, who often struggled with the vulnerability of trusting their child's mental health to another person.

Gigi emphasised the significance of the therapist being *"non-judgemental and professional"*, describing the relationship as being like *"having a third parent involved"*. The therapist's ability to clearly communicate and provide consistent support was valued highly, particularly when navigating the complexities of a teenager's mental health. Gigi also clearly reflected on the dual importance of both the therapist and the therapeutic process, stating, *"I think it was so effective because of the lady who was conducting the sessions. So, it's like 50/50. Yes, I think IPT-A is effective but equally so it was the lady conducting the sessions as well".* This indicates how intertwined these elements are in creating a successful therapeutic outcome. Gigi described the therapist as a 'third parent', reflecting how central the therapist became in her child's journey. This role seemed to go beyond the typical professional boundaries, with the therapist acting as an essential figure in both the child's and the family's life. The trust and reliance placed on the therapist illustrate the profound impact of the

therapeutic relationship, as well as the shift in family dynamics when an external figure plays such a pivotal role in the child's well-being.

Many parents also noted the importance of the therapist in empowering their child through a child-centred approach. Talia appreciated how the therapist not only listened to the child but also understood the broader family context, which was essential for building trust. Specifically, Talia mentioned that she couldn't always be present because she also had a son with a neurodevelopmental condition. She appreciated how the therapist listened to and understood the challenges this created, which was helpful. This approach was significant for Gigi as well, who highlighted how the therapist ensured the child had ownership over the therapy process, which was particularly important given the vulnerabilities associated with adolescence. The notion of the therapist as a *"middle person"* who could bridge the child's experience with the family context was vital in creating a holistic and supportive environment for the child's recovery.

The presence of a consistent, supportive therapist was a source of stability for both the child and the parents. Fran simply acknowledged the importance of *"having a supportive therapist"*, while Faye and Gigi emphasised the role of the therapist in maintaining continuity and providing constant reminders, which was crucial as the therapy was coming to an end. Gigi reflected on her experience from her daughter's perspective:

> *"I think my daughter said she didn't feel like she was just dropped. It wasn't like, right. You finished the sessions. Off you go. There was constant reminder of, OK, well, we've got three sessions remaining and in those sessions… so I know that's probably general practise but it works, and particularly with teens, I think they could very easily become overly dependent on somebody. They're vulnerable. So yeah, I thought that would… she would definitely say that it was a good experience".* - *Gigi*

This consistency seems particularly important among participants in mitigating the anxiety and uncertainty that often accompanies mental health treatment for teenagers.

Kevin used a metaphor to describe how the therapist has helped stabilise his child's emotional state.

> *"I think [therapist] has definitely steadied the ship. She's definitely steadied the ship and got her into the calmer waters as she was definitely in the choppy sea".* - Kevin

I interpreted Kevin's metaphor as describing how his child was once struggling, like being in *"choppy seas"*, which symbolised a turbulent and difficult time. By *"steadying the ship"*, the therapist has helped guide the child into *"calmer waters"*, representing a more peaceful and stable period in her life. This metaphor illustrates the positive impact the therapist has had in helping the child move from a place of distress to one of calm and stability.

4. Discussion

4.1 Chapter Overview

This chapter summarises the findings on the experiences of parents of their child's IPT-A, comparing them with the broader literature. I critically assess the study and discuss potential wider and clinical implications, and suggestions for future studies. The chapter will conclude with my reflections on the project.

4.2 Summary of findings

The thesis aimed to explore parents' experiences of their child's IPT-A intervention. Specifically, it aimed to answer the following research questions:

1) How do parents make sense of their child's IPT-A intervention?

2) How do parents perceive their involvement in their child's IPT-A intervention?

3) What are the perceived positive and negative aspects of the IPT-A intervention as experienced by parents?

Seven parents were interviewed for this IPA study. The analysis revealed three central themes and their respective subthemes, including the struggles of navigating the mental health care system, parent roles and boundaries in therapy and learning points for IPT-A. These themes reflect the complexities and emotional journeys parents undergo while supporting their child through therapy. These themes also touch upon the roles of parents in the therapeutic process and the perceived effectiveness of the IPT-A intervention.

4.2.1 The Struggles of Navigating the Mental Health Care System

Parents navigated a challenging emotional journey. Many parents expressed feelings of frustration and helplessness, describing long waits for therapy and previous negative experiences with mental health services. These findings align with existing literature that highlights the significant emotional burden parents carry when their child is dealing with depression (Armitage et al., 2020; Stapley et al., 2016). Moreover, these findings correspond with wider research suggesting that parents often feel lost and frustrated while navigating the mental health care system (Seney, 2024). Parents also described the challenges they faced in securing appropriate support for their children. The struggles parents faced in securing timely and appropriate support for their children resonate with broader concerns about access to mental health services (Chukwuere et al., 2022; Larsen & Stege, 2010). Parents in this study often felt the weight of responsibility and a sense of urgency in finding effective interventions, reflecting the parental drive to alleviate their child's distress.

Despite these challenges, parents were determined to do whatever it took to help their child, often feeling the weight of their child's struggles and the stress of navigating a complex mental health system. Parents' willingness to try anything for their child might be explained as part of their natural fight-flight-freeze response (Gilbert, 2013). In this "survival mode", parents may become focused on doing whatever it is necessary to protect and support their child, even if it means sacrificing their own needs. Parents in this study demonstrated resilience and a willingness to engage with the therapeutic process, even when their expectations were not fully met. This reflects the broader literature on parental involvement in therapy, which suggests that while parents are eager to support their child, they often face systemic barriers that hinder their ability to do so effectively (Reardon et al., 2017). The

emotional toll described by parents in this study highlights the need for greater support and communication with parents throughout the therapeutic process.

In addition to the emotional challenges and difficulties in the system that parents face, a social constructionist lens allows us to understand how society's views on mental health, especially depression, affect parents' experiences and what they expect from care. The notion of "long waits" and "inadequate support" can be seen not just as individual frustrations, but as reflections of how mental health systems are set up in a way that often emphasises clinical and diagnostic approaches instead of focusing on the whole family's needs. When parents feel "stuck" in the system, it may reflect a societal belief that mental health services should be the main source of expertise, which limits parents' ability to take charge of their situations. This situation highlights the need to see mental health care not just as a service but as a part of society that can make parents feel like outsiders, increasing their feelings of helplessness and frustration.

4.2.2 Parent roles and boundaries in therapy

Two subthemes emerged regarding the role of the parent in therapy. The first subtheme highlighted the different emotions parents experienced based on the extent of their involvement in the therapy process. The second subtheme emphasised the acknowledgment of boundaries and the appreciation of confidentiality within therapy.

The findings of this study contribute to the existing body of literature on parental involvement in adolescent therapy by providing a detailed understanding of parents' experiences of their child's IPT-A. While previous research has highlighted the significance of parental involvement in reducing child depressive symptoms (Dardas et al., 2018), this study emphasises the emotional complexity and varying perceptions associated with such

involvement. The findings reveal mixed emotions regarding parental involvement in IPT-A. Some parents felt excluded or disappointed by their limited involvement, while others felt their participation was sufficient and valued. The findings are associated with varying parental experiences from the wider literature, suggesting that although some parents described an isolated involvement in which they were not informed by professionals (Andershed et al., 2016), others felt that their involvement in their child's therapy enabled them to gain new insights and skills to better support their child (Chlebowski et al., 2018; Frauenholtz & Mendenhall, 2020; Green et al., 2023; Weaver et al., 2019).

Parents' perceptions of their involvement in therapy and its impact on their relationship with their child can be understood through the lens of attachment theory (Bowlby, 1969), which highlights the crucial role of the parent-child bond in shaping a child's emotional and psychological development. Specifically, parents who reported frustration and feelings of exclusion might have experienced a disruption or perceived distance in their bond with their child, leading to anxiety or helplessness. On the other hand, parents who had positive experiences, such as improved communication and a stronger bond with their child, may have reinforced their secure attachment by working together in therapy. The different emotions experienced by parents regarding their involvement in therapy supports the need for tailored approaches to parental involvement compared with one-size-fits-all assumptions. Parents who felt excluded, expressed frustration and a lack of understanding which can negatively impact their ability to support their child outside of therapy (Andershed et al., 2016). This finding is consistent with research indicating that effective communication between therapists and parents is crucial for fostering a collaborative therapeutic environment (Schlimm et al., 2021).

These experiences also highlight the tension between parents' willingness to be involved and the need to respect the adolescent's autonomy and confidentiality in therapy. This tension is well-documented in the literature, where parental involvement is both valued and seen as potentially intrusive (Cresswell et al., 2021; Gondek et al., 2017). Another study has reflected the importance that the degree of parental involvement is adjusted based on the child's age and ability (Liverpool et al., 2020). Parents in this study recognised the importance of their child's private space in therapy and respected the boundaries set between the therapist and their child. The appreciation of these boundaries by parents in this study suggests that they recognise the therapeutic benefits of giving their child space, even as they navigate their own anxieties about not being fully informed.

From a social constructionist viewpoint, the struggle between how involved parents should be and respecting their adolescent's independence reflects larger societal ideas about parenting and adolescence. Society often sees parents as the main protectors and problem-solvers, especially when it comes to health issues, which can create conflicts when these roles are limited in therapy. This can be especially tricky in mental health situations, where society expects parents to take responsibility, but therapy often emphasises the adolescent's right to privacy. The findings of this study show that parents must balance their relationship with their child and the societal pressures about their role as caregivers. For some parents, moving from being a protector to just an observer can be confusing and challenges the traditional ideas of parental authority.

4.2.3 Learning Points for IPT-A

This theme was divided into four subthemes: "perceiving benefits for the child alleviating concerns", "experiencing profound changes in the family dynamic beyond the

therapy encounter", "moving beyond therapy with new knowledge but caution", and "the vital role of the therapist".

Parents in this study observed various positive changes in their child, including improved confidence, ability to express their emotions, and acquisition of coping skills. These outcomes are consistent with existing research on the effectiveness of IPT-A in treating adolescent depression, which highlights the therapy's ability to enhance interpersonal functioning and reduce depressive symptoms (Mufson et al., 1999, 2004, 2018; Roselló & Bernal, 1999). Parents in this study observed positive changes in their child, which not only benefited the child but also had a positive impact on the entire family dynamic, leading to improved family communication and reduced stress within the household. This can be interpreted through Bowen's Family Systems Theory (1978) suggesting that when one family member changes their behaviour, it can lead to changes throughout the entire family system, promoting healthier dynamics and better coping mechanisms for all members involved. Additionally, the impact on family dynamics reported in this study aligns with previous studies showing that successful therapy for adolescents can lead to improved family relationships and reduced parental stress (Chlebowski et al. 2018; Goodkind et al., 2014).

However, parents also reflected on the future, with some feeling well-equipped to continue supporting their child, while others expressed concerns about ongoing challenges and the need for continued support. This echoes broader concerns in the literature about the need for ongoing support and follow-up after therapy ends to ensure sustained benefits (Hart et al., 2004). Also, the ongoing challenges after therapy, as reported by parents suggest that there is a need for a more comprehensive approach to support post therapy. This includes providing parents with tools and strategies to continue supporting their child's mental health, which is an area that has been identified as crucial in various studies (Chan et al. 2023;

Chlebowski et al. 2018; Muller et al. 2024). Parents in this study expressed hopes for continued progress beyond the IPT-A intervention, viewing therapy as just one part of a longer journey. This perspective is consistent with the broader literature, which indicates that recovery does not have a clear or defined endpoint (Anthony, 1993; Leamy et al., 2011; Searle et al., 2014). The study's findings highlight the importance of considering the family context in therapy and ensuring that both the child and the parents feel adequately supported throughout and after the intervention. As a researcher using an interpretivist approach, I aimed to understand and make sense of participants' views, rather than merely describe them. For instance, when parents expressed frustration over a lack of resources or asked for more information about their child's therapy, I interpreted these views as reflections of their unmet needs for support and understanding. Their requests for more resources could reflect a desire to be more involved in the therapy process and feel more valued. This pointed to a larger issue in how mental health support is provided. By interpreting their views this way, I could see their requests not just as immediate concerns, but as part of a bigger picture of how they experience mental health services. This aligns with the social constructionism view that people's experiences are shaped by the larger social systems they are part of.

Parents consistently highlighted the crucial role of the therapist in their child's progress. The relationship between the child and therapist was considered essential for successful therapy. Many parents praised the therapist for their understanding, support, and ability to build a trusting rapport with their child. The therapist was often viewed not just as a professional but as a significant figure who played an important role in their child's sense of safety and progress in therapy. The positive impact of the therapist, as reported by parents directly aligns with the concept of therapeutic alliance, suggesting that a strong therapeutic alliance between the child and the therapist is a key element in the process of therapy and in facilitating change (Capella et. al., 2015). Parents highlighted several key qualities in the

therapist, such as being non-judgmental, understanding and supportive. The qualities align closely with Roger's (1959) person-centred approach, which posits that for an individual to "grow", they require an environment that offers genuineness, acceptance and empathy. The emphasis parents placed on the therapist's ability to listen and validate the child's experience suggests that the therapist created a therapeutic environment where the child felt respected and valued. This likely contributed to enhancing the child's self-esteem and promoting therapeutic progress. Social constructionism encourages us to consider how societal views on mental health, therapy, and recovery shape parents' experiences and expectations of IPT-A. For instance, the importance placed on the therapist's role in helping their child improve reflects the common belief that mental health professionals have special knowledge and power to create change. Parents' high opinions of the therapist suggest they see the therapist as an authority figure, highlighting a social hierarchy where they rely on the therapist's expertise. This dynamic supports the idea of the therapist as a "third parent", where the therapist not only helps the child but also plays a role in family dynamics. Seeing the therapist as a parental figure shows how therapy relationships can mirror and reinforce societal roles, with therapists having a unique level of authority and influence.

Moreover, the study adds to the literature by highlighting the importance of the therapist's role, not just in the therapeutic process but in shaping parents' perceptions of the effectiveness of the intervention. The therapist's ability to build trust and rapport with both the child and the parents was seen as a critical factor in the success of the therapy. In child and adolescent therapy, the therapeutic encounter is seen as more than just a two-person relationship; it involves multiple layers of relationships—one between the child and therapist, and others between the caregivers and therapist (Gvion & Bar, 2014; Karver et al., 2018). These interconnected relationships can be understood as a triadic relational connection, where each relationship influences the others (Gvion & Bar, 2014). The strength of the relationship

between parents and therapist is connected to the parents' level of commitment and the support they provide outside of sessions, which in turn impacts the child's progress in therapy (Kazdin et al., 2006; Marker et al., 2013). A strong alliance with parents is linked to better parenting skills and enhanced family interactions (Kazdin et al., 2006), and it also affects the quality of the therapeutic alliance with the child (Campbell & Simmonds, 2011; Kazdin et al., 2006). This finding underlines the need for therapists to actively engage with parents, even when the primary therapeutic focus is on the child, to ensure a supportive environment that extends beyond the therapy sessions.

The above findings touch upon an important aspect of psychotherapy research; the debate over what factors most significantly influence therapeutic outcomes (Sprenkle & Blow, 2004; Wampold, 2015). The therapeutic alliance is considered a "common factor" and has been widely researched in psychotherapy (Horvath, 2017). Parents in this study emphasised the significance of the therapeutic alliance and therapist factors in contributing to the effectiveness of the intervention. Consistent with broader literature, this indicates that the effectiveness of any specific therapy model largely depends on the quality of the therapeutic relationship (Blow & Karam, 2017; Norcross & Wampold, 2011). It also reflects the findings of common factors in the literature (Friedlander et al., 2018; Wampold & Imel, 2015), which argue that the specific therapeutic model or technique may account for less of the variance in outcomes compared to the therapeutic relationship and therapist factors. In other words, the findings from this study suggest that while IPT-A as a model provides a framework for intervention, it is the interpersonal elements—such as the therapist's approach and the relationship with the child, therapist and parent—that might account for a significant portion of the positive outcomes observed.

The emphasis that IPT-A places on improving interpersonal relationships might explain why the therapeutic alliance was seen as so crucial by the parents in this study. IPT-A's structured approach to addressing interpersonal issues and enhancing communication potentially contributed to the positive changes that parents observed in their children. This focus on relationships is consistent with parents' reports of improved family dynamics and suggests that the model's relational emphasis is not only effective in treating adolescent depression but also in fostering healthier family interactions. Furthermore, IPT-A's focus on helping adolescents navigate significant life changes and transitions might account for the perceived benefits parents observed in their children. By addressing life events that contribute to the child's depression—such as changes in school, friendships, or family dynamics—IPT-A provides adolescents with tools to manage these transitions. However, the mixed feelings parents had about the sufficiency of IPT-A in addressing all their child's needs could suggest that while the therapy effectively tackles specific interpersonal issues, it may need to be complemented with additional support mechanisms to address ongoing or more complex challenges.

4.3 Clinical implications

The findings from this study offer valuable insights into parental experiences, with clinical implications to enhance the delivery and effectiveness of IPT-A therapy for parents. Some parents in this study expressed a desire for greater involvement and more communication regarding their child's therapy. Barrett's theory highlights the interconnectedness of awareness, choices, intentional actions, and involvement in creating change as a sense of power (Barrett, 2010). The limited involvement in their child's therapy may have left the parents in this study feeling powerless in their role of supporting their adolescent. This aligns with another study where parents often felt powerless due to a lack of

understanding of mental health issues, which contributed to ineffective management of their youth's mental health and served as a direct obstacle to recovery (Kelly & Coughlan, 2019). Clinicians should consider tailoring parental involvement to each family's unique needs, balancing the young person's need for privacy with the parent's desire for understanding. Joint sessions, where parents and adolescents can address issues together, have been shown to strengthen family relationships (Dardas et al., 2018), and many parents value a flexible approach that allows them to support their child effectively (Creswell et al., 2021). This involvement might include regular updates, participation in joint or individual sessions, and understanding the therapy to aid their child outside of sessions (Cardy et al., 2020).

Therapists could benefit from working collaboratively with families to set realistic expectations for therapy and provide space for parents to express their concerns and hopes. The findings from this study suggest that managing parental expectations can potentially help reduce frustration and enhance engagement in the therapeutic process. Moreover, parent involvement could extend beyond merely attending therapy sessions. For instance, parents might take on a facilitator role (Stallard, 2002), encouraging their child to practice newly learned coping strategies at home. Additionally, therapists could consider treating parents as co-clients (Stallard, 2002), offering them psychoeducation about depression and addressing both supportive and potentially counterproductive parental behaviours.

The findings also revealed that parents often experience significant anxiety and stress due to their child's condition and their role in the therapeutic process. Therapists should be mindful of this emotional toll and actively listen to parents' concerns. The emotional burden on parents highlights the potential value of additional support mechanisms, such as psychoeducation, support groups and consistent communication with therapists. Structured psychoeducation programs could educate parents on child development, positive parenting,

and coping strategies, which might lead to better outcomes (Jones et al., 2018; NICE, 2013). Family psychoeducation may enhance parent's understanding and equip them with tools to support their child's wellbeing and recognise early signs of relapse, leading to a reduction of depressive symptoms in adolescents (Sanford et al., 2006; Schlimm et al., 2021). Additionally, providing parents with support, education and counselling might help them navigate difficult emotions, preserve the parent-child relationship, and ensure the best possible care for adolescents (Al Yahyaei et al., 2024). However, considering that CAMHS teams are currently overstretched and struggling to manage record demand (NHS, 2023), the feasibility of implementing these interventions is variable. They would require additional resources, trained facilitators, and sustained funding, that many services may find difficult to provide.

Previous research has also emphasised the relationship between parent empowerment and low parenting stress, although this finding differed based on child characteristics (Bode et al., 2016). Therefore, it is important to recognise the potential benefits of meaningful family participation and the positive impact that engaging and empowering parents can have on their own wellbeing. Adopting a more inclusive approach can help the adolescent develop the skills needed to manage their mental health challenges, while also considering the impact of parental involvement. When caregivers feel like part of the team, the chances of successful interventions may increase (Jackson et al., 2020).

The importance of a strong therapeutic alliance, between the therapist, the adolescent and the parent, was a recurring theme in the study. Parents attributed much of their child's progress to the qualities and approach of the therapist. This suggests that training for therapists should emphasise skills in rapport-building and trust development from the onset, since a strong therapeutic alliance is crucial in the therapy process and in promoting change

(Capella et. al., 2015). Training programs could offer structured, in-depth skill development, incorporating interactive methods such as role-playing and feedback. Supervision and team meetings can complement this by providing ongoing support and addressing specific challenges as they arise. Additionally, professionals should work towards fostering a trusting environment where both the child and the parents feel understood and respected. In line with the study's findings, clear communication about therapy goals, progress, and boundaries is important for maintaining this trust. At the same time, professionals should ensure that both parents and children understand and respect the boundaries within therapy sessions is essential. This helps maintain the child's sense of autonomy while also keeping parents informed.

Several parents indicated concerns about their ability to support their child after therapy ends, highlighting a need for ongoing support. Research by Moore et al. (2008) suggests that parents may experience anxiety about maintaining their child's progress post-therapy and feel more confident knowing they will have continued support if problems arise. Evidence also indicates that post-termination booster sessions can be effective in reinforcing skills and maintaining therapy gains over time, either as a preventative measure or to address any setbacks (Vidair et al., 2017). Clinicians might therefore consider implementing follow-up sessions or providing resources to support the adolescent's continued growth and development.

4.4. Wider implications

Parents' struggles with accessing timely and effective support highlight systemic issues within mental health services, such as long waiting times and limited availability of therapists (Reardon et al., 2017). Participants in this study reported that these challenges can lead to frustration, anxiety, and a sense of helplessness, which can impact their ability to

support their child. The NHS Long term plan sets action within NHS services to improve mental health provision for young people and their families (NHS, 2019). The findings suggest the need for policy reforms that increase funding, expand the mental health workforce, and reduce waiting times. Implementing early intervention strategies and expanding access to evidence-based therapies like IPT-A could help alleviate some of these pressures and potentially improve outcomes for young people and their families.

The emotional burden on parents highlights the potential need for stronger community-based support systems, which align with Bronfenbrenner's Ecological Systems Theory (1977), emphasising the impact of broader environmental systems on individual wellbeing. Research has suggested that families benefit from peer interactions and shared experiences, from individuals who are not directly involved in their child's treatment (Geraghty et al., 2011). Additionally, parents who have participated in parenting programs for their own mental health issues stressed the importance of sharing the group experience with other parents facing similar issues, and highlighted how crucial this is in motivating participation in these programs (Coates et al., 2017). This suggests that local support groups, parent training programs, and community mental health resources could offer additional layers of support for families navigating mental health challenges.

The role of parents as experts by experience should not be overlooked. Involving parents in the design and evaluation of mental health programs, like IPT-A, could help ensure that services better align with the needs of family. Working in partnership with those who use services could improve health outcomes, enhance decision-making, and lead to a more efficient use of resources by tailoring services to meet actual needs. Parents' insights, drawn from their unique experiences, can help shape more effective and personalised interventions, ultimately leading to better support for young people and their families (NHS, 2023).

Furthermore, encouraging the formation of peer-led support groups where parents can share their experiences and advice could be beneficial. As reflected in this study, these networks may serve as platforms for parents to exchange practical tips and emotional support, reinforcing their role as experts by experience.

The disparity in parental experiences, with some feeling excluded from therapy and others satisfied, suggests the need for regular feedback mechanisms during therapy. In the context of IPT-A, the use of Patient Reported Outcome Measures (PROMS) is an integral component of the therapeutic process within the UK NHS framework (Edenbrook-Childs et al., 2017; Wolpert et al., 2016). These measures provide a structured approach for therapists to track progress and adjust their interventions, ensuring that both parents and adolescents feel engaged throughout the process. Clinicians could consider making greater use of existing PROMS that include parental perspectives and refine their current approach to ensure that parental feedback is systematically integrated into treatment planning. Regular feedback, whether verbal or written, can be reviewed in multidisciplinary team meetings and/or supervision sessions to enhance engagement. On a broader level, services might consider adopting more family-oriented care models that integrate the needs and voices of both young people and parents, leading to more holistic and effective care (NHS England & DoH, 2022).

4.5 Strengths and Limitations

To the best of my knowledge, this appears to be the first study focusing on the lived experiences of parents of their child's IPT-A intervention. The findings of this study contribute to the growing body of literature on parental experiences in adolescent therapy, specifically within the context of IPT-A. Using an IPA framework, this research offered valuable insights into how parents make sense of their child's IPT-A intervention, their perceived involvement in therapy as well as their experienced positive and negative aspects

of the therapy. It also highlighted important wider and clinical implications for enhancing the quality of care and providing better support for parents. The involvement of experts by experience in this study was a strength, which enabled me to further reflect on the issues experienced by parents whose child had completed treatment and navigated mental health services. The study achieved an appropriate sample size for IPA research (Smith et al., 2022). The sample was homogenous, consisting of seven parents who had lived experience of their child's IPT-A. This enabled me to delve deeply into each participant's experiences and perspectives.

Nevertheless, there are a number of limitations which should be considered. Since the current sample was predominantly White, the perspectives of parents from global majority were not sufficiently represented. The experiences of parents may vary significantly based on cultural and socioeconomic backgrounds, thus stressing the importance of exploring the experiences of parents from a wide range of backgrounds. Although two fathers participated in this study, their representation was limited compared to the seven parents involved. Greater efforts should be made to amplify fathers' voices, as they are often underrepresented in research (Davison et al. 2017).

Despite significant efforts to increase access, limitations may persist due to clinician's selection biases when choosing participants for this study (Smith et al., 2022). For instance, local collaborators might have selected participants who were more accessible, cooperative or aligned with the study's goals, potentially excluding certain perspectives. Additionally, by recruiting parents within a twelve month timeframe of their child's therapy, this study captured a diverse range of experiences at different stages of the therapy process, which can enrich the analysis. However, the variability in when therapy ended for each participant suggests a disparity that may affect the consistency of the findings.

This study has primarily focused on parent's experiences of their child's intervention. By excluding the adolescent child's perspective, the research may miss crucial insights into how adolescents make sense and experience the intervention directly. The child's own experiences, feelings, and responses to the IPT-A intervention are essential for a full understanding of the intervention's effectiveness and appropriateness. Moreover, parents and adolescents may have different perceptions and experiences of the same intervention.

4.6 Suggestions for future research

Given the promising results of IPT for adolescents in non-Western countries (Bolton et al., 2007, Rose-Clarke et al., 2022), future research should prioritise including a more diverse sample and investigate how cultural and socioeconomic factors shape parents' experiences of IPT-A, potentially leading to more culturally sensitive therapeutic approaches. Additionally, father involvement has been shown to directly impact young people and influence mothers' ability to support them (West & Honey, 2016). Therefore, including fathers' perspectives in future studies is crucial to ensuring they are actively engaged in their adolescent child's intervention, contributing to the best possible support for young people facing mental health challenges.

To better understand the changes of parental involvement in therapy over time, future research should focus on tracking parents' experiences over similar timeframes, offering insights into its longer-term impact. This study also highlights the need to investigate how varying levels of parental involvement can influence both the parent's and their child's therapy experience, as well as the long-term effects of such involvement. Furthermore, further research could explore how different methods of engaging parents in IPT-A, such as regular updates, joint sessions, or psychoeducation support, might influence therapeutic outcomes. Conducting controlled trials to compare these approaches would provide valuable

insights into how modifications in practice could affect symptom reduction, treatment adherence, and overall family satisfaction. Given that IPT-A is an evidence-based intervention, it is crucial that any proposed modifications are rigorously tested for their effectiveness and acceptability within the context of this framework. By doing so, researchers can ensure that suggested changes enhance, rather than disrupt, the therapeutic process and contribute meaningfully to the field.

Focusing solely on parents may overlook discrepancies between how parents perceive the intervention's impact and how the child experiences it. Therefore, future research should explore young people's lived experiences of undergoing an IPT-A intervention. Lastly, the findings gave rise to the importance of the therapeutic relationship, which appeared to be as critical to adolescents' improvement as the treatment method itself. Further research is needed to examine which therapist qualities most effectively contribute to positive outcomes in IPT-A, possibly through qualitative studies that gather insights from both parents and young people on the therapist's role.

4.7 Conclusion

This study explored parents' lived experiences of their child's IPT-A and highlighted the complex and multifaceted nature of these experiences. The findings emphasised that while parents generally recognise the positive impacts of IPT-A on their child, their own experiences are often shaped by their level of involvement, the therapist's approach, and the outcomes they observe in their child during and post therapy. The complexity of parental experiences in supporting their child's IPT-A, as demonstrated by the study findings, highlight the need for more comprehensive support systems that address the needs of the entire family. By integrating these findings into clinical practice and continuing to explore these areas through research, clinicians and service providers can work towards more

effective and supportive therapeutic interventions for adolescents with depression and their families.

4.8 Final reflections

As I conclude this research, I am struck by the resilience and dedication of the parents who participated in this study. Their willingness to share their experiences, both positive and negative, has provided invaluable insights into the parental perspective of adolescent therapy. It is my hope that these findings will inform clinical practices, emphasising the importance of tailored parental involvement, robust therapeutic relationships, and continued support for families beyond the therapy sessions. In reflecting on this journey, I am reminded of the subtle balance required in therapeutic interventions, balancing the needs of the adolescent with the expectations and emotional experiences of the parents. It is this balance that holds the key to successful outcomes, both for the child and for the family.

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Appendices

Appendix 1: Example of Reflective diary entries and self-reflection exercises

1a. Reflective diary entries

18/10/2023: consultation with IPT-A practitioners

The monthly meetings with the IPT-A practitioners have been really insightful. Today, we discussed IPT-A's concept of the "limited sick role". This idea seems to come from a more traditional medical view, where being sick and getting better is seen as a clear, straightforward process. But this made me wonder, how does this fit with my research's approach, which is based on social constructionism? Social constructionism suggests that ideas like illness and recovery aren't fixed; they are shaped by our social interactions and cultural contexts. This makes me question whether the "limited sick role" in IPT-A might unintentionally reinforce certain ideas about what it means to be healthy or sick, which might not match every family's experience. Thinking about this, I realise I need to be careful when analysing my participants' experiences, making sure I stay open to the different ways families might understand and talk about these concepts. A question I could keep asking myself is: how do parents interpret their experiences and what language do they use to describe their child's progress? This reflection has reminded me to be mindful of how my own beliefs might affect my interpretation of the data and to ensure that I consider the diverse perspectives of the families in my study.

5.4.2024: data collection

As I conducted my first interview with Fran, I noticed a mix of emotions within myself. Fran's frustration about her limited involvement in her child's therapy was noticeable, and I found myself empathising deeply with her situation. I had to consciously manage my reactions to remain an objective listener, even as I felt obliged to reassure her or share my

own thoughts. Fran's willingness to open up and share her frustrations left me with a strong sense of responsibility to honour her experience in my analysis. Reflecting on this interview, I became aware of how my own assumptions about parental involvement might have influenced the way I framed my questions. Moving forward, I need to stay aware of how my own beliefs about what parents should or shouldn't be doing might influence my interpretation of their accounts.

20/6/2024: data analysis

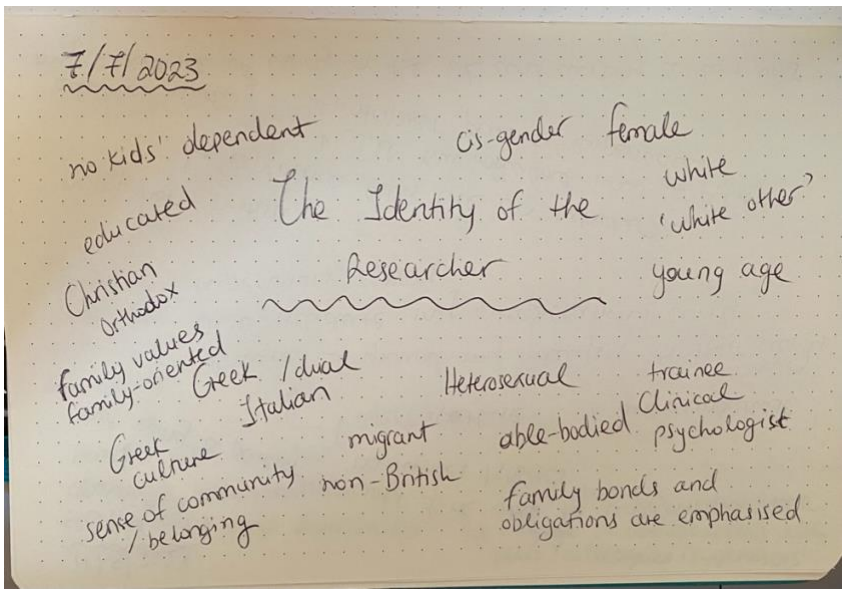
The process of analysing the data has been both challenging and enlightening. Initially, I found myself drawn to the emotional intensity of the parents' experiences, but I struggled to remain neutral, as I felt a strong desire to advocate for them. I had to remind myself of the importance of letting the data speak for itself, rather than imposing my own narrative on it. Kevin's words of "not knowing" really stuck with me. It seems that he felt a significant gap in communication, which left him feeling unfulfilled by the therapeutic process. This made me consider how crucial it is for parents to feel informed and included in their child's therapy, as active participants who are given knowledge and tools to support their child effectively. Kevin's frustration prompts me to look deeper into other parents' experiences of communication in the therapeutic context. I wondered if other parents shared similar feelings of uncertainty and frustration and how these were expressed.

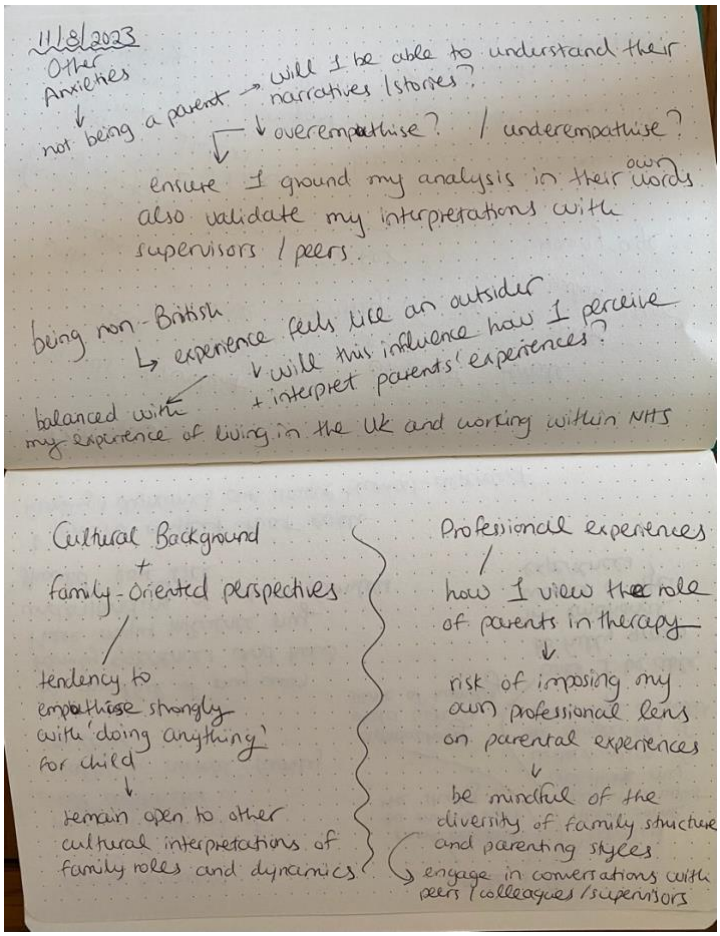
19/7/2024: write up

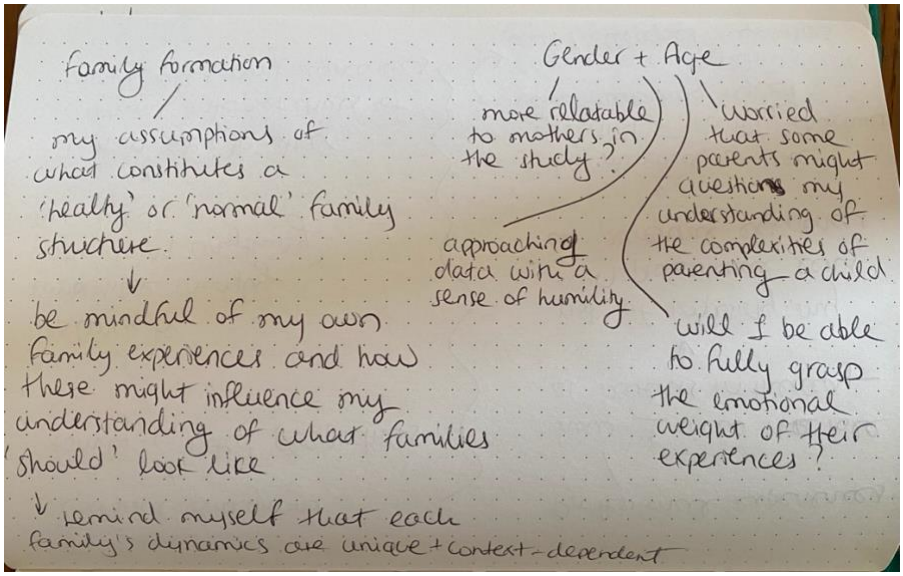
As I began writing up my findings, I was struck by the challenge of presenting the parents' experiences in a way that felt both authentic and organised. The richness of their stories sometimes felt difficult to capture within the structured format of a thesis. I found myself constantly balancing the need to stay true to their voices with the academic requirement to categorise and analyse their experiences. I noticed that there were moments when I might

have overlooked the depth of some parents' experiences, which prompted me to revisit sections to ensure that I was accurately representing my participants' accounts.

1b. Self-reflection exercises






Family formation
my assumptions of what constitutes a 'healthy' or 'normal' family structure
be mindful of my own family experiences and how these might influence my understanding of what families 'should' look like
remind myself that each family's dynamics are unique + context-dependent
Gender + Age
more relatable to mothers in the study?
approaching data with a sense of humility
worried that some parents might questions my understanding of the complexities of parenting a child
will I be able to fully grasp the emotional weight of their experiences?

Appendix 2: Quality assessment tools

2a. CASP tool (CASP, 2018)

	Was there a clear statement of the aims of the research?	Is a qualitative methodology appropriate?	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between the researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	How valuable is the research?
Brown (2018)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	The study adds valuable insights into the role of parental involvement and self-efficacy in adolescent mental health treatment outcomes.
Chan et al. (2023)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	The research provides valuable insights into the role of parents in CBT for children with ASD, which can inform future

										clinical practices and interventions.
Chlebowski et al. (2018)	Yes	Yes	Yes	Can't tell	Yes	No	Can't tell	Yes	Yes	The research provides valuable insights for improving the delivery of interventions for Latinx families in publicly funded mental health services. It highlights important cultural considerations and suggests areas for enhancing parent engagement and support.
Eadie et al. (2022)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	The research provides important insights into the perceptions of carers, highlighting strengths and areas for improvement in the specialist

										mental health service. The findings can inform service development and policy decisions to better support children in care and their carers.
Frauenholtz & Mendenhall (2020)	Yes	Yes	Yes	Can't tell	Yes	No	Yes	Yes	Yes	The research provides valuable insights into the effectiveness of family-centred approaches in mental health, highlighting the importance of personalized services and family empowerment in achieving better clinical outcomes.
Grudin et al. (2024)	Yes	Yes	Yes	Yes	Yes	No	Can't tell	Yes	Yes	The research provides insights into the experiences of adolescents and parents with online BA,

										highlighting the importance of therapist support and parental involvement. It offers practical implications for tailoring interventions and suggestions for future research.
Hart et al. (2005)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	The study offers significant insights into user involvement in CAMHS and provides a model for achieving attuned practice, which can be applied to other specialist services. It contributes to the understanding of how to integrate user perspectives in therapeutic settings effectively.

Hurley et al. (2022)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	The study is of good quality, with clear aims, appropriate methodology, and significant findings relevant to community mental health interventions.
Lundkvist-Houndoumadi et al. (2016)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	The study provides valuable insights into the challenges parents face as co-therapists in CBT, highlighting areas for improvement in clinical practice and suggesting directions for future research. The findings can inform the development of more effective support mechanisms for parents involved in their children's therapy.

Muller et al. (2024)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	The study provides valuable insights into improving parental engagement in online youth mental health programs. It provides useful qualitative data on a relevant topic.
Schlimm et al. (2021)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	The research provides important insights into parents' perspectives, which can inform clinical practice and enhance therapy outcomes for adolescents with depression.
Sheridan et al. (2010)	Yes	Yes	Yes	Can't tell	Yes	No	Yes	Yes	Yes	The research provides important insights into parents' perspectives on family therapy, offering practical

										implications for clinicians to better engage parents and improve therapeutic outcomes.
Thompson et al. (2007)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	The research provides insights into the implementation of digital mental health interventions and highlights the importance of parent and child perspectives.
Weaver et al. (2019)	Yes	Yes	Yes	Yes	Yes	No	Can't tell	Yes	Yes	Overall, the study appears to be of good quality, with a clear focus, appropriate methodology, and significant findings relevant to community mental health interventions.

2b. MMAT tool (Hong et al., 2018)

	Are there clear research questions?	Do the collected data allow to address the research questions?	Is there an adequate rationale for using a mixed methods design to address the research question?	Are there different components of the study effectively integrated to answer the research question?	Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?
Goodkind et al. (2012)	Yes	Yes	Yes	Yes	Yes	Yes	No
Green et al. (2023)	Yes	Yes	Yes	Yes	Yes	Yes	Can't tell
Kingston et al. (2013)	Yes	Yes	Yes	Yes	Yes	Yes	Can't tell
Macdonald et al. (2023)	Yes	Yes	Yes	Yes	Yes	Yes	Can't tell
Mirzadegan et al. (2024)	Yes	Yes	Yes	Yes	Yes	Yes	Can't tell

Appendix 3: Outline of process of SLR thematic synthesis

Key concepts

Challenges to attend

Accessibility/ barriers to treatment (such as stigma)

Technical difficulties

Longer to build relationship with therapist

Lack of time and capacity

Busy schedules

Facing numerous stressors and pressing priorities

Hectic lifestyles

Competing priorities

Increased Confidence/ sense of empowerment

Managing child's difficulties

Better equipped to navigate system

Their own- taking more control, renewed confidence, growth of agency in relating with child, feeling confident in therapists and in the ways they approached family's problems

Increase in warmth and encouragement for children

Deeper understanding and compassion for child

Provide child with praise and encouragement: contributed to child's confidence and self-accomplishment

Celebration of successes

Encourage child to continue

Increase in knowledge

Improvement in their and child's understanding

Increased communication with children

Quality of communication

Become closer emotionally

Spent time together

Communicating better with children

Strengthened parent-child relationship/enhancing parent-child bond

Brought them close

Deepen relationship with child

Change in interactions and relationships, change among and within family unit

Family relationships appear stronger and more harmonious, fewer disputes

Improvement in relationship dynamics

New bonds between parent-child

Relationships with family, development of connections, improved relationships and ability to solve problems

Interact more authentically with one another

Changes in child's wellbeing and behaviour

Day to day changes in adolescent's way of relating, adolescent comes to terms and deal with difficult issues

Children move toward becoming accountable and responsible

Returning to old self

Re-engage with family

Social interactions

Shift in mindset

Equipping adolescents with adaptive skills

Improved self-confidence and self-efficacy

A change in child, positive change to child's happiness and self-confidence

Previous treatment experiences

Negative and inadequate

Felt disjointed and impersonal

Frustration, confusion, feeling excluded, sense of blame, judgement, diminished hope, constant turmoil

Out of options, state of panic, guilt, blame, considered it their responsibility, out of desperation, their only choice

Inclusion of family voice

Deep sense of satisfaction

Prioritisation of family needs

Respected as valued partners

Relationship with therapist

Healthy and supportive

Honest and direct approach to communication

Some lack of communication to parent

Individualised approach/ individualised support/ family needs

Parenting skills

Given strategies and solutions

Gaining tools for use in everyday life

Learn how to use coping skills, regulate emotions independently

Change in their parenting style and their lives, capacity to set limits with child

Encourage child to grow in independence

Learning new things limits blame

New ideas about varying their parenting style

Shifts in their perceptions and behaviours, personal growth, gaining awareness and insight, understanding, knowledge

More capable and confident to recognise their roles, responsibility, appropriate boundaries

Increased self-esteem, trusting themselves

Education in ways of managing communication and responses

Improvement in empathic family communications, less conflict

Parent being self-reflexive, listening more

Increased understanding, learn new skills

Taught strategies, increased understanding of child's needs

Change dysfunctional patterns of transaction

Own ability to effectively manage the children's needs

Engage and interact as a family subsystem

Greater appreciation and understanding of other family member's perspectives

Meet their child's needs, up skill themselves, additional strategies to try out

Learning new skills and gaining insights

Learned more about themselves

Modify their expectations of their children's responses to problems

Therapist

Knowledge, expertise

Responsiveness, availability

Making treatment understandable and relevant to family needs

Maintaining motivation and engagement

Inclusive, relatable

Communication, openness, honesty, listening with respect, compassion, empathy, warmth, eagerness, flexibility

Personal qualities: Understanding, patient, approachable, friendly, caring, open, trusting, vulnerable, flexible, observing, listening, assessing family's circumstances, non-judgemental: increased parental confidence, encouraging, challenging parents, dealing fairly and consistently, friendly, empathise, non-judgemental, empowering, flexible, positive influence on their lives, being listened to, friendly to talk to

Professional qualities: knowledgeable, informative, reliable, flexible, available

Presence helpful: reduce caregiver burnout

Helpful when shown interest in learning about previous experiences, needs

Difficulty working with youth without therapist, Seeing as expert

Acted as role models

Professional support helpful

Having problem solving skills, dealing with family's problems

Therapist relationship

Supportive therapeutic climate

Trust and security in therapist and process

Feeling heard and understood, able to express

Relationship between therapist and adolescent is key

Parent trust and confidence in therapist

Personal connection, therapist who is warm and friendly

Development of trust and mutual respect

Strong rapport with therapist, feeling like a team, collaborative process

Positive connection, collaborative relationship, feel comfortable and accepted

<u>Descriptive themes</u>

Challenges and barriers to attend/engage: online, transportation, busy schedules, hectic lifestyles, difficulty with treatment materials

Increased confidence: their own, in relation to their child

Observed changes in their child

Knowledge and understanding: for their child, for their own difficulties, ability to show more compassion which leads to child's self-confidence

Improved communication and relationships: parent child bond, within family

Previous experiences: bringing difficult emotions

Acquiring parenting skills

The importance of therapist: personal qualities, professional qualities, relationship with therapist

Inclusion of family voice, collaboration, working together

Analytic themes

Experience of therapy

Strengthening relationships

Therapist is key

Navigating obstacles

Appendix 4: Recurrence of themes in the SLR

	Theme 1	Theme 2	Theme 3	Theme 4
Green et al. (2023)	x	x	x	x
Goodkind et al. (2014)	x	x	x	x
Frauenholtz & Mendenhall (2020)	x	x	x	
Kingston et al. (2013)	x	x	x	
Grudin et al. (2024)	x	x	x	
Eadie et al. (2022)		x	x	
Chan et al. (2023)	x	x	x	
Mirzadegan et al. (2024)	x			
Brown (2018)	x			
Lundkvist-Houndoumadi et al. (2016)	x		x	x
Sheridan et al. (2010)	x	x	x	
Schlimm et al. (2021)	x	x	x	
Hurley et al. (2020)	x	x		
Chlebowski et al. (2018)	x	x	x	
Weaver et al. (2019)	x	x	x	x
Macdonald et al. (2023)	x	x		
Muller et al. (2024)	x		x	x
Hart et al. (2004)			x	x
Thompson et al. (2007)	x	x	x	

Appendix 5: Involvement of IPT-A practitioners and EbE

Initial discussions about the research topic	Feedback from IPT-A practitioners: Practitioners highlighted the need to better understand the specific role parents play in IPT-A, such as how they were involved in different phases of the therapy and their understanding of the problem area. Their experience with IPT-A helped ensure that the research questions were grounded in the realities of clinical practice. They emphasised the importance of exploring both the therapeutic relationship and the practical aspects of parental involvement, which shaped the direction of the research. Feedback from EbE: Parent highlighted the importance of understanding parents' emotional journeys and the challenges they face when their children undergo therapy. This led me to focus more on the emotional and psychological aspects of parental involvement in IPT-A, ensuring the research topic was relevant and meaningful to those directly impacted by these interventions.
Development of interview schedule	Feedback from IPT-A practitioners: Practitioners pointed out that some of the interview questions could be misleading since IPT-A primarily focuses on the child. As a result, questions were rephrased to better focus on how parents supported their child during therapy (e.g., "How were you involved in the therapy?"). This revision ensured the questions were clear and accurately represented the parents' supportive role. Practitioners emphasised the importance of addressing how parents were involved during specific phases of therapy (e.g., initial, middle, ending) and their understanding of the problem area. This led to the inclusion of questions such as "How many sessions did you attend together with your child in the IPT-A work?" and "Do you

	know the identified problem/focal area being worked on?" These revisions allowed for a more nuanced exploration of parental involvement throughout the therapy. Practitioners recommended exploring whether parents were informed about the therapy's goals and care plans. Questions like "Did your child share the care plan with you or discuss or show you their IPI or goals?" were added, ensuring that the interview schedule captures how well-informed parents felt during the therapy process. Feedback from EbE: The parent also reviewed the questions to ensure they accurately reflected the parents' involvement. The parent's review helped refine the language, ensuring that the questions were parent-friendly and that the interview process remained manageable, focusing on capturing the most crucial aspects of their experience. The parent emphasised the importance of understanding how parents could take the learning and skills forward, reflecting the practical aspects of post-therapy life. This insight led to the addition of questions such as "How would you take the learning/skills forward? Do you feel better informed and equipped for the future?" This ensured that the schedule captured both immediate and sustained impacts of IPT-A.
Data collection	Feedback from IPT-A practitioners: Practitioners provided guidance on ethical considerations and practical strategies for conducting interviews with parents who might be dealing with sensitive issues. They advised on how to approach difficult topics, ensuring that the data collection process was respectful and professional. Feedback from EbE:

	Parent suggested ways to create a more comfortable environment for participants, such as allowing them to choose the location of the interviews or offering breaks if the conversation became emotionally challenging. This helped ensure that the data collection process was sensitive to the needs of the participants.
Dissemination of findings	Feedback from IPT-A practitioners: Initial discussions around dissemination, advising on how best to share the findings with clinical audiences, such as IPT-A practitioners and mental health professionals.

Appendix 6: Research advert for local collaborators

Doctoral Research: Carers' Experiences of Interpersonal Psychotherapy for Adolescents (IPT-A)

Dear IPT-A trainees/practitioners/supervisors, I would be so grateful for your support in recruiting for my doctoral research project about IPT-A. Please see an overview below and my contact details at the end.

Investigator:

- Koralia Bentivoglio; University of Hertfordshire; Doctorate in Clinical Psychology; k.bentivoglio@herts.ac.uk

Principal Academic Supervisor:

- Dr Scott Steen; University of Hertfordshire; Doctorate in Clinical Psychology; s.steen@herts.ac.uk

Background & Rationale:

I am a Trainee Clinical Psychologist at the University of Hertfordshire and I am interested in exploring carers' experiences of undergoing an Interpersonal Psychotherapy for Adolescents (IPT-A) intervention. Broadly, there is a lack of existing qualitative research within IPT-A, and no exploration of the experience of the intervention. This is surprising given IPT-A is a NICE guideline recommended therapy for adolescents with depression. Therefore, this project aims to fill the gap by giving voice to carers' experiences; develop the evidence base; and provide insight for IPT-A practitioners and services more widely who are supporting young people and their families.

Aims & Research Questions:

- What are the experiences of carers who have undergone an Interpersonal Psychotherapy for Adolescents (IPT-A) intervention?
- What was helpful about the intervention from the standpoint of the parent/carer.
- What was less helpful about the intervention from the standpoint of the parent/carer.
- To develop the clinician's understanding of how the intervention is experienced by the standpoint of the parent/carer, with the hope to generate important recommendations for IPT-A practitioners and services more widely who are supporting young people and their families.

Design:

I will conduct semi-structured interviews with carers individually, which will last approximately one hour and take place remotely via an online platform. I will ask participants open questions about their experiences of IPT-A. The interviews will be recorded and transcribed, and the analysis will draw out themes of their experiences. Participants will be compensated for their time with a voucher.

Recruitment:

Inclusion criteria:

- Aged 18 years or over (in keeping with the 'Adult' definition set by NHS England)

- Deemed to have the capacity to consent by their care team
- Deemed to be suitable for recruitment by the care team
- Able to read, speak and comprehend English suitable for understanding the study materials (Participant Information Sheet; Consent Form; Debrief sheet)
- Carers who have undergone an IPT-A intervention within the last 12 months
- Carers who have been involved in a minimum of two sessions of IPT-A, according to the IPT-A manual (Munson et al., 2004). In line with the IPT-A manual, parents or guardians are invited for 1-3 sessions as needed. However, the research team may consider carers who have had less participation in sessions but enough involvement to provide feedback on their experiences

Exclusion criteria:

- Carers who have had very limited involvement for an IPT-A intervention
- Identified current risk to self and/or others

Ethical Considerations:

I have applied for NHS Ethics and received HRA/REC approval for this research project. I will consult with the Research and Development teams within each NHS Trust to follow their internal protocols and procedures. I will also adhere to the BPS guidelines regarding conducting virtual interviews.

Ethical considerations will include, for example, informed consent, the right to withdraw, anonymity, confidentiality, safeguarding and the distress/discomfort with the process of being interviewed. Information regarding risk-related issues will be incorporated into the information sheets and discussed with participants at the start of their interview. There will be a clear procedure in place around the disclosure of risk-related issues, involving the principal academic supervisor and secondary supervisor (who is IPT-A trained), the responsible clinician and the local service's policies.

Time Schedules:

I aim to interview carers between January 2024 and March 2024.

Please let me know if you may be able to help with recruitment! If so, please email me with your name, and the NHS Trust and service that you are working in.

My email address is:

k.bentivoglio@herts.ac.uk

Thank you very much in advance.

Appendix 7: Participant Information Sheet (PIS)

08/01/2024 | Version 1.3 | IRAS Number: 330849

University of Hertfordshire

IRAS Number: 330849

PARTICIPANT INFORMATION SHEET

University of Hertfordshire

Study Title: What are carers' experiences of receiving an Interpersonal Psychotherapy for Adolescents (IPT-A) intervention?

Invitation

You are being invited to take part in this research study. Before you decide, it is important that you understand why the research is being done and what it would involve for you. Please allow time to read this information carefully and please feel free to ask any questions or clarify anything that is not clear.

What is the purpose of this study?

We would like to understand better the experiences of carers who have undergone an Interpersonal Psychotherapy for Adolescents (IPT-A) intervention. Previous research has shown positive outcomes and lower depressive symptoms in families following a course of IPT-A intervention. However, there is a lack of research on the experience of the intervention. We are hoping that this understanding will help practitioners and services more widely to provide better support for families in the future.

Why have I been invited?

You have been invited to take part in this study because you have undergone an IPT-A intervention alongside your child. We aim to recruit 12-18 parents/carers, who have undergone an IPT-A intervention and who would like to talk about their experiences. We hope that the information you give us will help us to understand more about the experience of IPT-A and may help shape how services are run in the future.

What would taking part involve?

If you decide to take part in the study, the lead researcher for the project will contact you to arrange a time to meet with you for the interview. This would be over Microsoft Teams remote video technology. You will be invited to have a discussion about the Participant Information Sheet prior to commencing the interview. You will have the opportunity to ask questions before deciding to take part. If you agree to take part, you will be asked to sign a Consent Form. The interview can take place straight after this. The online interview will last approximately 60 minutes; this is to allow you time and space to talk about your experience. You will only be invited to talk about what you feel willing and able to. The interview will be audio/video recorded and consent for this will be requested from you before commencing the interview. You will be encouraged to describe your experience of undergoing an IPT-A intervention alongside your child. You will be invited to share your thoughts on the processes of IPT-A and any changes that you have noticed following a course of IPT-A.

Do I have to take part?

The choice to take part in this study is completely up to you. If you decide that you would like to take part, we will ask you to carefully read this information and complete an expression of

interest form. Before the interview, we will also ask you to sign a consent form. If you do not want to take part in this study, you do not have to give a reason and no pressure will be placed on you. Please know that you have the right to withdraw at any stage if you change your mind.

What happens to the information I provide?
All Information collected is strictly confidential. Information will be stored and secured on password protected files within an NHS secure system and will only be accessed by the researcher. Data collected from interviews will be anonymised and kept confidential. Information that could identify you, such as your name and other details, will be removed and changed. You will be given the right to choose your own pseudonym to ensure anonymity. People who do not need to know who you are will not be able to see your name or contact details.

Audio/video recordings will be stored on an encrypted and password protected NHS system and will be kept secured for the duration of the study. These recordings will only be accessible by the researcher. This is to enable the researcher to return to recordings, should she need to, whilst data are being transcribed. Audio/video recordings of the interview will be kept until transcription is complete and will then be permanently deleted. Written interview transcripts will be kept anonymous and stored on a password protected file within NHS secure system. These will be kept secured with the University for at least 5 years following completion of this study, in line with the University of Hertfordshire guidelines and procedures. After this, data will be permanently deleted.

Other documents containing personal identifiable information, such as expressions of interest forms and/or consent forms will be stored separately on password-protected files and stored on NHS secure system. This information will be kept secured until findings are disseminated and will then be permanently deleted from the NHS secure system. We will keep all information about you safe and secure.

Are there any situations when information will be shared?
If during our conversation you disclose risk-related information indicating concerns about your own and/or others' safety, the researcher will follow the confidentiality agreement protocol and if appropriate correspond with your care team within 24 hours as her duty of care. Further support might be sought from the research team. The researcher will try to talk to you first about this to explain the reasons behind and what will happen next.

How will this information be used?
The results of the research will be written up in a report as this project is in partial fulfilment to the Doctorate in Clinical Psychology. This may contain anonymised quotes from the interview. The research will be written up for submission to peer-reviewed academic journals and conferences, so that other IPT-A practitioners can learn from the research. We will write our reports in a way that no-one can work out that you took part in the study.

What are your choices about how your information is used?

- You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.

- We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

Where can you find out more about how your information is used?
You can find out more about how we use your information

- at https://www.hra.nhs.uk/information-about-patients/
- by sending an email to the University of Hertfordshire's Data Protection Team on dataprotection@herts.ac.uk, or
- by sending an email to the researcher on k.bentivoglio@herts.ac.uk

What are the possible benefits of taking part?
This study endeavours to provide a space to think and talk about your experiences, which may be helpful in making meaning from the experience, and feeling heard and understood. Your feedback will help inform existing knowledge and shape intervention services for families.

Are there any potential risks in taking part?
There are no known risks; however, we recognise that people can get upset while talking about their experiences. You will only need to talk about what you feel able and willing to talk about, at a level of detail and in a way that you feel comfortable with. If you feel upset at any point during the interview, you can take a break or make the decision to stop at any time. A list of relevant services is provided below if you require further support.

Will I be reimbursed for taking part?
You will be offered a £10 voucher as a gesture of taking part and offering time to share your thoughts. You will be emailed your voucher directly after completion of your interview.

What happens after the interview?
Following the interview, you will have no further involvement in the study. A list of available services will be provided to you should you need further support. Following the end of the project, a summary of the findings will be documented and made available to you, if you would like.

What happens if I agree to take part but then later change my mind?
You can withdraw from the interview at any time, until the point that data are anonymised. You can withdraw for any reason, and you do not have to tell the student investigator the reason you would like to withdraw. If you wish to withdraw from the study, you should contact the student investigator, Koralia Bentivoglio in the first instance – k.bentivoglio@herts.ac.uk

What if there is a problem?
If you wish to make a complaint, or have any concerns please contact Koralia Bentivoglio in the first instance- k.bentivoglio@herts.ac.uk, and if you continue to have concerns please contact Dr Scott Steen, the Principal Academic Supervisor of this project – s.steen@herts.ac.uk , 01707285122.

Who has reviewed the study?

This study has been reviewed by University of Hertfordshire Ethics Committee and NHS Ethics Committee.

The University of Hertfordshire, as sponsor, will cover your involvement in this study and holds appropriate insurance policies.

Contact details for further information:

If you would like to discuss this study in more detail, please contact Koralia Bentivoglio – k.bentivoglio@herts.ac.uk or Dr Scott Steen – s.steen@herts.ac.uk

List of available services:
Mind; https://www.mind.org.uk

Samaritans; 24 hours a day, 365 days a year. Call 116 123; www.samaritans.org

Shout; For immediate support text SHOUT to 85258 to chat by text to a trained volunteer; free, confidential and available 24 hours a day, 365 days a year; www.giveusashout.org

Relate (counselling for relationship support); https://www.relate.org.uk

Cruse Bereavement Support; https://www.cruse.org.uk

Mermaids (support for transgender, nonbinary and gender-diverse children and young people and their families); https://mermaidsuk.org.uk

Additional local parent support groups and workshops for parents (e.g., understanding teens, bullying, social isolation)

Appendix 8: Expression of interest form

01/12/2023 | Version 1.1 | IRAS Number: 330849

University of Hertfordshire

EXPRESSION OF INTEREST FORM

University of Hertfordshire

Study Title: What are carers' experiences of receiving an Interpersonal Psychotherapy for Adolescents (IPT-A) intervention?

Name Researcher: Koralia Bentivoglio

Thank you for your interest to participate in this research study. Please make sure you have first read the Participant Information Sheet.

PLEASE COMPLETE SECTIONS BELOW

First and last name:	
Age:	
Gender:	
Ethnic background:	
How many IPT-A sessions have you had together with your child?	
How many IPT-A sessions did your child have (if known)?	
How long has it been since your child had their final IPT-A session?	
Do you have any special needs that the researcher should be aware of?	
Do you have access to a computer/laptop for the remote interview?	
Any other information you think is important:	
Telephone number to be contacted:	
Email address:	

What happens to this information?
The above information you have provided will be kept **strictly confidential** in accordance with the Data Protection Act 1998. Electronic documents will be kept stored on password protected files within a secure NHS system and will only be accessed by the researcher. You will be given the right to choose a pseudonym so that you cannot be identified.

Thank you for your time

Appendix 9: Ethical approval and Letter of sponsorship

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Dr Scott Steen
Doctorate in Clinical Psychology
Health Research Building, College Lane Campus
University of Hertfordshire, Hatfield
AL10 9AB

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

11 January 2024

Dear Dr Steen

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**What are carers' experiences of receiving an Interpersonal Psychotherapy for Adolescents (IPT-A) intervention?**
IRAS project ID:	**330849**
Protocol number:	**To be confirmed**
REC reference:	**23/WM/0276**
Sponsor	

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The standard conditions document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **330849**. Please quote this on all correspondence.

Yours sincerely,
Andrea Bell

Approvals Specialist

Email: approvals@hra.nhs.uk

Copy to: *Mrs Sarah Beeley*

University of Hertfordshire UH

University of Hertfordshire
Higher Education Corporation
Hatfield, Hertfordshire
AL10 9AB

Telephone +44 (0) 1707 284000
Fax +44 (0) 1707 284115
Website www.herts.ac.uk

John M Senior
BSc MSc DSc PGCE CEng FIET FRSA FHEA
Professor of Communication Networks

Dr Scott Steen
Department of Psychology, Sport and Geography
LMS

26th October 2023

Dear Dr Steen

Re: UNIVERSITY OF HERTFORDSHIRE SPONSORSHIP IN PRINCIPLE for the following:
RESEARCH STUDY TITLE: Carers' experiences of receiving an IPT-A intervention
NAME OF CHIEF INVESTIGATOR (Supervisor): Dr Scott Steen
NAME OF INVESTIGATOR (Student): Koralia Bentivoglio

This letter is to confirm your research study detailed above has been reviewed and accepted, and I agree to give University of Hertfordshire sponsorship in principle.

Before you commence your research you must be in full compliance with all Health Research Authority governance requirements. You must also secure full University of Hertfordshire sponsorship, for which you will need to have supplied the following documentation:

- Final version of the submitted IRAS form (pdf)
- Approval from the relevant Health Research Authority (HRA) Research Ethics Committee (REC) as well as confirmation of favourable opinion of any amendments arising during approval
- Evidence of relevant NHS Permissions (eg Research Passport) and Confirmations of capacity and capability as they are received
- Confirmation of University protocol number
- The final versions of the protocol, patient information leaflet and informed consent form
- For externally funded research, confirmation of adequate funding in the form of the award letter
- Any other regulatory permissions required, eg from the National Information Governance Board (NIGB), under the Human Tissue Act or the Ionising Radiation (Medical Exposure) Regulations
- If applicable, copies of any contracts/agreements with external organisations (eg funders, collaborators, co-sponsors) involved in your research study.

As a condition of receiving full sponsorship, it is the responsibility of the Chief Investigator to inform the Sponsor of any changes to the duration or funding of the project, changes of investigators, changes to the protocol and any future amendments, or deviations from the protocol, which may require re-evaluation of the sponsorship arrangements. It is also the responsibility of the Chief Investigator to inform the funder, the HRA NHS Research Ethics Committee (REC) and any other relevant authority of any of these changes. Annual and end of study reports must be submitted to the HRA and copied to the Sponsor.

University of Hertfordshire UH

University of Hertfordshire
Higher Education Corporation
Hatfield, Hertfordshire
AL10 9AB

Telephone +44 (0) 1707 284000
Fax +44 (0) 1707 284115
Website www.herts.ac.uk

I look forward to receiving the above documents before you commence your research. Please email these to research-sponsorship@herts.ac.uk so the University can confirm sponsorship. In the meantime, we wish you well in pursuing this interesting research study.

Yours sincerely,

Professor J M Senior
Sponsor Representative
University of Hertfordshire

Encl: Insurance certificate(s)

Appendix 10: Consent form

28/12/2023 | Version 1.2 | IRAS Number: 330849

University of Hertfordshire

IRAS Number: 330849

PARTICIPANT CONSENT FORM

University of Hertfordshire

Title of Project: What are carers' experiences of receiving an Interpersonal Psychotherapy for Adolescents (IPT-A) intervention?

Name of Researcher: Koralia Bentivoglio

Please initial box

1. I confirm that I have read and understood the Participant Information Sheet (V1.3). I have had the opportunity to consider the information, ask questions and have had these questions answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I have the right to withdraw at any time without giving a reason, without any medical care or legal rights being affected. ☐
3. I know that I have the right to change my mind about taking part in this study and can withdraw at any time, until the point that data are anonymised. ☐
4. I agree to audio/video recording and the use of anonymised quotes in research reports and publications. ☐
5. I have been told how information relating to me will be handled; how it will be kept secure, who will access it, and how it may be used. ☐
6. I am aware that if the researcher felt concerned about risk to me or others then she may have to speak to the research team about this, but would always try and discuss this with me first. ☐
7. I know who to contact in case I feel need for any further support after the study and contact details have been provided. ☐
8. I give my agreement to take part in the above study. ☐

_____	_____	_____
Name of participant	Date	Signature
_____	_____	_____
Name of Researcher	Date	Signature

Appendix 11: Debrief form

28/12/2023 | Version 1.2 | IRAS Number: 330849

University of Hertfordshire

PARTICIPANT DEBRIEF FORM

University of Hertfordshire

Title of Project: What are carers' experiences of receiving an Interpersonal Psychotherapy for Adolescents (IPT-A) intervention?

Name of Researcher: Koralia Bentivoglio

I would like to thank you for taking the time to share your views and experiences with me. Your contributions will help me to make sense of your experiences of undergoing an IPT-A intervention and shape intervention services for families.

What next:
I am completing a number of interviews with other parents/carers. The next step for me will be to listen again to the interviews, bring all the ideas together and generate relevant themes. Audio/video recordings will only be accessible by the student investigator and will be securely deleted following transcription of the interviews. I will then write up what I found in a formal thesis to hand to the University of Hertfordshire. If you decide that you do not want to be part of this study then you have the right to withdraw up to 2 weeks following your interview.

If you have any further comments or queries, please do not hesitate to contact me on k.bentivoglio@herts.ac.uk.

Complaints:
If you're not happy with any part of this study then you have the right to make a complaint. If you feel happy to talk to me first, please email me on k.bentivoglio@herts.ac.uk. In any other case, you can speak to the principal academic supervisor at the University of Hertfordshire, Dr Scott Steen- s.steen@herts.ac.uk, 01707285122.

For further support, please refer to the available services as listed below:
Mind; https://www.mind.org.uk

Samaritans; 24 hours a day, 365 days a year. Call 116 123; www.samaritans.org

Shout; For immediate support text SHOUT to 85258 to chat by text to a trained volunteer; free, confidential and available 24 hours a day, 365 days a year; www.giveusashout.org

Relate (counselling for relationship support); https://www.relate.org.uk

Cruse Bereavement Support; https://www.cruse.org.uk

Mermaids (support for transgender, nonbinary and gender-diverse children and young people and their families); https://mermaidsuk.org.uk

Additional local parent support groups and workshops for parents (e.g., understanding teens, bullying, social isolation)

Appendix 12: Interview schedule

28/12/2023 | Version 1.3 | IRAS Number: 330849

University of Hertfordshire

Interview schedule for Parents

General experience

- Can you tell me about your experience of IPT-A? What was it like?
- What do you think your child would say about IPT-A?
- How were you involved in the therapy?

Processes

- How was IPT-A introduced to you and your child at session 0 (assessment)? Did you understand the offer? What were your thoughts?
- How many sessions did you attempt together with your child in the IPT-A work? Were these during the initial, middle and ending phases? At any other times?
- Do you know the identified problem/focal area being worked on?
- Was the problem area shared with you and how did you make sense of the problem?
- Did the therapist discuss the information in more detail with you (with consent/together with your child)?
- Did your child share the care plan with you or did your child discuss or show you their IPI or goals?
- What changes did you notice with your child following IPT-A?
- Have you noticed any particular benefits of undergoing the IPT-A intervention?
- Have you had other therapy and if so did IPT-A seem to be more/less or the same effective?
- Would you recommend IPT-A and why?
- How well do you think the evaluation process captured your experiences?
- How would you take the learning/skills forward? Do you feel better informed and equipped for the future?

- Is there anything else you would like to add? Anything more about your experience of IPT-A?

General prompts:

Anything else?

Would you tell me a bit more?

Can you tell me more about that experience?

What was it like for you?

Can you give me an example?

What are your thoughts on that?

What do you think your child's opinion would be on that?

Appendix 13: Example of extract of the analysis process

Experiential statements	Transcript	Exploratory notes
	I: And then the rest of the questions are more around processes. So they are more specific to the intervention. All that will make sense, but do let me know if you do have any questions. So the first question is, can you tell me about your experience of IPT-A? What was it like?	Takes time to answer first question. Pauses and thinks.
Explanation about her role and involvement but still felt involvement was lacking	P: hmm (pauses and thinks) So this is the specific sessions, isn't it? That.. so…OK. I have to say that my son did most of it by himself, without me being in the room. So in one way it's quite **hard** for me to say. Hmm I was advised by the practitioner that this was gonna be used. Hmm and	Seems unsure about what to say specifically about the IPT-A sessions, uncertainty?
Parental responsibility for child's future	that I would be bought in at the middle and the end of the sessions to hmm to participate and for us hmm to be shown how to deal with [young person] and his… How I could almost carry it on afterwards? However, at	Without me being in the room Hard to say since involvement was limited
Uncertainty as to how to support YP	the end of the sessions, that didn't happen so hmmm. In I suppose in one way I felt let down by that because it wasn't actually shown to me. Pause…[young person] is an older you know, he's 17 now hmm and	Feeling excluded from therapy I could almost carry it on afterwards; seeing it her responsibility as a parent to
Limited involvement/final reflections lead to negative emotions	doesn't communicate openly hmm about the sessions, so it was quite **hard** for me to gauge hmm how.. What was happening in them, I suppose? hmmm He would share with me things like they discussed. His autism. How he may hmm how he felt about that, how he may interact with	continue supporting her child But feels uncertain how to support her child going forward
High expectations for parental involvement	others. (Pauses and thinks)..How hmm making choices, no how he could make better choices, I think. But that literally is about as much as I managed to get out of him most of the time. (Laughs)	Expected to be involved and wasn't involved at the end which made her feel let down
The more limited the involvement, the hardest it is for her to gauge	I: Sure, sure. I think I think it can be quite tricky because the intervention is mostly for the young person, isn't it? And then there is some involvement from parents, but that involvement will vary quite a lot from family to family. I understand that absolutely. In terms of your involvement, how were you involved in the therapy? So maybe how	Had high expectations about involvement? Hard to gauge Repeats word **hard**, hard to say, hard to gauge

Own attempts to find more from young person Understanding of focal area increases as parent is involved in middle phase Providing real life examples give better chance to communicate parent's understanding of YP's difficulties	many sessions? I know you've said you've had, you were involved in the middle stage, is that right? P: Yeah, well actually, it was more at the beginning hmm so my involvement was kind of initially giving my thoughts about hmm what had happened to [young person], I suppose in his history and the journey he'd been on. hmm and then (pause) each time I went I would **kind of** go at the beginning of the session and and **kind of** give my input as to how I thought [young person] have been. hmm (pause) and then there was some maybe I would say only in the middle the the hmmm (pause) there was the. A little bit more about how he was interacting with people or I suppose it was more the hmmm (pause and thinks) how hmmm (long pause) he had presumed or how he thought people had reacted to him and things he'd gone through and how looking at their perspective of that same situation hmmm and I think actually bringing some of that. So he had an issue with two boys. He felt very much that they had hmm that he had supported them when they needed help, but when he was going down he didn't feel very supported by them and it was kind of flipping around the experience. And he could. He could actually see that hmm he had never expressed them any of the issues he'd had or how he was feeling, and that he was kind of assuming that they understood what was going on inside him (laughs) without expressing it to them. And in fact, after that he did start talking to these boys again, which I was nervous about hmm but they said we had no idea that they had no idea what he was going through. And actually, you know, it's now. they continue to I'm not sure friends is the right thing. They have all gone their separate ways, but they talk online and things like that. So it feels that there was some repair there and some growth in [young person]. I: OK, OK. Lovely. That's really, really positive to know. Absolutely, absolutely. What do you think [young person] would say about the intervention about IPT-A?	I wonder if she makes reference to how hard it is for her as a parent, reflects on parental concerns, struggles I wonder why she laughed at the end? in a way not sure what else to say? **Kind of** repetition, shows uncertainty? Number of pauses, including long pauses again showing uncertainty Seems to have some understanding of child working on his interactions with people and looking at different perspectives Gives real life example to show understanding Why was she nervous about talking to these boys? Shows parental concern about child's struggles? Sees repair and growth in child

Different views between YP and parent on how they view therapy Acknowledgement of therapeutic benefits, of repairs and growth in child Previous experiences/struggles lead parents to try out anything for their child	P: (laughs following question). So [young person] has always hmm, I feel I should have probably talked to him about this beforehand because he was whilst we were going through all therapies, the talking therapies, he's been quite, I don't know if dismissive sounds too harsh, but a bit like I don't know what the point of this is. But you can, like I've just explained that situation. I can see that there's benefit that's come out of it. I think his thinking is the medication is what's made him feel better. All the way through it, he was very much I'm doing this because I have to do it. Because they won't give me medication until I've been through the talking therapy. But I could see that there were benefits that came out of it. I: Sure, sure, absolutely. it's good to hear from you that you feel the therapy had some benefits because you've seen some difference and some repairs. I: So going more to the processes, how was IPT-A introduced to you and your child at that first session? So the assessment, I think in CAMHS, they call it session 0. And did you understand the offer? What were your thoughts? P: OK so [young person] had other therapists before the one that did the IPT-A. He'd had crisis therapy and then moved to a local CAMHS therapist. She left. So it was when a different therapist took over that we were offered this as a I suppose you know, possibility for him. It was hmmm It was I would say quite a high level described to us. I was told the therapist said. It said that they were doing training and that the sessions would need to be recorded. And would [young person] be happy with that? Hmm It's very **hard** because I think when you're a parent of somebody who's going through trauma, you are willing to try anything. In my mind so it wasn't a **hard** sell. If you see what I mean. (laughs). But the way, yeah, the way it was described to me was that they would work	I should have properly talked to him before hand; feels responsibility as parent to get consent from her child? Why? She might be thinking that child has a differing view about therapy Child is dismissive, thinks what the point of it is, parent rather sees benefits of therapy for child Shows how child mainly thinks about medication, has to do it Whereas she could see there were benefits that came out of it Had other therapists Seen in crisis; risk involved? Local CAMHS therapist left, shows systemic changes, changes in therapists, impact to young person and family Makes reference to sessions being recorded so wonder if therapist was a trainee Again repeats word **hard**. Parental concern

The role of the parent is hard, willing try anything is linked with feelings of desperation and helplessness Limited involved perceived as downside	with [young person] as to say and then I would be offered the sessions to learn how to continue, but I wasn't. I: Sure, sure. I: How many sessions did you attend together with [young person] in the IPT-A work? I think we've covered some of this, where these during the initial, middle and ending phases or at any other time. P: So obviously at the beginning when it was **kind of** described to me, but that there was only one session in the middle where I spent a bit longer in with them. The rest of the time it was. It was either that I just went in for the first few minutes and said how he'd been for the week and that was it. I: OK, OK. I: Do you know the identified problem or the focal area as they call it as part of the intervention? Which is, you know, the area being worked on in the intervention. P: I.. I believe it was so at the time I can't remember if he got his diagnosis in the middle of it or quite soon before it, so it was his understanding his diagnosis and working on how he could hmm relationships basically. Peer type relationships. I: Sure. So I guess it was more around relationships, interpersonal difficulties, I guess building those relationships with peers absolutely. OK. P: Yes. Yeah. I: Was the problem area shared with you and how did you make sense of the problem?	Willing to try anything for child Wasn't a **hard** sell Seems like they were left with no options other than trying out anything that comes their way: this shows desperation and helplessness? She laughs again, is her laugh a sign of awkwardness? Again mentions how she wasn't involved, feeling frustrated? They would be working on… feeling excluded? Only one session That was it Feeling uninvolved? Understanding of diagnosis Peer type relationships Seems to have some understanding of what has been worked on, but would try anything Takes time to give answer, stops and thinks. It seems like asking herself how much she knows and how mum it was shared with her Lack of involvement? Feeling excluded?

Parental expectations for therapy in agreement with chosen therapy Indirect vs direct experience; indirect parental involvement still results in increased understanding about child's struggles and focal area	P: (stops and thinks, looks elsewhere) was it shared with me? It was shared with me that he they would be working on relationships in his diagnosis. Sorry, what was the second part of that? (laughs) I: No problem, that's OK. How did you make sense of the problem? P: I suppose it automatically made sense to me that hmm one hmm the diagnosis coming to terms with it, he didn't seem to have an issue coming to terms with it, but I know some people do. Or he didn't display that to me (laughs), however the relationships part definitely made sense because that seemed to be one of the things that was continually coming out of previous therapies that he'd had. Hmm and it seemed to be a focal point when he went into burnout, but I think actually it was autistic burn burnout rather than particularly the friendship relationships. I think that just happened at that time and didn't hit his support network at the time he went into burnout, felt to him that they'd let him down. So. But I know he does struggle though with relationships.	Forgets about second part, asks again, Unsure how to respond? Automatically made sense to me Seems to be in agreement with work Her expectations of work are in agreement with chosen therapy Although it seems that she feels she lacked involvement, the focal area still makes sense to her, seems that indirect experience was present as understanding of focal area? Appears to be something that has come up in previous therapies, shows complexity of their journey to therapy and services

Appendix 14: Drafting experiential notes and example of PETs for one participant

Experience of therapy is linked with the extent of her involvement

Limited parental involvement perceived as downside

Different roles between YP and parent in therapy

Parental responsibility for child's future

Supporting her to gain tools to support her child seen as important

Limited involvement/final reflections lead to negative emotions

Appreciation of age of young person and acknowledgement of his needs for independence

The more limited involvement, the hardest it is for her to gauge, own attempts to find more from YP

Understanding increases as parent is involved in the middle phase, increased understanding about diagnosis and peer relationships

Acknowledgment of repairs and growth in child

Different views between YP and parent on how they see therapy

Seeing the benefits provides trust in process

Previous experiences lead parents to try out anything for their child

Explanation about her role and involvement, however involvement lacking

Goals in therapy stay between therapist and YP

Child gains understanding and tools to deal with situations

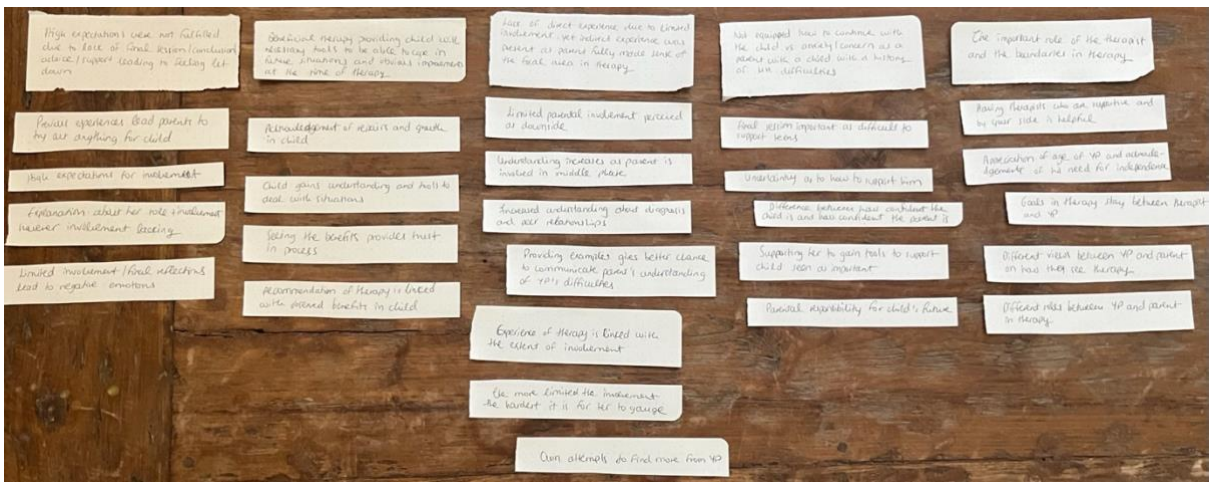
Having therapists who are supportive and by your side is helpful

Recommendation of therapy is linked with observed benefits in child

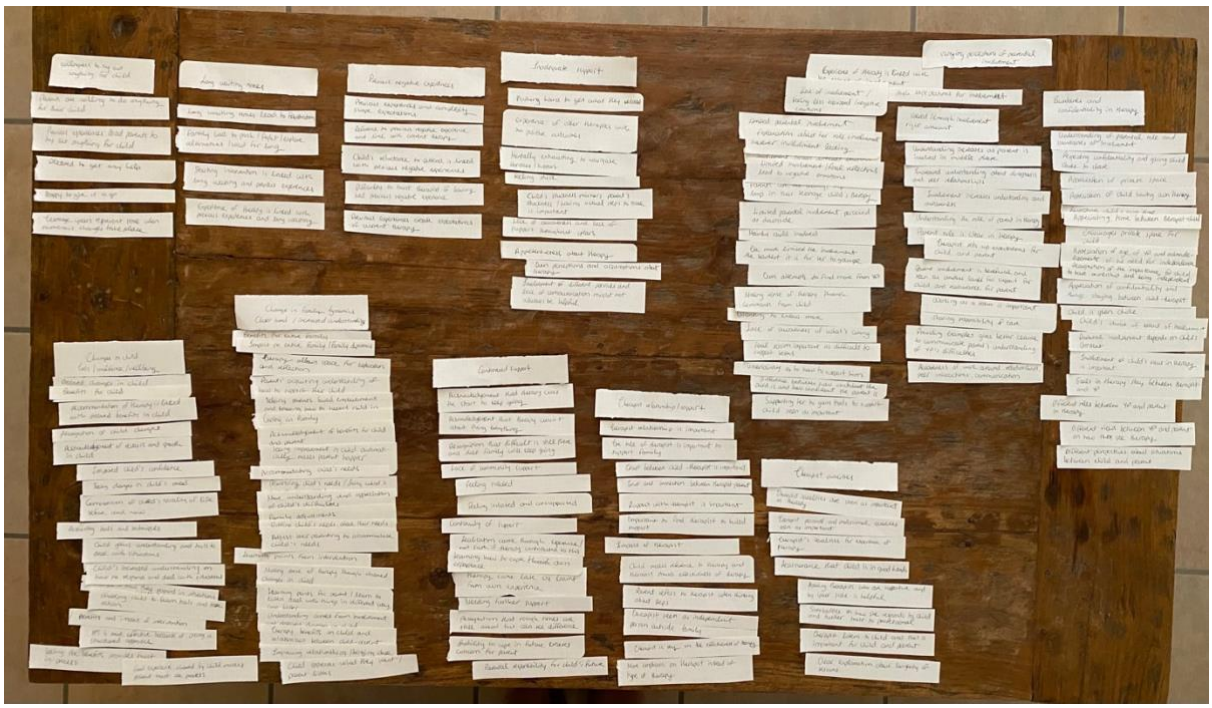
High expectations for involvement

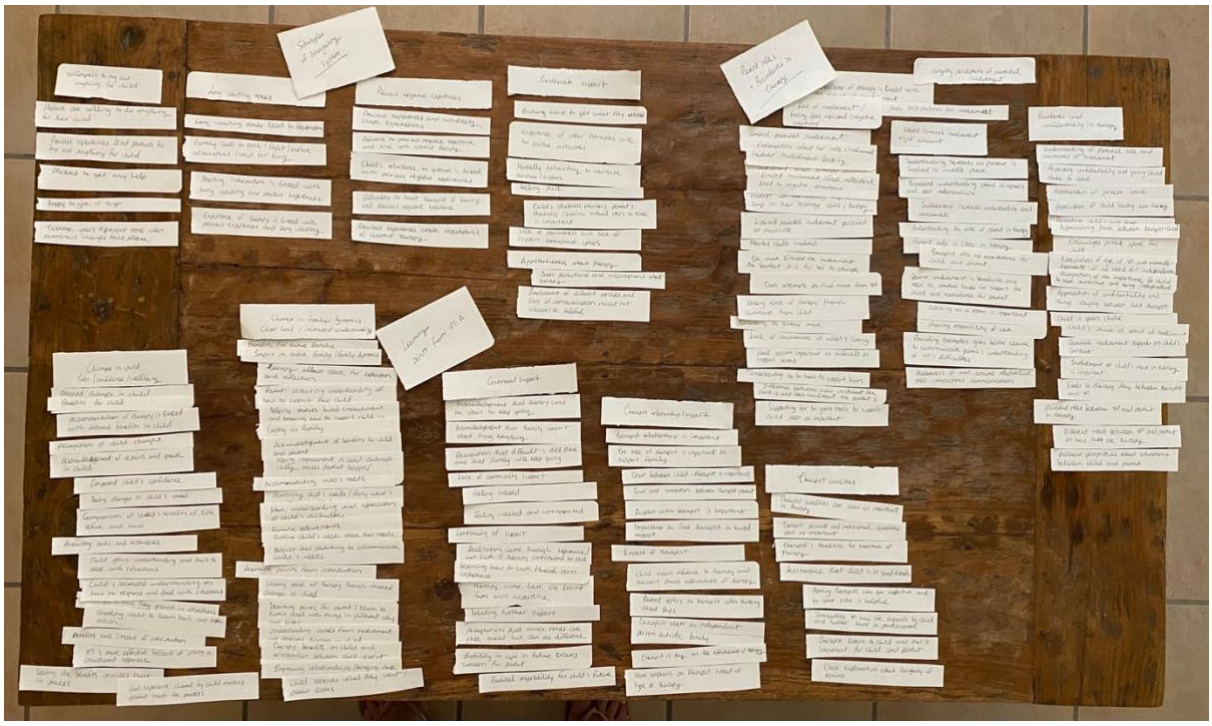
Final session important as difficult to support teens, uncertainty as to how to support him

Difference between how confident the child is and how confident the parent is



Appendix 15: Cross-case analysis





Appendix 16: Recurrence of themes across participants

Participants	GETs and subthemes						
	1.0	2.1	2.2	3.1	3.2	3.3	3.4
Fran	x	x	x	x	x	x	x
Gigi	x	x	x	x	x	x	x
Jacob	x	x	x	x	x	x	x
Kali	x	x	x	x	x	x	x
Talia	x	x	x	x	x	x	x
Kevin	x	x	x	x	x	x	x
Faye	x	x	x	x	x	x	x