Supporting Parents to Support Children:
The Role of Parents in Therapeutic Services and Interventions

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Thesis Portfolio Abstract

Background:

A wealth of literature has highlighted the key influence of parent mental health on child mental health (Fitzsimons et al., 2017; Kessler et al., 2010) and parental involvement within child mental health treatment is an important predictor of treatment outcomes (Dowell & Ogles, 2010). Therefore, it is in the best interest of children, for services to establish the most effective models and methods for supporting their parents. The thesis portfolio aimed to investigate how services can best support parents to support children. This included a) a review of the evidence regarding a specific type of therapeutic intervention (CFT), and b) an exploration of parent experiences of a specific model of child inpatient care (i.e. admitting parents alongside their child to a child mental health unit).

Method:

This portfolio comprised a systematic review and an empirical paper. The systematic review synthesised and appraised studies focusing on Compassion-focused interventions (e.g. CFT, Cetho etc.) for parents on a) parent mental health outcomes and b) child mental health outcomes. The empirical paper explored parents' experiences of being admitted to a child mental health unit alongside their child and parents' perceptions of how the admission and therapeutic work influenced their mental health.

Results:

Within the systematic review, most studies indicated improvements in parent mental health outcomes (after receiving compassion focused interventions). However, of the nine included studies, just two had active control groups and bias was identified across all studies. Only two

studies included measures of child mental health, and both observed significant improvements for children, yet neither study included an active control group. The empirical paper revealed the joint-inpatient admission was intense and stressful, yet parents were grateful to be admitted alongside their child and learned a lot from the experience. Therapy supported parents to make sense of their own difficulties and intergenerational family patterns, and to develop more compassionate narratives regarding their parenting. Relationships with staff and other parents, as well as children and non-admitted family members, had a key influence on parent wellbeing.

Conclusion:

The systematic review provides preliminary tentative evidence that compassion focused interventions may be helpful for parents and their children, though greater, high-quality research is needed. The empirical paper revealed that parents experienced the joint admission as stressful, yet were grateful to be there with their child and learned a lot from the experience and through therapy. Taken together, the papers provide tentative evidence that a) compassion-focused interventions may hold promise for working with a wide range of parents and b) the joint-inpatient model may be beneficial for parents of children with complex mental health difficulties (providing greater opportunities to support parents to support their children).

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A Systematic Review of the use of CFT in supporting parents:

impact on parent and child outcomes

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Abstract

Background: Compassion Focused therapy (CFT) is a transdiagnostic approach which has demonstrated efficacy across a wide range of clinical presentations (Kirby et al., 2017; Leaviss & Uttley, 2015). The link between parent mental health and child mental health is well established (Goodman et al., 2011; Gross et al., 2008; Kessler et al., 2010) and parents commonly experience pressure, judgement, stress and setbacks. If parents are able to soothe themselves and respond to these challenges compassionately, threat-based emotions (such as anger and anxiety) may be more manageable and less likely to negatively influence interactions with other members of the family system. As such, Compassion focused interventions for parents have the potential improve mental health outcomes in both parents and children. To date, the available evidence for compassion focused interventions (i.e. Compassion Focused Therapy or Compassionate Mind Training) for parents has not been systematically reviewed.

Aims: The present systematic review aimed to synthesise all the available research focusing on Compassion-focused interventions (e.g. CFT, CMT etc.) for parents on a) parent mental health outcomes and b) child mental health outcomes.

Methods: Papers were identified by searching the databases APA PsychInfo, CINAHL Ultimate, MEDLINE Ultimate and Directory of Open Access Journals (DOAJ). Due to the heterogeneity of the studies, a narrative synthesis was conducted. The methodological quality of randomised control trials was assessed using the Cochrane Collaboration's tool for assessing risk of bias (Higgins et al., 2011) while non-randomised studies were assessed using the Risk of Bias Assessment Tool for Non-randomised Studies (RoBANS; Kim et al. 2013).

Results: Nine studies met the review inclusion/exclusion criteria. Papers covered a wide range of parent samples, including parents of children experiencing an array of mental health and physical health difficulties as well as self-critical parents (irrespective of child difficulties). The majority of studies observed significant improvements in parent mental health outcomes, particularly for depression, anxiety, parental wellbeing and trauma symptoms. The evidence regarding the impact of CFT on parent stress levels was less consistent. Two studies included measures of (parent-rated) child mental health and both observed significant improvements. Bias was identified across all included papers, randomised control trials and non-randomised studies, thus the positive findings should be interpreted with caution.

Conclusions: The review provides tentative preliminary evidence that Compassion focused interventions may be helpful for a wide range of parents (including parents of children with mental health and physical health difficulties), yet more research is required, especially high quality RCTs and studies with active control groups. Studies of individual CFT for parents are needed, as well as research including moderator variables (e.g. fears of compassion, parenting quality etc).

Keywords: compassion, compassion focused therapy, CFT, parents, mental health

Introduction

The relationship between parent mental health and child mental health is well established (Connell & Goodman, 2002; Goodman et al., 2011; Pardini et al., 2008). Growing up with a parent experiencing mental health difficulties is one of the strongest predictors of later psychiatric disorder, alongside other adverse childhood experiences such as abuse and neglect (Kessler et al., 2010). Moreover, research has highlighted that the relationship between child and parent mental health is bidirectional (Gross et al., 2008; Pardini et al., 2008) such that parents and children exert reciprocal influences on one another, creating a cycle that can span across generations. As such, interventions that improve parent mental health could have significant impacts not only on the parents themselves but also on the mental health of their children. To date, most evidence-based parenting interventions have targeted child behavioural problems (e.g. Incredible Years, Triple P; Webster-Stratton, (1998) and child anxiety (Creswell & Cartwright-Hatton, 2007). Although evidence suggests such interventions are effective (Morawska et al., 2011; Sanders & Kirby, 2014), parenting researchers also suggest existing approaches could be improved (Garcia et al., 2019; Martínez et al., 2019). For example, there is a need for interventions to promote adaptive and prosocial outcomes (as well as reducing difficulties) and it is not yet known whether more optimal outcomes could be achieved if other dimensions of parenting were also targeted, such as parental self-criticism (Kirby, 2022).

Parenting challenges and Self-Criticism

As well as being a rewarding and meaningful role, parenting is not without challenges, including setbacks and disappointments (Kirby et al., 2019). Parents experience a considerable amount of pressure to meet cultural expectations, such as spending lots of time

with children and ensuring children access a wide range of activities (Sidebotham, 2001). Additionally, parents often feel judged: the findings of a study involving over 2,000 US parents found that 90% of mothers and 85% of fathers felt judged by other parents and strangers, with 50% feeling judged almost all the time (Zero to Three, 2016). The scrutiny that parents face, can trigger self-blame and self-criticism among parents, affecting their mental health and potentially impacting their children. Indeed, research indicates that children subjected to coercive, dismissive, or controlling parenting styles are more likely to experience adverse outcomes such as emotional and behavioural difficulties (Laurin et al., 2015; Mcdowell et al., 2003). The link between parental self-criticism and psychologically controlling parenting (Ahmad & Soenens, 2010) suggests that reducing self-criticism among parents could lead to more positive parenting approaches and better outcomes for children.

What is Compassion Focused Therapy?

Compassion may be defined as a sensitivity to suffering, in oneself and others, combined with a commitment to alleviate it and prevent it (Gilbert & Choden, 2013; Jinpa, 2015). Gilbert's model of Compassion Focused Therapy (CFT) emphasises the utility of cultivating compassion for working with distress and regulating emotions. The model describes three interlinked emotion regulation systems: the threat system, the drive system and the soothe system. From an evolutionary perspective, each of these systems has evolved to meet specific needs linked to our survival. The drive system motivates the acquisition of important resources, such as money and food. The threat system is concerned with our immediate safety and is linked to emotions such as fear, disgust and anger. The functions of the soothe system include connecting with others and allowing 'rest and digest'. Activation of the soothe system is associated with feelings of calmness and contentment, producing a regulating effect on distressing threat-based emotions. Gilbert hypothesised that the soothe system is less well

developed and harder to access for people high in shame and self-criticism, whose 'threat' system dominates their relationship to their inner and outer worlds (Gilbert, 2009). One of the key aims of CFT is to help people develop experiences of inner warmth, safeness and soothing, utilising compassion and self-compassion.

Why might Compassion Focused Therapy (CFT) be helpful for parents?

While challenges are an inevitable part of the parenting journey, there are several reasons Compassion-Focused Therapy (CFT) may be helpful for parents as well as their children. CFT is designed to help individuals develop three flows of compassion: compassion toward themselves, compassion toward others, and the ability to accept compassion from others (Gilbert et al., 2017).

Firstly, developing self-compassion may help parents regulate threat-based emotions such as anger and anxiety. Indeed, cross sectional studies have shown that self-compassion is associated with lower levels of depression, anxiety and stress (MacBeth & Gumley, 2012; Neff & Vonk, 2009). From a social-learning perspective, improvements in parents' emotion regulation skills may help children to learn the skills to regulate their own emotions (Bandura & Walters, 1977). Additionally, if parents can respond to challenges with self-compassion, rather than self-criticism, this may free up emotional resources enabling them to address challenges constructively (Beaumont & Hollins Martin, 2015) rather than avoid them.

Secondly, developing compassion for others may help parents to tolerate and respond to their child's distress in more helpful ways, particularly as CFT aims to develop several helpful capacities such as distress tolerance, empathy, emotion regulation and perspective-taking (Kolts, 2016). Moreover, compassion contains a warm orientation towards suffering; a warm motivation and affective tone can produce feelings of safeness/safety enabling a shift from a

mindset which is rigid and threat-focused, to one which is more open, reflective, and flexible (Kolts, 2016). Such gains may facilitate parental responsiveness, fostering greater attachment security in the parent-child relationship (Raval et al., 2002).

Thirdly, developing the ability to accept compassion from others may benefit wellbeing (Gilbert, 2005; Hermanto et al., 2016); allowing support from others may provide additional coping resources and further enhance parents' ability to self-regulate.

What is the evidence regarding self-compassion and parent mental health?

Self-compassion has been linked to reduced levels of stress in parents, regardless of their child's mental health (Stenz et al., 2023) and has been found to be a stronger predictor of parental stress and well-being than the severity of their child's emotional and behavioural problems (Shenaar-Golan et al., 2021). In an experimental study, Sirois et al., (2019) investigated the effects of dispositional and induced self-compassion on parental guilt and shame in a sample of 167 parents of children 12 years and under. Parents were randomly assigned to recall a guilt provoking or shame inducing parenting event and randomly allocated to either a self-compassion prompt or a control condition. Parents were required to write about an event that made them feel guilty/ashamed about their parenting. Those in self-compassion condition were instructed to re-read the event they had written about and then respond in writing with self-compassion, whereas those in the control condition were instructed to re-read the event and write objective facts about the event (e.g. the day of the week and the weather). The results revealed that parents allocated to the self-compassion condition reported higher levels of self-compassion, and lower levels of guilt and shame, than parents allocated to the objective control condition. This difference was maintained after controlling for baseline levels of self-compassion (Sirois et al., 2019). The study provides

evidence that compassionate self-talk may be beneficial for promoting parent wellbeing following challenging parenting events.

As well as compassionate self-talk, another method of self-compassionate responding, in a challenging situation, is to practise meditation. One type of meditation which is integral to compassion focused interventions is a Loving Kindness Meditation (LKM) (Kirby, 2016). A randomised micro-trial investigated the impact of loving kindness meditation on parents' responses to difficult child behaviour vignettes (Kirby & Baldwin, 2018). Sixty-one parents were randomly allocated to either receive a LKM or a control focused imagery exercise. Parents who received LKM showed higher levels of self-compassion compared to the control group, though not compassion toward others. Additionally, parents in the LKM condition had more positive (e.g. calm and sympathetic) and less negative emotional responses (e.g. frustration and anger) in response to situations of childhood distress, highlighting the value of including LKM in compassion interventions for parents and their children.

A systematic review explored the efficacy of parenting interventions that included self-compassion-promoting components for parent and child outcomes (Jefferson et al., 2020). The authors defined self-compassion-promoting-components as those which may 'be reasonably expected to improve any of the positively loaded elements of self-compassion (i.e., self-kindness, common humanity and mindfulness) or decrease any of the negatively loaded elements of self-compassion (i.e. self-judgement, isolation and overidentification)'. The review identified 13 trials that met the inclusion criteria and found that interventions which included self-compassion components were effective in improving parent depression, anxiety, stress, self-compassion and mindfulness, with small to moderate effect sizes. Four of the studies included child mental health outcomes and three of these studies observed improvements on at least one child mental health outcome. While the findings of this review

provide valuable preliminarily evidence regarding self-compassion interventions for parents, the majority of included studies focused on mindfulness interventions (*k*=9) (e.g. Mindfulness Based Cognitive Therapy; MBCT, Mindfulness Based Stress Reduction; MBSR) rather than self-compassion/compassion (*k*=3). Similarly, another review investigated mindfulness and compassion-based parenting interventions in the postpartum period and concluded that including mindfulness and compassion in parenting interventions appears beneficial, yet the majority of studies were of mindfulness-based interventions (Fernandes et al., 2022). While mindfulness is a key component of self-compassion, mindfulness on its own is not synonymous with compassion. Thus, more research on interventions including other components of self-compassion are needed (i.e. self-kindness and common humanity). Further, as CFT aims to develop three flows of compassion (not only self-compassion), it is important that the evidence for compassion focused interventions are reviewed in their own right. To date, the evidence base for CFT parent interventions has not been systematically reviewed.

Research Questions

The study aimed to investigate the primary research question of 'What is the effect of Compassion Focused Therapy for Parents on parent mental health outcomes?'. The study sought to understand the efficacy of compassion focused interventions for parent mental health outcomes.

The secondary research question was: 'What is the effect of Compassion Focused Therapy for Parents on child mental health outcomes? The study aimed to investigate the impact of CFT interventions for parents on child outcomes, where the parent intervention was the only intervention (i.e. to what extent does children's mental health benefit from a parent focused intervention?).

Method

The protocol was registered with PROSPERO (CRD42023483789). This systematic review is reported in line with PRISMA guidelines (Shamseer et al., 2015). Ethics approval was not required as no direct human data were collected.

Participants

Eligible studies were those that investigated biological parents, adoptive parents, foster parents or caregivers of an infant, child or adolescent between the ages of 0 and 18 years. All studies of current parents were eligible (i.e. parents of children with mental health difficulties/physical health difficulties or neurodevelopment differences, or if the parents themselves experienced difficulties).

Studies were excluded if the sample comprised parents of adult children or if the sample consisted of professional caregivers (i.e. those in a residential setting). Studies that focused on pregnant/intending parents were excluded so as to focus on current parents.

Interventions

Eligible studies employed a compassion focused intervention for parents which aimed to improve parent and/or child outcomes. The interventions were specifically compassion-focused (e.g. compassion focused therapy, compassionate mind training, compassion therapy or self-compassion therapy) rather than more general or other therapeutic approaches that just included a self-compassion component (e.g. mindfulness-based therapy or acceptance and commitment therapy). Studies were included if interventions were delivered individually, in groups, online or in person.

Studies that administered an intervention protocol grounded in compassion/self-compassion were included. Experimental studies that did not include a tailored compassion intervention were not included – for example, studies that only gave a self-compassion cue, or prompt were excluded. Studies were required to include, at minimum, some form of compassion psychoeducation and may also include some type of compassion enhancement or skill development (e.g. meditation or compassionate writing). Studies that did not include any form of psychoeducation (e.g. solely meditation skills) were excluded.

Comparisons

Studies were included irrespective of whether they included a comparison group or not.

Outcomes

Studies were required to include at least one measure of parent mental health or child mental health, measured pre- and post-intervention.

Study Designs

Studies were included if they were published in a peer-reviewed journal from 2000 up until November 2023 and were written in the English language. The start date was chosen because the first known paper discussing Compassion Focused Therapy (CFT) was published in 2000. Studies were included if they were a randomised control trial (RCT) or a non-randomised study with or without a comparison group.

Case studies were excluded, as were studies that did not include quantitative analyses due to their limited generalisability. Meta-analyses, systematic reviews and observational studies were also excluded.

Search Strategy

A search of the electronic databases APA PsychInfo, CINAHL Ultimate, MEDLINE Ultimate and Directory of Open Access Journals (DOAJ) was completed. The Boolean Operators 'AND' and 'OR' were used to combine words within the search (see Table 1). MeSH terms 'MH' were utilised to account for variations in language (e.g. British English vs American English) and abbreviations. Delimiters were the dates searched (2000- November 2023) and language (English). The search strategy was developed through consultation with the University Information Librarian.

Table 1

Search Terms

Parent or caregiver Terms		**Compassion Intervention terms**
(MH "Parents") OR parents OR parent OR adoptive parent OR foster parent OR caregiver OR mother OR father OR mum OR dad OR guardian	**AND**	'compassion focused therapy" OR "compassion* therapy" OR "compassionate mind training" OR "CFT" OR "compassion-focused therapy" OR "self-compassion focused therapy'

Study Selection

The studies were screened to remove duplicates and then by title and abstract. The primary author (AM) assessed the remaining articles based on analysis of the full text to determine eligibility, and a second reviewer assessed 50% of these studies, which were selected at random. Disagreements between reviewers were discussed to ensure that the selected studies met the inclusion and exclusion criteria. A manual search was also conducted, and references of the included papers were checked for eligible papers.

Data extraction

Data extraction was performed by the primary author (AM). Data were extracted into an excel database and checked by an independent reviewer. All studies were screened via titles/abstracts and duplicates were removed as well as those that did not meet the eligibility criteria (see figure 1). A Microsoft Excel table recorded extracted data including Author, Year, Country, Population/Sample, Number of Participants, Study Design/Comparison, Analysis, CFT frequency and delivery, parent mental health outcomes, child mental health outcomes.

Data synthesis

Due to the heterogeneity of the studies (i.e. considerable variation across study designs, intervention types and outcome measures), a narrative synthesis was conducted. The extracted data were synthesised narratively in line with the review objective. This involved a detailed examination of the numerical and narrative summary findings and conclusions with respect to the effectiveness on parent mental health outcomes and child mental health outcomes. Further, parent outcomes were grouped according to specific types of mental health outcome: depression, anxiety, stress and burnout, trauma and wellbeing (note: this was

only done for parent outcomes as there were only two studies with child outcomes). The narrative synthesis approach considered guidelines of Popay et al., (2006) including: familiarisation with the selected studies through reading and annotating content, extracting and presenting key study findings in a table, producing a written 'narrative' summary of the key findings with respect to the research questions and, finally, critical appraisal.

Risk of Bias Assessment

For randomised control trials, the methodological quality and risk of bias were assessed using the Cochrane Collaboration's tool for assessing risk of bias (Higgins et al., 2011). Non-randomised studies with repeated measures designs were assessed using the Risk of Bias Assessment Tool for Nonrandomized Studies (RoBANS; Kim et al., 2013). A third of the articles, selected at random, were assessed by a second reviewer and discrepancies were resolved through discussion until consensus was reached, and centred around the thresholds for 'high' vs 'unclear' bias where there was a lack of detail.

Figure 1
PRISMA Flow Diagram

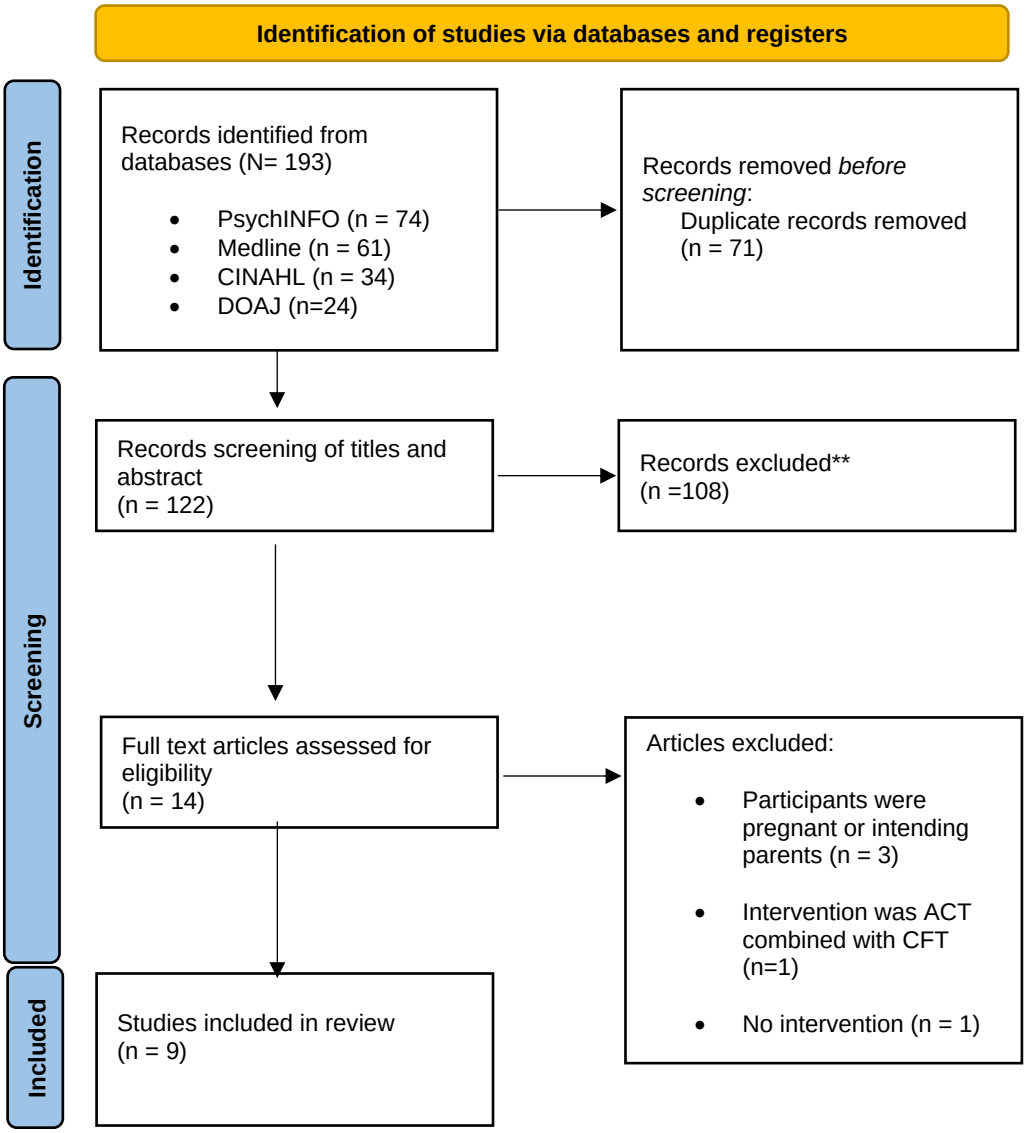

Table 2
Summary of Included Studies

Author(s), Date and Country	Population/Sample	Number of Participants	Study Design & Comparison	Analysis	CFT Frequency and delivery	Parent Mental Health Outcomes	Child Mental Health Outcomes
(Bratt et al., 2020) Sweden	Parents of Adolescents under psychiatric outpatient treatment	*N* = 77 CFT group n = 28 (17 mothers, 11 fathers) TAU group n = 49 (30 mothers, 19 fathers)	Non-randomised control trial with control group (Treatment as usual; TAU)	Paired samples t-tests, independent samples t-tests	8 sessions of group-based CFT; Parents group leader was a Clinical Psychotherapist; (Separate group for Adolescents)	Perceived Stress Scale (PSS)(Cohen et al., 1983); No significant differences between TAU and CFT groups for either mothers or fathers	Not applicable as Adolescents also received intervention
(Cwinn & Guillen, 2022) Canada	Parents/caregivers of young people with mental health difficulties	*N* = 18	Repeated measures design (no control group)	Paired samples t-tests	3 sessions of the CFT caregiver protocol delivered virtually from a mental health clinic	Parental Burnout Scale (PBS)(Roskam et al., 2017); burnout significantly decreased,	Behaviour and Feeling Survey (BFS) (Weisz et al., 2020); child mental health difficulties significantly decreased

Author(s), Date and Country	Population /Sample	Number of Participants	Study Design /Comparison	Analysis	CFT Frequency and delivery	Parent Mental Health Outcomes	Child Mental Health Outcomes
(Khoshvaght et al., 2021b) Iran	Mothers of children with Cerebral Palsy	*N* = 40 CFT = 20 Control= 20	Non-randomised control trial (control group did not receive an intervention)	ANCOVA, MANCOVA	8 60 minute weekly sessions of CFT	Beck Depression Inventory (BDI) (Beck et al., 1996)and Beck Anxiety Inventory (BAI)(Beck & Steer, 1993); significantly reduced levels of anxiety and depression in the CFT group at both post-test and follow-up test	
(Khoshvaght et al., 2021a) Iran	Mothers of children with Cerebral Palsy	*N* = 45 CFT = 15 Metacognitive therapy = 15 Control= 15	Non-randomised control trial (participants assigned to metacognitive therapy, CFT or control)	Repeated Measures ANOVA	CFT group - 8 sessions (60 minute sessions per week) Metacognitive therapy group - 12 sessions of 60 mins per week	Beck Anxiety Inventory (BAI) (Beck & Steer, 1993); both metacognitive therapy (MTC) and compassion-focused therapy (CFT) were effective in reducing anxiety in the mothers of children with cerebral palsy. No significant difference between the effects of	

Author(s), Date and Country	Population /Sample	Number of Participants	Study Design /Comparison	Analysis	CFT Frequency and delivery	Parent Mental Health Outcomes	Child Mental Health Outcomes
(Lennard et al., 2021) Australia	Community sample of mothers of infants (under 2 years old)	248 mothers (intervention = 94, waitlist-control = 154) however for 2nd set of analyses intervention group was =59 - those who engaged with the online resources	Randomised control trial (CFT vs waitlist control)	ANCOVA	Online resources (same as Mitchell, 2018) based on CFT principles and consisting of two videos and downloadable tip sheet. Participants received unlimited access to the resources over the stduy period - 7 weekly SMS reminders were used to scaffold resource use	Depression, Anxiety and Stress scale (DASS-21) (Lovibond & Lovibond, 1995) ; no significant differences for the full sample DASS-21) analyses were repeated with only the participants (n = 59) who received the intervention per protocol and CFT group had significantly lower levels of depression Impact of Events Scale (IES-R) (Weiss, 2007). Full sample results - greater improvement in IES-R Hyperarousal scores for mothers allocated to intervention compared to waitlist-control IES-R; For the ‘per-protocol’ sample - greater	

				improvements in scores for posttraumatic stress symptoms (IES-R Intrusion, Hyperarousal, and Total scores)

Table 2
Summary of Included Studies

Author(s), Date and Country	Population /Sample	Number of Participants	Study Design /Comparison	Analysis	CFT Frequency and delivery	Parent Mental Health Outcomes	Child Mental Health Outcomes
(Kirby et al., 2023) Australia	Self-critical parents	*N* = 102 (102 parents; 87 mothers) CFT group = 48 Waitlist control = 54	Randomised control trial; Participants were measured at pre-, 2-week post-intervention and the CFT group again at 3-month follow-up.	ANOVA	A single 2 hour CFT parenting seminar; Parents provided with a workbook containing exercises and recorded audio tracks	Depression, Anxiety and Stress (DASS-21) (Lovibond & Lovibond, 1995); no significant intervention effect on parents' depression or anxiety symptoms, but there was a significant effect on parental stress. Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) (Tennant et al., 2007); well-being indicated significant differences between the CFT group and the control group after the intervention, with wellbeing increasing significantly in CFT group post-intervention	SDQ (Goodman & Goodman, 2009); emotional and peer problems significantly reduced at post-intervention SDQ; emotional, conduct, peer problems and hyperactivity all significantly reduced at 3 month follow-up

Table 2
Summary of Included Studies

Author(s), Date and Country	Population /Sample	Number of Participants	Study Design /Comparison	Analysis	CFT Frequency and delivery	Parent Mental Health Outcomes	Child Mental Health Outcomes
(Mitchell et al., 2018) Australia	Community sample of mothers of infants (under 1)	262 mothers	Repeated measures design (no control group)	Paired samples t-test	Online resources based on CFT principles and consisting of two videos and downloadable tip sheet. Participants received unlimited access to the resources over the study period - 7 weekly SMS reminders were used to scaffold resource use	Impact of events scale IES-R (Weiss, 2007); Mean total scores for posttraumatic stress symptoms decreased from pre- to post-intervention. This was largely driven by decreases in Intrusion and Hyperarousal symptom scores, whereas there was no significant change in the mean score for avoidance	

Table 2
Summary of Included Studies

Author(s), Date and Country	Population /Sample	Number of Participants	Study Design /Comparison	Analysis	CFT Frequency and delivery	Parent Mental Health Outcomes	Child Mental Health Outcomes
(Navab et al., 2019) Iran	Mothers of children with ADHD	N = 20 Treatment group = 10	Non-randomised control trial (CFT vs waitlist control)	Mann Whitney U	8 weekly session of group CFT (90 mins weekly)	Depression Anxiety and Stress Scale (DASS-21)(Lovibond & Lovibond, 1995); post-intervention the psychological symptoms of the mothers in the CFT group were significantly lower than those of the mothers in the control group	
(Yazdi et al., 2023) Iran	Mothers of children with hearing impairment	N= 30 Treatment = 15 Control = 15	Non-randomised control trial (CFT vs waitlist control)	ANCOVA	Group CFT in 8 90-minute sessions (three per week) delivered by an expert in family counselling	Cattle Anxiety Questionnaire (CAQ) (Movahhedi Rad et al., 2012); results of ANCOVA showed a significant difference between the pretest and posttest scores of the CFT group	

Results

Data Extraction Outcome

The included studies are summarised in Table 2. A total of nine studies met the inclusion criteria – two of these were randomised control trials (RCTs), five were non-randomised control trial, and two had a repeated measures design with no control group.

Sample characteristics

The study sample sizes ranged from 18 (Cwinn & Guillen, 2022) to 262 (Mitchell et al., 2018) and just four of the studies had sample sizes above 50. Four of the studies took place in Iran, three studies were conducted in Australia/New Zealand, one study was in Sweden and one in Canada. Two studies had active control groups: one compared CFT to metacognitive therapy, another compared CFT to treatment as usual (TAU). Five studies had a waitlist control group, while two studies did not have a control group.

Two studies recruited community samples of mothers of infants (Lennard et al., 2021; Mitchell et al., 2018). Two studies focused on mothers of children with cerebral palsy (Khoshvaght et al., 2021a, 2021b). One studied mothers of children with ADHD (Navab et al., 2019). One study investigated mothers of children with a hearing impairment (Yazdi et al., 2023). One study focused on parents of adolescents under psychiatric outpatient treatment (Bratt et al., 2020), whilst another investigated parents of children with mental health difficulties receiving outpatient care (Cwinn & Guillen, 2022). Finally, one study was of self-critical parents (Kirby et al., 2023) of any child (i.e. child mental health difficulties or other difficulties were not necessary for parents to be eligible). Thus, the included studies focused on a wide range of samples, including community samples, self-critical parents and parents of

children with mental health difficulties, physical health difficulties and neurodevelopmental differences.

As detailed in Table 1, there was also considerable heterogeneity in terms of the intervention, with respect to the type, format and length. Five studies provided the CFT intervention in a group format, two studies provided online psychoeducation resources only (i.e. videos and a downloadable tip sheet), one study virtually delivered the CFT caregiver protocol (including psychoeducation, training and practice with emotion coaching, training on behaviour change etc.) and one study delivered a brief 2-hour CFT parenting seminar and provided a workbook and audio-tracks for parents to continue their own practice. The length of interventions varied greatly. Brief interventions included - two studies involving online resources only (e.g. videos and tips), one study involved a single two-hour CFT parenting seminar. Two studies employed longer/more intensive interventions by delivering 8 x 90 minute sessions.

Assessment of methodological quality

Appendices B and C summarise the quality ratings for the included studies. The Cochrane Collaboration's tool for assessing risk of bias in Randomised Control Trials (RCTs) was utilised (Higgins et al., 2011). Both RCTs were assessed as having a 'high' overall level of bias. For Kirby et al., (2023), there were concerns regarding detection bias and reporting bias. For Lennard et al., (2021) there was a high level of bias for attrition bias and reporting bias, and concerns regarding detection bias.

The Risk of Bias Assessment Tool for Nonrandomised studies (Kim et al., 2013) was utilised to determine the methodological quality of pre-post intervention studies (see Appendix B). Bias was identified in all pre-post studies included in this review. All studies were assessed as demonstrating high risk in selection bias, as samples were either voluntary, self-selecting or purposive. Bratt et al., 2020), Mitchell et al., (2018), and Navab et al., (2019) showed bias in

relation to attrition. Several studies were assessed as ‘high’ detection bias (Cwinn & Guillen, 2022; Khoshvaght et al., 2021b; Mitchell et al., 2018; Navab et al., 2019; Yazdi et al., 2023).The non-randomised study with the lowest levels of bias was (Khoshvaght et al., 2021a) with ‘high’ selection bias only.

Parent Mental Health Outcomes

The majority of included studies observed significant treatment effects on parent mental health outcomes: eight of the nine studies observed a significant improvement in at least one domain of mental health. Bratt et al.’s, (2020) investigation of group CFT for parents of adolescents with mental health difficulties was the only study that did not observe a significant improvement in parent mental health, though the sample sizes in this study were particularly small (e.g. only 11 fathers in the CFT group) limiting the generalisability of the findings.

Depression

Four studies (two RCTs and two non-randomised studies) investigated the impact of CFT on parental depression. Kirby et al’s, (2023) randomised control trial investigated the impact of a brief online CFT intervention for self-critical parents (total n= 102: CFT n= 48 and waitlist control n= 54). As measured by the Depression, Anxiety and Stress Scale (DASS-21) (Lovibond & Lovibond, 1995), there were no significant differences between the CFT group and waitlist control group after the intervention. There was also no significant long-term intervention effect on depression at the 3 month follow up.

Lennard et al.’s, (2021) RCT investigated the impact of a CFT intervention, consisting solely of online resources (i.e. two videos and downloadable tip-sheet), on a community sample of mothers of infants under two years of age. For the full sample (N=

248), there were no significant differences in depression (DASS-21) between the CFT group and waitlist-control group. The analyses were repeated with only the participants (n = 59) who received the intervention per protocol (i.e. watched the psychoeducational video and/or tip sheet and completed the guided self-compassion exercise at least once). These 'per protocol' analyses revealed significantly lower levels of depression after receiving the intervention, $p = .028$, $\eta_p^2 = .024$, representing a small effect size. Notably, the 'per-protocol' group was found to have lower baseline scores for fear of compassion from others compared to the full sample, indicating that fears of compassion mediated engagement with the intervention.

A non-randomised control study of group CFT (8 x 60 minute sessions) for mothers of children with cerebral palsy assigned 20 mothers to the CFT group and 20 to the control group (Khoshvaght et al., 2021b). Levels of depression, measured by the Beck Depression Inventory (BDI) (Beck et al., 1996), were significantly lower in the CFT group at both post-test test, $p < .001$, $\eta_p^2 = .49$ (representing a moderate effect size) and at follow-up $p < .001$, $\eta_p^2 = .89$ (denoting a large effect size).

Navab et al., (2019) investigated the impact of group CFT (8 X 90 minute sessions) on mothers of children with ADHD (n = 20, 10 in the treatment group). After intervention, the CFT group reported significantly lower levels of depression (DASS-21) compared to the control group, $p = 0.01$. Additionally, the CFT group showed significantly lower levels of depression after the intervention than before the intervention, $p < .05$.

Thus, three of the four abovementioned studies observed a significant treatment effect on depression.

Anxiety

Six studies explored the impact of CFT interventions on parents' anxiety levels.

Kirby et al's (2023) randomised control trial, of a brief CFT intervention for self-critical parents, found no significant intervention effect on parents' anxiety symptoms (DASS-21). At the three-month follow up, there was also no significant intervention effect on anxiety.

Lennard et al.'s (2021) randomised control trial of an online CFT intervention for mothers of infants also found no significant differences in anxiety (DASS-21) between the CFT group and waitlist-control group for the full sample (N= 248), or for the subsample who received the intervention 'per-protocol'(n = 59).

A non-randomised control study compared the impact of a CFT group (8 x 60 minute sessions) to a metacognitive therapy group (12 x 60 minute sessions) and a control group (n= 15 per group) on anxiety levels (BAI) (Beck & Steer, 1993) in mothers of children with cerebral palsy Khoshvaght et al., (2021a). The findings revealed that both CFT and metacognitive therapy were effective in reducing anxiety in the mothers of children with cerebral palsy (CP) ($p=0.0001$). Notably, there was no significant difference between the effects of CFT and metacognitive therapy on anxiety in this group of mothers.

In another study by the same authors, Khoshvaght et al., (2021b) compared the anxiety levels of a mothers who received group CFT (8 x 60 minute sessions) to the waitlist-control group. Levels of anxiety, measured by the Beck Anxiety Inventory (BAI), were significantly lower in the CFT group at both post-test $p < .001$ (with a small effect size, $\eta_p^2 = .33$), and at the 45-day follow-up $p < .001$, $\eta_p^2 = .69$, representing a large effect size.

Navab et al. (2019) studied the effectiveness of group CFT (8 X 90 minute sessions) on mothers of children with ADHD (n = 20, 10 in the treatment group). After the

intervention, (DASS-21) anxiety levels were significantly lower in the CFT group compared to the control group, $p = 0.007$. Additionally, the CFT group showed significant lower levels of anxiety after the intervention than before the intervention, $p < .05$.

Yazdi et al. (2023) investigated the impact of group CFT (8 x 90 minute sessions) on the anxiety levels of mothers of children with hearing impairments, compared to a waitlist control group. As measured by the Cattle Anxiety Questionnaire (Movahhedi Rad et al., 2012), there was a significant difference between the pre-test and post-test anxiety scores of the intervention group, $F(1,23)=14.15$, $p<0.001$. Thus, mothers who received the CFT group intervention had lower levels of anxiety after the intervention. The authors reported 'the effect size indicated that 46% of the variances in anxiety were related to the effects of the intervention', yet it is unclear whether this effect size refers to between group (i.e. pre vs post) or within group differences (i.e. CFT vs control).

Hence, four of the six studies observed a significant treatment effect on anxiety. Notably both RCTs did not find significant differences, and both RCTs employed brief interventions or online resources only, whereas the four studies observing significant treatment effects all employed group CFT interventions.

Stress and Burnout

Four studies investigated the impact of CFT interventions on parental stress levels and one study focused on burnout.

Kirby et al.'s (2023) randomised control trial of brief CFT for self-critical parents found a significant intervention effect on parental stress levels. The DASS-stress score of the CFT group reduced significantly (from $M = 9.44$, $SD = 3.95$, to $M = 7.23$, $SD = 4.40$), $F(1,57.98) = 5.24$, $p = .03$, with no significant changes found within the control group,. The

effect size of change was d = 0.18, representing a small effect. The stress score of the CFT group was also significantly lower at follow-up (M= 6.83, SD = 4.88) compared to pre-intervention (M=9.44, SD = 3.95).

Lennard et al.'s (2021) RCT of CFT for mothers of infants found no significant differences in stress (DASS-21) between the CFT group and waitlist-control group for the full sample (N= 248), or for the 'per-protocol' subsample.

Navab et al.'s (2019) study of group CFT for mothers of children with ADHD observed no significant differences in stress levels (DASS-21) between those who received the CFT group intervention and the control group.

Additionally, Bratt et al. (2020) compared the impact of a CFT group (8 sessions) to treatment as usual (TAU; including CBT, psychodynamic therapy or family therapy) for parents of adolescents with mental health difficulties. There were no significant differences in stress levels (Perceived Stress Scale; Cohen et al., 1983) between the two groups for either mothers or fathers, though sample-sizes were small. The findings indicate the efficacy of the CFT group was similar to TAU, however the lack of detail regarding TAU limits the extent to which clear comparisons can be made.

Cwinn & Guillen's (2022) pilot study investigated the impact of the CFT caregiver protocol for parents (n= 18) of children with mental health difficulties. The findings showed that levels of burnout (Parental Burnout Scale; Roskam et al., 2017) significantly decreased after receiving the CFT caregiver protocol, $t(17) = 3.05$, $p<.01$, and the effect size was large, $d= .72$.

Of the four studies to explore the impact of CFT on stress, the only one to observe a significant intervention effect was Kirby et al.'s (2023) RCT of brief CFT for self-critical

parents. The one study to measure burnout found a significant intervention effect (Cwinn & Guillen, 2022).

Trauma

Two studies explored the impact of CFT on parents' trauma symptoms – one RCT and one non-randomised control trial.

Lennard et al.'s (2021) randomised control trial of online CFT for mothers of infants observed significant intervention effects on trauma symptoms. Specifically, there were greater improvements in hyperarousal scores (Impact of Events Scale; IES-R; Weiss, 2007) for mothers in the intervention group, compared to waitlist-control, $p = .038$, $\eta_p^2 = .017$, representing a small effect. There was also a trend toward greater improvements on the total post-traumatic symptoms scale, $p = .051$, $\eta_p^2 = .015$, representing a small effect. There were no significant differences between the intervention and control groups on either avoidance or intrusion symptoms, for the full sample. The analyses were repeated with only those who received the protocol (i.e., watched the psychoeducational video and/or tip sheet and completed the guided self-compassion exercise at least once). These 'per-protocol' analyses revealed greater improvements in post-traumatic symptoms. There was significantly greater improvements in Intrusion ($p = .026$, $\eta_p^2 = .023$), Hyperarousal ($p = .034$, $\eta_p^2 = .021$) and Total scores ($p = 0.28$, $\eta_p^2 = .023$) for those who received the intervention 'per-protocol' compared to the control group. The effect sizes, for change in Intrusion, Hyperarousal and Total scores, all denote small effects.

A pilot study, Mitchell et al., (2018), also investigated the impact of an online CFT intervention for mothers (n = 262) of infants. Posttraumatic stress symptoms (IES-R) significantly decreased from pre- to post-intervention, $p = .002$, with a small effect size, $d = .11$. This change was largely driven by decreases in Intrusion ($p = .001$) and Hyperarousal (p

= .002) symptom scores, as there was no significant change in the mean score for Avoidance symptoms. The effect sizes for Intrusion and Hyperarousal were small, *d* = .14 and *d*= .12 respectively.

Both studies investigated the impact of online CFT on mothers of infants and observed significant treatment effects.

Wellbeing

One randomised control trial (Kirby et al., 2023) investigated the impact of a brief CFT intervention on wellbeing of self-critical parents. After intervention, Kirby et al., (2023) observed significant differences in parental wellbeing, as measured by the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS; (Tennant et al., 2007) between the CFT group and control group. The WEMWBS score of the CFT group increased significantly at post-intervention (M = 49.20; SD = 8.31) compared to pre-intervention (M = 44.90; SD = 7.71) while no changes were observed in the control group. The effect size of change was found to be *d = 0.20,* representing a small effect. The effect of CFT was maintained at follow-up, $t(29) = 3.70$, $p < .01$.

This finding indicates a brief CFT intervention led to significant improvements in parent wellbeing after treatment and the benefits were maintained at the 3 month follow up.

Child Mental Health Outcomes

Two studies investigated the impact of CFT interventions for parents on child outcomes – one RCT and one pilot study with a repeated measures design.

Kirby et al.'s, (2023) randomised control trial of CFT for self-critical parents observed significant reductions in parent-rated child adjustment difficulties as measured by

the Strengths and Difficulties Questionnaire (SDQ) (Goodman & Goodman, 2009). In terms of child social, emotional and behavioural outcomes, an interaction effect was found for emotion $F(1, 58.00) = 4.52$; $p = .03$, and SDQ-peer problems subscales, $F(1, 58) = 5.14$, $p = .03$, indicating that the intervention was effective in reducing emotional and peer problems in children. The SDQ-emotion score reported by the CFT group reduced from M = 3.67 (SD = 2.61) prior to intervention to M = 2.60 (SD = 1.72) post-intervention. The effect size of change found for the emotion subscale was $d = 0.15$, representing a small effect. Before the intervention, the peer problems score reported across the CFT group was M = 2.29 (SD = 1.98) which then reduced to M = 1.58 (SD = 1.69). However, peer problems reported by the control group increased from intervention at M = 1.74 (SD = 1.82) to M = 1.83 (SD = 1.88) at post-intervention. Crucially, at 3 month follow up the improvements were maintained and there were significant reductions in child conduct, emotion, hyperactivity and peer problems, indicating that further improvements occurred over the long term.

Cwinn & Guillen (2022) studied the effectiveness of the CFT caregiver protocol for parents (n= 18) of children with mental health difficulties. The results revealed that, parent-rated, child mental health difficulties, measured by the Behaviour and Feeling Survey (Weisz et al., 2020), significantly decreased post intervention, $t(17) = 2.72$, $p<.05$ and the effect size was large, $d= .64$.

The findings of both abovementioned studies indicated CFT interventions for parents had significant impacts on parent rated child mental health difficulties.

Discussion

The review sought to investigate the efficacy of Compassion focused interventions (i.e. CFT or CMT) for parents in relation to both parent mental health outcomes and child mental health outcomes. Of the nine studies included in this review, eight observed a

significant treatment effect with respect to at least one domain of parent mental health. Just two studies included measures of child mental health and both observed significant improvements. However, few studies included active control groups and bias was identified across all studies, limiting the extent to which conclusions can be made.

The review highlights preliminary evidence that CFT interventions for parents may be helpful for depression (Khoshvaght et al., 2021b; Lennard et al., 2021; Navab et al., 2019), anxiety (Khoshvaght et al., 2021a, 2021b; Navab et al., 2019; Yazdi et al., 2023), trauma symptoms (Lennard et al., 2021; Mitchell et al., 2018), burnout (Cwinn & Guillen, 2022), wellbeing (Kirby et al., 2023) and child mental health outcomes (Cwinn & Guillen, 2022; Kirby et al., 2023). However, the available evidence regarding CFT for stress was less consistent – with just one of the four included studies observing a significant treatment effect (Kirby et al., 2023).

The review is the first to focus, specifically, on compassion focused interventions for parents; a previous review investigated the impact of parenting interventions that included 'self-compassion-promoting components', however almost three-quarters of the studies were of mindfulness-based interventions, and just three were specific compassion- based interventions (Jefferson et al., 2020). Since compassion focused interventions encompass other components, in addition to mindfulness, the present study represents a valuable addition to the field. Both reviews observed improvements in parent and child outcomes and, thus both can be taken as preliminary evidence for the inclusion of compassion in parenting interventions. A difference between these two studies, is that Jefferson et al. (2020) found interventions were effective in reducing parental stress, whereas the present review yielded mixed outcomes with respect to stress. The inconsistent findings of the present study, regarding stress, are challenging to understand due to the heterogeneity of study designs,

samples and intervention types/formats. Differences in the methodological quality of studies could mean that some findings are not robust – for instance, small sample sizes may mean that significant effects are not detected even when they exist, or multiple testing may inflate the likelihood of significant results. Theoretically, the inconsistent findings may also be attributed to the different conditions studied (e.g. parents with high self-criticism vs parents of children with ADHD etc.) or differences in pre-existing stress levels. Further research is needed to better understand the efficacy of compassion focused interventions for parent stress, as well as which intervention components are most helpful and for whom. Notably, several studies have observed reduced stress levels after CFT across various contexts (Duarte et al., 2017; Lucre & Corten, 2013) and as such, it would be anticipated that CFT would lead to similar stress reductions for parents.

Just two studies included measures of child mental health outcomes (Cwinn & Guillen, 2022; Kirby et al., 2023) and both found significant treatment effects. Cwinn & Guillen, (2022) delivered the CFT caregiver protocol to parents of children with mental health difficulties and observed improvements of a moderate effect size (d = .64) in child mental health. Although limited by the small sample size, the moderate effect size may be partly accounted for by the unique protocol, as the CFT caregiver protocol includes elements of traditional CFT for caregivers *combined* with training in evidence-based parenting practices. Indeed, it has been suggested that combining parenting skills training with CFT may be most efficacious (Kirby et al., 2023), particularly as CFT promotes the development of adaptive attributes and emotional states, rather than just reducing negative symptoms (Petrocchi et al., 2024). Kirby et al.'s (2023) RCT of brief online CFT for self-critical parents observed significant treatment effects on emotion and peer problems at post-intervention, and these effects were maintained at the 3 month follow up and additionally, there were significant improvement in conduct problems and hyperactivity. This finding suggests that

brief CFT parent interventions may lead to positive mental health outcomes for children, and that greater benefits may be observed over the longer term, though more research is needed to confirm this. The authors hypothesise that learning, practicing and integrating CFT takes time so shorter follow up periods may be less likely to capture the benefits, particularly on more distal targets such as child outcomes (Gilbert & Kirby, 2019).

Limitations and Future Research

The review is the first to synthesise and appraise the efficacy of Compassion focused interventions on parent mental health and child mental health outcomes. A key limitation is the small number of studies that met the inclusion criteria. However, the review was limited to compassion focused interventions specifically, rather than broader interventions including aspects of compassion/self-compassion (e.g. Mindfulness based intervention or Acceptance and commitment therapy), to be able to ascertain the efficacy of these interventions on their own and disentangle the effects of CFT from other intervention types. A further limitation is that the review excluded non-English articles and grey literature, which may have reduced the risk of publication bias, as well as providing additional evidence on compassion-focused interventions. More studies are required to understand the efficacy of CFT for parents on parent and child outcomes. Notably, both the studies which included child mental health outcomes relied upon parent-ratings. It is possible that Compassion focused approaches influenced the way that parents perceived their children, enabling them to be more present to any improvements in their child's behaviour. Further research is needed, including multiple raters of child mental health, including children, parents and teachers (De Los Reyes et al., 2013). This would elucidate whether improvements are also perceived by children themselves after a CFT parent intervention, as well as whether such improvements are noticed across other contexts (e.g. school).

Given the bias identified across the included studies, higher quality studies are also needed to improve upon the methodological limitations, especially RCTs. Larger sample sizes are needed, as are active comparison groups (e.g. traditional parenting interventions, other third-wave approaches such as ACT etc.) and less bias sampling methods (e.g. stratified random sampling or simple random sampling). With the publication of more heterogenous studies, meta-analyses can begin to elucidate how effective these approaches are for supporting parents and their children.

The review focused exclusively on mental health outcomes and did not include process variables, such as parenting quality or fears of compassion. Hence, future studies are required to understand mediation and moderator variables of CFTs effectiveness on parent and child outcomes. Certainly, the results of Lennard et al., (2021) revealed that fears of compassion mediated engagement with an online psychoeducation CFT intervention. Notably, fears of compassion do not necessarily indicate that CFT is not suitable; in fact, fears may be a sign that compassion focused approaches could be helpful (Steindl et al., 2023), but more intensive/tailored interventions (1-1 or group) may be necessary to help people overcome these fears. This highlights the need for studies of individual CFT for parents (i.e. rather than group or psychoeducation/self-help interventions). Notably, there is a dearth of studies focusing on individual CFT more generally (Craig et al., 2020). While the 'common humanity' (Neff, 2003) element of compassion may benefit from group delivery, individual therapy may facilitate individual meaning-making (i.e. formulation) which is regarded as a crucial process to overcoming fears, blocks, and resistances to compassion (Steindl et al., 2023).

Conclusion

The present review provides preliminary tentative evidence that Compassion focused interventions for parents may be effective in improving parent mental health and wellbeing. The findings also suggest CFT parent interventions may lead to benefits for child mental health. CFT interventions appear to hold utility for a wide range of parents, including parents of children with mental health difficulties, physical health difficulties and neurodevelopmental differences, as well as self-critical parents. This makes sense considering that CFT is a transdiagnostic approach and has demonstrated efficacy across a wide range of clinical populations more generally (Craig et al., 2020). Given the small number of studies included and the high levels of bias identified across studies, the positive findings should be interpreted with caution. Further research is needed, especially high quality RCTs with more intensive (group and individual) interventions, rather than brief/psychoeducation interventions. The inclusion of moderator variables (e.g. fears of compassion and parenting quality) will be imperative to understanding whether certain groups of parents benefit more from CFT, as well as the processes which lead to gains for parents and children.

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Chapter 2

Empirical Paper: Parental wellbeing and experiences of undergoing therapeutic work when admitted alongside their child to a children's mental health unit

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This paper has been developed for submission to PLOS ONE. Author guidelines are outlined (Appendix A). Word Count Limit: None.

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Abstract

Background:

In the UK, six of seven child inpatient units separate children from their parents for an inpatient stay. Although research shows that child inpatient treatment has a positive impact on child mental health, research suggests that families can experience the separation as painful and stressful. Just one UK child inpatient unit avoids this separation by admitting parents alongside their children. During their stay, parents undergo therapeutic work alongside their child. No studies have investigated parents' experiences of being admitted to a children's inpatient unit for the full duration of their child's stay. There is also no research on parents' experiences of receiving therapy during an inpatient admission to a children's mental health ward.

Objective:

The current study aims to address this gap in the research to better understand: 1. What are parents' experiences of undergoing therapeutic work when admitted alongside their child to a children's mental health unit? 2. How do parents perceive this admission and therapeutic work to influence their wellbeing and that of their wider family system?

Method:

Parents who have been discharged from the service were invited to take part in an online Semi-structured interview, covering the experience of their stay and of undergoing therapy. The interviews were analysed using reflexive thematic analysis from a critical realist stance, thus allowing broad inferences to be made while recognising the unique circumstances of the participants.

Results:

Three key themes were identified including: (1) The Tension: ‘Albeit a horrific journey, quite an enriching one’, (2) Understanding is key: ‘opening the can of worms’ in therapy and (3) ‘Like a big family’: an extended family system. The results highlighted that the inpatient admission was intense and stressful, yet parents were grateful to be admitted alongside their child and learned a lot from the experience. Therapy supported parents to make sense of their own difficulties and intergenerational family patterns, and to develop more compassionate narratives regarding their parenting. As the ‘family’ system extended during the inpatient admission, relationships with staff and other parents had a key influence on parent wellbeing, as well as children and non-admitted family members.

Conclusion:

Findings revealed that parents experienced the joint admission as stressful, yet were grateful to be there with their child and learned a lot from the experience and through therapy. Relationships were perceived to have a key influence, including those with staff and parents, and non-admitted family members. The joint admission influenced the entire family system: some considered the admission positively influenced their whole family, while others regarded the experience as challenging for non-admitted family members.

Introduction

In the UK, approximately 3,500 children are admitted to inpatient Child and Adolescent Mental Health (CAMHS) Tier 4 units every year (Article 39, 2021). Within the National Health Service (NHS) stepped care model, Tier 4 Child and Adolescent Mental Health Services (CAMHS) provide assessment, risk management and treatment for children experiencing significant mental health difficulties that are challenging to address in community settings. Notably, most children within these services undergo inpatient stays without their parents, a practice observed in six of the seven CAMHS inpatient units serving children under 13 years old (Cousins & Holmes, 2021). This practice is somewhat surprising considering Bowlby's (1973) landmark research underscoring the potential trauma associated with separating children from their parents during hospital admissions. Just one CAMHS inpatient unit admits parents alongside their children for the entire inpatient stay, setting it apart as the sole facility adopting such a model for under 13s in the UK.

Research on Child Inpatient Treatment

Reviews suggest that CAMHS inpatient treatment is effective (Green, 2002; Pfeiffer & Strzelecki, 1990; Pottick et al., 1993) yet studies have been limited by insufficient sample sizes, limited measurement, rater bias and short follow-up periods. (Green et al., 2007) addressed several of these limitations, conducting the first large-scale study into the effectiveness of inpatient treatment for children and adolescents. The prospective cohort study was conducted across 8 UK NHS units (4 child and 4 adolescent), with a one-year follow-up. The study reported significant and sustained improvements in mental health outcomes, indicating the efficacy of inpatient treatment across diverse diagnoses. Longer stays, positive therapeutic alliance and better pre-morbid family functioning independently predicted better outcomes. Swart et al., (2023) also addressed methodological limitations in

this body of research by conducting the first qualitative investigation of parent and child perspectives' of child mental health outcomes, post discharge from a pre-adolescent mental health unit in South Africa. The findings revealed that inpatient admission was generally viewed as having a positive impact on children, though significant mental health challenges remained post-discharge. This study provides a valuable addition to the field by including the voices of parents and children, yet the participants all attended the same mental health unit so findings may not be transferable to other units in South Africa, or internationally.

Although research indicates child inpatient treatment has a beneficial impact on child mental health (Green et al., 2007), some studies suggest that parents and children experience the separation involved in inpatient admissions as painful and stressful (Gross & Goldin, 2008). Merayo-Sereno et al. (2023) explored the experience of caregivers of adolescents admitted to an inpatient ward and found that the experience of the admission was traumatic for parents. Parent-child collaboration improved the experience and reduced suffering, while the period of receiving less information about their child's emotional state (i.e. the first 24 hours after admission with no visits permitted) was found to be particularly challenging, highlighting the importance of researching parents' experiences further.

Moreover, the relationship between parent mental health and child mental health has been found to be bidirectional (Gross et al., 2008; Pardini et al., 2008) and it is unknown whether greater improvements would be observed if parents were included in the inpatient admission. Family Systems theory (Cox & Paley, 1997) and Attachment theory (Bowlby, 1973) both contend that relational factors are highly influential to a child's emotional and behavioural adjustment. Specifically, Family Systems theory emphasises that to be able to understand the development of an individual, their family context must be considered (Cox & Paley, 1997). From an attachment perspective, children are more likely to develop relational security (and

have better adjustment) when their parents are emotionally available, responsive, and sensitive to their needs (De Wolff & van Ijzendoorn, 1997; Dunst & Kassow, 2008). Considering these theories, as well as the research which highlights the crucial role of family processes for children's adjustment (Conger et al., 2010) it may be expected that admitting parents alongside their children could be advantageous for parents, children and families, thus highlighting the importance of researching joint parent-child inpatient experiences specifically.

Research on Joint Parent-Child Inpatient Treatment

Quantitative studies investigating the efficacy of joint parent-child inpatient treatment are emerging, across Europe, and so far have found positive effects on both child and parent mental health outcomes (Hansson et al., 1992; Ise et al., 2015; Rimehaug et al., 2012). Ise et al. (2015) evaluated the effectiveness of inpatient treatment for families with severe parent-child interaction difficulties. Significant improvements were observed on all outcomes during the four-week treatment period and these improvements were maintained at the four-week follow-up period. In relation to parents, improvements were observed in parent mental health, parenting stress, parenting quality and parents' belief in their self-efficacy in solving difficult parenting situations. Continued improvement was observed at the four week follow up (Ise et al., 2015) although studies with longer follow-up periods are required to understand the long term effects of this treatment model.

Although the findings of these initial studies are promising, more research is needed. Qualitative studies of the joint admission model are crucial to gain a richer and more nuanced understanding of families' experiences of this joint admission. To date, just one study has investigated the experiences of parents admitted to a child mental health unit. Shilton et al., (2023) explored parents' experiences of being admitted alongside their child to a mental

health unit in Israel, for the first week of their child's stay. Thirty parents of sixteen children (aged 6-12 years) participated in semi-structured interviews after their week of joint admission. Parents expressed that staying with their children for the first week of the admission helped to mitigate the anxiety and distress of the admission by fostering a sense of security and support for their child. Parents reported feeling more involved in their child's care and observed that their presence eased the child's adaptation to the hospital environment. Most parents reported that one week was long enough; although separating from the child after this week was still somewhat challenging, parents were exhausted from the testing period that led to hospitalisation, had to return to work and care for their other children at home. Additionally, the shared stay allowed parents to better understand the therapeutic process and contributed to more effective communication with staff. Overall, the study concluded that shared parent-child hospitalisation during the first week can improve the overall experience for both the child and the parent.

The findings of Shilton et al., (2023) provide valuable insight into the experiences of parents undergoing a joint admission for the first week of a child's stay, yet no study has explored the experiences of parents admitted alongside their child for the full duration of the inpatient admission and many questions remain unanswered. For example, it is unknown whether parents perceive the joint admission to be advantageous (as research and theory may suggest). Additionally, the challenges of this joint admission and of undergoing therapeutic work are also unknown. Therefore, research exploring the subjective experiences of parents admitted alongside their children is crucial.

The Present Study: Aims and Research Questions

Considering the wealth of research which demonstrates that the relationship between parent mental health and child mental health is bidirectional (Gross et al., 2008; Pardini et al., 2008) it is especially important to understand how CAMHS inpatient services impact parents as well as children. As parents undergo their own therapeutic work during their inpatient stay (specifically family therapy and drama therapy) the service offers a special environment for researching how parents perceive this parallel work to influence their own wellbeing, as well as their child's and that of their wider family. Thus, the current study has two over-arching research questions: 1. What are parents' experiences of undergoing therapeutic work when admitted alongside their child to a children's mental health unit? 2. How do parents perceive this admission and therapeutic work to influence their wellbeing and that of their wider family system?

Methods

Design

Qualitative interviews, based on a critical realist framework (Willig, 2016), were employed to elicit in-depth accounts of parents' subjective experiences. Data were collected through online semi-structured interviews and were analysed using reflexive thematic analysis (Braun & Clarke, 2006, 2021). Yardley's, (2000) characteristics of 'good' qualitative research were considered, including sensitivity to context, commitment and rigour, transparency, and coherence, as well as impact and importance.

Recruitment

Purposive sampling was utilised, a strategy which involves seeking out individuals with knowledge of a specific topic (Etikan, 2016) and thus all parents who had been admitted to

the service within the last three years were invited to take part. The study gatekeeper (clinician at the service) contacted parents by email with the study poster (Appendix F) and a permission to contact form (Appendix G). Parents returned their permission to contact forms to the study gatekeeper who shared participant contact details with the researchers (AM and FL). The researchers contacted parents to provide the study information sheet (Appendix H), offer a time to discuss the study and answer any questions, before arranging an interview time and obtaining consent (Appendix I).

The inclusion criteria were caregivers of children admitted to the service in the last three years who had been discharged. Notably, all caregivers that had been admitted to the service were invited to take part (including grandparents), and in this paper parent is used as an inclusive term for anyone who holds parental responsibility for a child. Additionally, a qualified clinician assessed the risk of parent involvement in the study – no parents were excluded due to mental health concerns. A heterogenous sample was sought to capture minority narratives as well as more dominant discourses – the information sheet described that the interview would be a safe space to talk about both positive and negative experiences. This was in accordance with the critical realist stance which emphasises the salience of contextual factors (Maxwell, 2012). The service is an eight-bed unit that offers time-limited assessment, formulation, and treatment, for children under the age of thirteen and their parents. The admission criteria were as follows:

- children with severe and complex developmental or psychiatric disorders associated with significant safeguarding or safety risks to themselves, or others, to a degree where they are no longer able to be managed safely in the community.
- children requiring specialist intensive mental health support rehabilitation under close observation away from their home environment

Over the last three years, the main recorded reasons for admission have been eating disorders (51.28%), challenging behaviour (20.51%), OCD (7.69%) and Pervasive Arousal Withdrawal Syndrome (PAWS; 7.69%).

Participants

Eleven parents participated in the study and were aged between 37 and 62 years of age (M= 47.6, SD= 7.6). All participants lived in the United Kingdom and British Isles, as the service admits children and parents from a wide geographical area. The majority of participants were white-British/white-other (82%) and the remaining participants indicated another nationality (note: other nationalities are not reported to maintain participant confidentiality). Seven participants identified as female and four identified as male. Ten participants were parents, and one participant was a grandparent, with parental responsibility. All were cisgender, meaning their gender corresponded with sex assigned at birth. Of the participants who shared their sexual orientation (n= 9), all (100%) identified at heterosexual. The social class of participants ranged from working class to upper-middle class, with most self-identifying as middle class (using free text entry). Three participants had one child, five had two children and three had three children. Eight of the children admitted were female (73%) and three were male (27%). The length of admission ranged from 11 to 31 weeks, with a mean admission length of 18.6 weeks (SD = 6.7). Due to the small sample size and the small number of families attending the service each year, further demographic details are not reported to maintain participant anonymity.

Procedure and Measures

Parents who expressed their interest in being involved in research and gave permission to be contacted were contacted by one of the researchers by telephone/email and were invited to take part in a semi-structured interview lasting approximately 1- 1.5 hours. Participants were

sent the study information sheet and given the opportunity to ask questions, before giving written consent to participate and being interviewed online. Participants were also asked to complete a demographic information sheet to ascertain the representativeness of the sample (Appendix J). Participants were interviewed over Microsoft Teams at a time of their choosing by one of two Trainee Clinical Psychologists (AM or FL) about their experiences of being admitted to the service alongside their child. The interviews were audio recorded and transcribed automatically using Microsoft Teams software, before transcriptions were finalised by the researcher. After the interview, parents were sent a debrief form (Appendix K), thanked verbally for their participation and were gifted a £10 shopping voucher as a token of appreciation. Pseudonyms were used to protect participants' identities and data are presented verbatim. In the results section, ellipses have been utilised to indicate pauses, omitted interjections, or brief tangents. Square parentheses have been used to provide contextual information to participant quotes to facilitate understanding.

Semi-structured interviews were chosen as they allow for an interview guide to be used (and for the same topics to be covered with each participant), whilst also offering flexibility for the exploration of participants' individual experiences (Brinkmann & Kvale, 2019). The interview topic-guide covered: pre-admission experiences, the admission process, the stay at the inpatient unit, impacts on the wider family system, parents' experiences of undergoing their own therapeutic work (specifically family therapy and drama therapy), the discharge process, reintegration to 'normal' family life and parents recommendations/support needs. The interview topic guide was informed by PPI focus groups held, separately, with service staff (including a ward manager, nurse, healthcare assistant, occupational therapist, consultants, clinical psychologists, and family therapists) and one parent (who had previously been admitted to the service). This enabled careful consideration of whether interview

questions covered relevant and meaningful areas for parents, which is in line with Yardley's (2000) criterion of impact and importance.

The semi-structured interviews comprised two parts pertaining to two doctoral projects. Part one pertained to the present doctoral thesis (AM) and focused on the impact of the inpatient admission on parent wellbeing and parent experiences of undergoing therapeutic work. Part two was relevant to another Trainee Clinical Psychologist's thesis (FL) and questions covered the parent-child relationship. AM conducted six interviews and FL conducted five (interviews were divided evenly, yet the first author was able to complete an additional interview due to differing project timelines/deadlines).

Ethical Considerations

The study was granted ethical approval by the NHS Health Regulation Authority (Ref: 23/WA/0195; Appendix D). The study was carried out in accordance with the ethical guidelines of the British Psychological Society (BPS) Code of Human Research Ethics (British Psychological Society, 2021) Participants gave written informed consent to participate in the study and had a right to withdraw from the study up until the point of data analysis. During the interview, participant wellbeing was a primary consideration and, as trainee clinical psychologists, the interviewers drew upon their clinical experience, aiming to be aware of any signs of participant distress (Pascoe Leahy, 2022). Participants were reminded that they did not have to answer all questions and that they could pause or stop the interview at any point. In line with data protection legislation (Data Protection Act, 2018) confidentiality was maintained by assigning pseudonyms to participant quotes and removing all identifying information. Anonymised research data were saved within the study master file on the UEA OneDrive folder.

Analysis

A critical realist epistemological stance was taken, as this is consistent with the study aims and context. This stance suggests that psychological phenomena do have some basis in reality outside of an individual's interpretation, but these phenomena are inherently affected by culture and context (Willig, 2016). Therefore, such a framework permits broad inferences to be made while recognising the unique circumstances of the participants (Fletcher, 2017). The data were analysed using reflexive thematic analysis (RTA; Braun & Clarke, 2006, 2021). Thematic analysis is a qualitative research method for identifying, analysing and reporting patterns of meaning within a dataset (Braun & Clarke, 2006). The analytic approach was primarily inductive, meaning it was guided by the data rather than predefined theories or hypotheses, allowing themes to be identified from the data itself (Braun & Clarke, 2006). This approach ensured flexibility and responsiveness to the data's subtleties, which is fundamental to inductive analysis (Patton, 2014). While the data were initially examined without an explicit theoretical framework, it is acknowledged that the researcher's analytic preconceptions inevitably influenced the analysis process (Braun & Clarke, 2019).

In accordance with Braun and Clarke (2006), the researcher began data familiarisation through re-listening to the audio-recordings and re-reading the interview transcripts. Following this, initial line-by-line coding of all eleven transcripts was conducted using Microsoft Word (Appendix L). A 'complete coding method' was utilised, coding all data relevant to the research question. Codes were revised and themes and subthemes were developed and refined, before quotations were selected to illustrate aspects of each theme, and the results were written up (Clarke & Braun, 2013).

Reflexivity and Rigour

Importantly, in RTA, themes are not just passively discovered, but rather the researcher plays an active role in identifying patterns, selecting those of interest, and reporting them to the reader (Braun & Clarke, 2019). The reflexive component of RTA highlights the centrality of researcher subjectivity and reflexivity in meaning making. That is, the themes a researcher identifies, selects and reports depend on their own unique set of experiences and the lens through which they view the world, as well as the extent to which the researcher reflects on the relationships between themselves, the participants, and the research field. To aid with researcher's reflexivity process, a reflexive journal was completed after each interview and during the analysis process (Braun & Clarke, 2021). In the final stages of analysis, the authors met to discuss, reflect upon, and re-work the themes as necessary. One theme (The Struggle for Support) was cut, to keep the focus specifically on aspects of the joint admission (in accordance with the study aims and research questions). The struggle that parents face accessing CAMHS is important to address and has been previously reported (Ashworth et al., 2024; Crouch et al., 2019; Hansen et al., 2021).

The researcher is a non-parent, trainee clinical psychologist, who has previously engaged in personal therapy (with a mixture of positive and negative experiences). Thus, while the researcher may have been perceived by participants as an outsider (due to being a trainee clinical psychologist), the researcher may also be considered as an 'insider' with respect to having received therapy and having a 'felt' sense of therapy challenges. Additionally, growing up with a parent experiencing mental health difficulties has contributed to the researcher's systemic orientation. All authors have experience of working clinically with children and parents and it is acknowledged that one of the authors (FW) is employed within the service.

Results

The results revealed three key themes, and all themes addressed both research questions. This was reflective of the participants' experiences as therapeutic experiences were difficult to fully disentangle from the inpatient admission. The themes are detailed below.

Theme 1 (The Tension: 'Albeit a horrific journey, quite an enriching one') describes the tension in parents' narratives between, on one hand, perceiving the inpatient admission as intense and stressful and on the other hand, expressing gratitude for being able to stay alongside their child and for the support they received. Moreover, subthemes revealed specific tensions of the stay: (1) Short-term mental health vs Longer-term family functioning, (2) ward rules/restrictions vs freedom and autonomy.

Theme 2 (Understanding is key: 'opening the can of worms' in therapy) captures the value of meaning-making through therapy. Parents articulated the value of looking at, and talking about, their own difficulties for the first time, as well as gaining a more compassionate perspective of their role in their child's difficulties- which had a powerful influence on their mental health and confidence as a parent. Drama therapy was felt to be especially helpful in making-connections and expressing emotions that may not have been possible through talking alone. Finally, therapy enabled parents to reconnect to the importance of taking care of their own needs.

Theme 3 ('Like a big family': an extended family system) highlights the salience of relationships, both on and off the ward, for parent mental health. As families enter the ward environment, their family system extends to encapsulate the other parents on the ward, as well as staff. Subthemes were: (1) a complex collaboration between parents and staff, (2) common humanity: parent-parent relationships as therapy (3) their pain is my pain; their gain

is my gain. The subthemes denote the complexity, interconnectedness and common humanity present within this extended family system.

Theme 1: The Tension: 'Albeit a horrific journey, quite an enriching one'

The first theme underscored the tension within parents' narratives: on one hand, the joint admission was described as highly stressful and intensely challenging and, on the other hand, it was viewed as a 'privilege…priceless' (Reed) and a unique opportunity for growth and learning, for which most parents were grateful. For many parents this tension within their narratives was expressed across different time points within the interview, whereas for some, the tension was expressed at the same time, within the same sentence: '*I found it, albeit a horrific journey, quite an enriching one'* (Reed).

Parents described the admission as inherently stressful, as having a child with difficulties that require Tier 4 mental health treatment is not something that any parent would ever envisage or hope for;

> *'The first aspect is just the nature of what it is being in a secure hospital with your child is incredibly traumatic and it's not a situation that you ever, ever imagine that you're, you know that you're ever gonna find yourself in.'* (Aurora)

Several parents expressed how distressing it was to witness the severity of their child's mental health difficulties ('*the sheer hell of having your daughter so unwell*' Reed). Some described the difficulty of disentangling the stress of the inpatient admission from the multiple and complex stressors they were experiencing more generally in their lives, as well as the highly stressful journey that led to their child's Tier 4 admission;

> *'I felt for quite a long time afterwards that I was living with some form of PTSD as a result, but not only of the (inpatient unit). I have to be clear, as a result of the*

previous three years, which…had involved a lot of difficulties. So I would be unfair to pin it all on the (inpatient unit). But I do think that... it is deeply traumatising.' (Reed)

Despite the intensity and stress of the joint inpatient admission, crucially most parents described how grateful they were to be on the ward alongside their child, and to the service for the improvements the admission led to for their families.

'Well, I suppose ultimately… I am completely grateful to them. As difficult as it was at times and as much as you kind of get caught up in this sort of day to day, that's annoyed me or so and so's done this ultimately, you know why you're there.' (Hazel)

'On the whole, I think for us as a family, I mean myself, it was really positive. There was some, definitely some frustration. And it wasn't, you know, ideal, but I don't think it is ideal being in a Tier 4…but I think on the whole, it's definitely helped us. So yeah, I'm glad we did…I think it's important …to offer it. It's a shame that it can't be offered in more places' (Robyn)

Thus, although the joint admission was challenging, parents expressed a preference for this model compared to the alternative of having their child removed to undergo a challenging admission on their own and recognised that despite the stress, much was gained for their families.

There were times when (child) was really struggling when it was really stressful and but by and large, I was glad that I was there with her to be going through that with her because she said she wouldn't have wanted to be there without me. (Dawn)

Relatedly, Robyn experienced the admission as a relief, not only for her child, but also in relation to her own mental health:

> ‘*But to be honest, I think if we hadn’t gone to the (inpatient unit), I probably would have had a breakdown…I was probably at that point of burning out…I feel like for me, I feel a lot happier’* (Robyn).

Finally, while Reed expressed that stay was ‘challenging beyond words’, he also felt that overall:

> *‘It was a privilege to be there and I felt that what I was witnessing and learning was the kind of things that I don't know a parent that wouldn't be interested in actually learning some of that stuff.’* (Reed)

The stay was viewed as a unique opportunity to receive valuable parenting support and guidance that most parents would benefit from having access to.

Tension: short-term mental health vs longer-term family functioning

Specific aspects of the joint admission appeared to pose a tension between parents’ immediate mental health needs and the longer-term functioning of their families. This included the intensity of the therapeutic work parents underwent during their stay. Additionally, the perceived constancy of observational assessments appeared to clash with parents' immediate needs for privacy and personal space.

Aurora expressed;

> *‘That kind of intensive therapy is very difficult, like usually people do therapy for like 50 minutes a week. I was doing hours…and sometimes I've added up that I'd have done like 7 or 8 hours of some therapy or another over a week, which is like quite exhausting… I was only able to do it because of the situation that I was in…I wouldn't have been able to go to leave and go out to my job… it was only because you’re...in*

this… immersive, you're kind of living it, that you were able…to do it …and when you had…the bigger therapy sessions you would … have a clear schedule for the rest of the day. So for the rest of the day…you were able to… process, so… it was incredibly difficult and… emotionally and mentally…draining in lots of ways… And there was some really positive things like you do you start off by going through a family tree.. .you go through…your history…which is really… it's stuff that you… don't get the opportunity to do and that is really positive.'

For Aurora, the experience of doing therapeutic work on the ward was extremely intense and emotionally draining, and yet, at the same time, she expressed gratitude for having the opportunity to explore her own family history. This highlights the importance of balancing the need to undergo therapeutic work for longer term family functioning, with the need to take time to rest, recover and process therapy for her immediate wellbeing. Notably, Aurora also expressed that such intensive therapeutic work was only possible in such a unique context (i.e. being admitted to the ward alongside her child) which highlights both the value of the model in providing multiple opportunities for learning *and* the level of sacrifice that parents make within their own lives, when admitted to the ward for their child's mental health.

Similarly, although in the longer-term Willow described feeling '*refreshed*' for having done the therapeutic work (described in detail in Theme 2), during the inpatient admission she perceived the therapeutic work as having a negative impact on her immediate health and functioning;

'I did a couple therapy sessions …and got pretty ill the day later…I woke up in the early hours of the night… with the most horrendous migraine…The (inpatient unit) was just overwhelming me.'

However, notably several parents didn't raise the therapeutic work as an intense aspect of the stay. This indicates that some parents may experience this combination (of doing therapy while being admitted to the inpatient unit) as more intensive and challenging than other parents. It is possible that parents with more complex trauma histories, or with greater intergenerational family difficulties, may, understandably, have experienced this work as more destabilising and overwhelming. This highlights the need to pace this work on an individual basis, particularly during a joint admission where other aspects of the stay are experienced as intense.

The feeling of being under constant observation was an aspect of the stay that most participants perceived as intense and stressful.

> *'Very stressful, to be in an environment that you know that everyone sees you and knows where you are and what you're doing and what you said and how you said it.'* (Willow)

Lily articulated how being watched added an extra 'layer of stress' and led to her '*constantly second guessing'* her behaviour and how her interactions with her child would be perceived by staff. Parents expressed how challenging it felt to live on the ward with very little privacy or space for themselves. This included feeling as though they did not have a space to talk to other parents without staff observing ('*we had all these whispered conversations over the island in the kitchen*' (Aurora), as well as limited space away from their child;

> *'As much as I love (child), it's not sort of normal to be around each other 24/7, so that that was quite challenging and no privacy, you know, sharing a bathroom.'* (Lily)

While many parents understood the importance of staff observations, for their longer-term family functioning, the observations, at times, appeared to clash with their immediate

wellbeing on the ward. Several parents expressed a need for greater privacy: '*there should be a private family parent room like a small space with a little coffee machine and just a couple seats just to actually unwind'* (Willow).

After challenging therapy sessions or meetings, this need for private space acutely intensified:

> *'You just want that 10 minutes after a big meeting and your child's screaming and crying and you know you're pulling your hair out and all you wanna do is cry and you gotta go out on the street and walk up and down a road with all the cars passing you… cause there's nowhere to go.'* (Willow)

Tension: Ward Restrictions and Rules vs Freedom and Autonomy.

As well as the need for privacy, another aspect which contributed to the intensity and stress of the joint admission were the ward rules and freedom restrictions. Lily described the strong impact the rules and restrictions had on her sense of agency both as a parent and as a person.

> *…I felt very disempowered as a parent… you go from being sort of a functioning independent adults managing a job and a family and.. a social life … And then you're suddenly in an environment where you have to ask for everything... You feel like you've massively regressed, and you're still very responsible for somebody. It is like going back to being a child because you're quite powerless* (Lily).

This suggests a tension between feeling powerless and childlike, alongside knowing that she is still responsible for her child. For Lily, the experience of trying to parent her child within the constraints of the ward seems disorienting and confusing, as she grappled with trying to maintain her power as a parent, while losing her sense of autonomy due to the rules and restrictions of living on the ward.

Another participant highlighted a significant tension between feeling restricted in the unit, whilst also recognising the benefits of the in-patient stay:

> *'It was a prison. Not only for (child) but was prison for me too…And yet I've gotta be here. I've got to be here because it's best for (child) and the best for me.'* (Willow)

Notably, as well as describing the inpatient unit as a 'prison', later in the interview when discussing gaining a diagnosis for her child, Willow expressed:

> *'I just feel like completely exonerated. It's like I was gonna be serving a life in prison and someone come along with a magic wand and said it's ok we have the answer.'* (Willow)

Thus, there is a clear tension in Willow's narrative between positioning the inpatient unit both as a 'prison' and as saving her from 'prison' (with 'a magic wand' of diagnosis). This suggests feelings of being trapped, not just by the restrictions of the inpatient unit, but by her child's illness and the impact this has on her life more generally. Further, feeling 'exonerated' may denote the weight of responsibility she had been carrying in relation to her child's illness and how, through gaining a diagnosis that made sense to her, she was freed from feelings of guilt and self-blame that had been keeping her imprisoned. Notably, not all parents experienced the rules and restrictions as entirely negative. For Sky, life on the ward was also 'intense', yet the level of structure provided him with a sense of security at a time of profound instability: '*there were some tough days, but. I actually loved it and it's mad… I feel a bit of security in the (inpatient unit)*' (Sky).

Theme 2: Understanding is key: 'opening the can of worms' in therapy

Parents highlighted the value of meaning-making through therapy – gaining a better understanding of difficulties was viewed as the start of a long journey of healing.

For some parents, the joint admission provided the first opportunity, to look at and talk about their own difficulties:

> *'I think it's probably raised a lot of issues for myself and my personal life…but I am still working through those now… I feel refreshed for that because I think that there's a lot of things in life, in past life, in present life, that have never been discussed…You know that makes you very stressed inside because you know all those things, but you don't talk to anyone about it. So I feel more able to talk about those things now and that does not solve it. … but it just opens up that can of worms, doesn't it? Once the worms are poking their head out. At least you can kind of like actually look at them.' (Willow)*

As well as gaining significant insights about themselves, several parents expressed the value and power of therapy for making sense of their role in their child's mental health difficulties. Prior to admission, many parents felt totally responsible for their child's difficulties, leading them to feel shame and guilt. However, staff supported parents to make sense of their child's difficulties in more compassionate and nuanced ways:

> *'I just thought I'm a failed parent whose child has become, …unwell and I felt quite…guilt torn … I felt that the…admission gave me perspective to think … how caring and loving I have been towards her in order to get her better…I'm not a bad parent and it's not because of me, and I think these are all … things which have helped me to develop confidence as a parent'* (Dahlia)

> *'When we went in… I felt very much responsible… It was for me to fix these things, and if I did the right things, we wouldn't be in this …the staff explained to me that actually that wasn't the case…I'm not responsible for everything and …I haven't got*

to fix everything …it took pressure off of me and allowed me to think this is how it is for (child). And I have to work with how it is for (child) rather than I'm responsible for it.' (Dawn)

Thus, parents described learning something powerful- their child's difficulties were not their fault *and* at the same time, there were things they could do to help. Further, through reflecting on patterns within their own families of origin, parents learned to break unhelpful intergenerational cycles:

'When you do your family tree and …you went through since you are 2,3,4,5 years old …they're very good …it was… really really really powerful and [you] maybe learn not to put as much pressure on your son because whatever happened to you in your past.' (Sky)

Although some parents appreciated the opportunity to 'open the can of worms', other parents perceived family therapy as less useful. Lily expressed '*probably the least helpful part of it was picking over our wider family dynamics',* while Hazel articulated '*I'm quite practical, so it was the practical stuff. Like, why don't you try this type of pasta?...rather than maybe if you all sit together in a room and talk about things.'.* The perception that therapy is unhelpful may represent an understandable coping mechanism, as 'opening the can of worms' is not an easy thing to do. Alternatively, it may be that parent resources were already so taken up (by their child's difficulties), that exploring their own family patterns and ways of relating was not perceived as helpful or a priority. It is also possible that the child's presentation may have influenced parent perceptions of therapy, as some difficulties (e.g. eating disorders) require greater practical support, as weight gain is a key treatment aim (Treasure et al., 2020).

Despite the mixed perspectives on family therapy, drama therapy was unanimously experienced as helpful: '*the drama therapy was absolutely amazing'* (Sky). Drama therapy appeared to be a useful method for making connections between things that are hard to express with words alone. For example, for Lily, having the focus of the postcards appeared to facilitate her connection to how her child was feeling:

> '*That was really, really helpful. She had this box of postcards with lots of different pictures on and…We had to choose different pictures that made us think of different things…and talk about what they'd sparked in us…but I remember one picture…Like a black plastic figure, but absolutely covered with pins like all over, and …I look at that and I can see my (child), (child's) got all these pins and I can't get near… because I can't, like, we can't put our arms around (child)*' (Lily)

For Lily, this communicates a deep sense of loss around not being able to hold her child and not being able to relate to her child in the way she hoped and imagined. The process of engaging with images allowed parents to articulate their experiences and connect to strong emotions in ways that, perhaps felt more accessible and less intense, highlighting the value of alternative therapies where talking alone may feel too direct, or exposing.

Moreover, Dahlia described how drama therapy helped parents to learn to focus on themselves, she recounted:

> *'The drama therapy sessions… are quite helpful and useful for you to think about your own well being as well…when the drama therapist was asking [parents] about anything…everyone was making them go back to their children. And so I think that was a…theme which all of us…reflected on that we need to think about ourselves as*

well, just rather than actually thinking… just about the family members and their happiness'

The observation that parents found it hard to focus on themselves and their own needs is an important one and, notably, this is a pattern the researcher also noticed during interviews with parents. Several parents reported they had learned to take more care/time for themselves, and some spoke of the value of doing new activities as part of their self-care:

'*The painting in part is a very big part of my therapy because that is my release from life, from daily life.'* (Willow)

Theme 3: 'Like a big family': an extended family system

The third theme highlights the significance of relationships, on and off the ward, for parent mental health. As families enter the ward environment, their family system extends to encapsulate the other parents on the ward, as well as staff members.

Sky described the inpatient ward as '*like a big family'* as he articulated the strength and value of the connections between everyone on the inpatient ward. Similarly, Reed expressed the inpatient unit:

'…is a family like any other system… it's a system like social services and it's a system like a school. So by definition…Sometimes that system…Doesn't work, and actually does…have… the weaknesses or the threats that any system would have. That's what I'm trying to say.' (Reed)

This suggests how all members of the inpatient unit were perceived as an extended family, and highlights how, the inpatient unit, just like any other human system, was viewed as having strengths and weaknesses.

A Complex Collaboration between parents and staff

Notably, some relationships within the system were more complex in nature than others. Parents described the complexities of the parent-staff relationship on the ward; relationships with the same members of staff could be experienced, at times, as intimate and positive and at other times as tense and challenging.

> *Parental professional relationships on the ward… they're very complex because you quite often have, umm, positive relationships with the professionals, especially people like (family therapists) where you're spending a lot of your time. You know you're talking to, about the most intimate parts of your life… I found there was kind of a positive relationship that was built, but there is also this other dynamic which is when there is… a clash of… professional opinion and your personal experience… They're very difficult relationships to manage*. (Aurora)

This demonstrates that parents were simultaneously supported and challenged by staff members; staff held the demanding dual role of supporting parents whilst prioritising child mental health (i.e. as children were the identified patients). Further, as part of supporting their child's mental health, staff are often required to challenge the family's status quo and previous way of functioning, through role-modelling alternative behavioural management approaches, and this could be challenging for parents.

Finding the balance between supporting parents alongside children appeared to be an ongoing challenge. Some parents found staff to be "*really, really supportive"* (Rowan) whilst other parents expressed a need to be considered more:

> '*I think more can be done to understand what the parents are going through…There was one [staff member] who I think really was unable to pause and reflect…'cause,*

they… rightly talk about internalising the children, but I think I think that …they should also internalise the parents a little bit.' (Reed)

This suggests a need to be held in mind, as parents were experiencing an exceptionally challenging time -witnessing their child's distress while trying to work on themselves. Moreover, Aurora voiced:

'*I wish that I had been… a bit more at the centre and I also.. kind of almost think like… you might make more progress with the children if you focused a bit more on the parents...because…our children are… you know because of us.* (Aurora)

Aurora's assertion that focusing more on parents would be helpful for children is in accordance with a systemic perspective which contends that family members exert reciprocal influences on one another, and parents have an especially strong influence on children as they typically hold more power within the system.

Given the complexity of parent-staff relationships within the busy ward environment, parents highlighted the importance of clear communication and working together as a team:

'I just think communication is key of what expectations are for both sides so that you're kind of on the same page because there was a lot of miscommunication that could have just been easily resolved.' (Robyn)

Moreover, Aurora emphasised that being listened to would have enhanced the impact of the inpatient stay:

'I'm not a psychiatrist or…a therapist, but I do know my child and …you have to understand that I'm the professional when it comes to (child)…I'm… the only person that has seen him go through all of these different things and… has lived that…if you

listen to me, the impact that the collaboration between them and me …would have been so much greater.'

Aurora expressed a need for staff to hear and value parental expertise, alongside their own expertise, to collaborate optimally. As well as parents and staff sharing knowledge, this also suggests the importance of delicately balancing power between parents and staff, to empower parents to support their children.

However, several parents did feel listened to and where parents and staff had positive collaborative relationships, the overall inpatient experience felt more contained and manageable:

'The nursing staff were always there to and like offer support if it became stressful. So I always felt that I was supported, even if even if it was stressful.' (Dawn)

Parents reported several ways in which trusting parents-staff relationships were established, including feeling accepted, the dedication and commitment of the staff team, forming genuine caring connections, and being heard '*without feeling, being judged or anything'* (Dahlia):

'*It wasn't as if, you know, that's my day job. They actually did want to invest in you and… I thought that was superb and it, you know, think it allowed you to be more honest if you need to be. But it also allowed you… to feel and know that you're being listened to*.' (Rowan)

'When (child) left and we left… you could see tears and people crying and it meant.. it was not just a job it was. I mean, their job is not ohh. I'm going to work and I don't care. I think it's a way of life.' (Sky)

Rowan and Sky clearly conveyed the sense that staff connected with parents on a deeper level. Further, the emotion shown by staff, as families were discharged from the service demonstrated the significance of parent-staff relationships and the ongoing recalibration of this 'big family' system.

Common Humanity: Parent-Parent relationships as therapy

Whereas parent-staff relationships were complex, parent-parent relationships appeared more straightforward which makes sense as parents were alongside each other sharing the intense experience of the inpatient ward with their own challenges and children to focus on. Several parents expressed that the presence of other parents on the ward was extremely valuable. Parents described a sense of common humanity, being surrounded by individuals who could understand and support each other through such a unique experience:

> *'This is another point that's widely underestimated… is how important those parental relationships are, and I don't know if… we were just lucky to have you kind of formed the friendships that we have, but they are by far the most important people that you meet in there…[our children were] in there for different reasons…so there were things that we didn't relate to. But you are the only people on the planet… that understand that we've had to listen to…children's screaming from the clinic room that have been… to the same professionals and have had quite similar conversations.'* (Aurora)

One parent described the significance of hearing stories from other parents, as opposed to just receiving information from doctors, in providing a sense of normalisation:

> '*It's all right. We've been there. It's hard. I know how you feel, but it's not just you. It's, you know, it's a process.. it helps a lot the parents to hear that maybe not*

from doctors because sometimes they feel like you're reading a book… your psychology book... But from other parents when there…without lecturing them. But it's alright. You're not on your own.' (Sky)

This highlights the importance of being understood by other parents in a 'felt' sense, as they are the only others to have lived through something similar, which contrasts with the more intellectual understanding that some staff members may have. Another parent articulated the healing power of being surrounded by non-judgemental, accepting others at a time of suffering; an experience that is not always easy to replicate on the outside world:

'There's no judgment because we're all there and our children are all suffering. So there's no judgment among their parents. There's no judgment among the children. Everybody is just there having a difficult time and everybody is sort of accepted and … No matter what is going on and I think that's a really good thing because you know outside of such a unit, people can be incredibly judgmental.' (Dawn)

The connections made with other parents and children created a sense of belonging on the ward, and some parents felt this was missing from their everyday lives:

'That word isolation is a very, very useful one with (child) and me and his mom and his (sibling)…we are all extremely isolated by this condition.' (Jasper)

Whereas the severity of their child's mental health issues usually lead to disconnection and separation, it was the thing (on the ward) that brought everyone together. Thus, some parents expressed sadness at letting go of living communally within this supportive extended family:

'So…at the (inpatient unit) every morning, there would be lots of people to say hello to. I don't have that anymore…But you know, so that …was kind of a nice positive

thing but however nice and positive it was, obviously I wanted to come home because home is home, and the cats are at home.' (Dawn)

Their pain is my pain; their gain is my gain

While relationships with staff members and other families (the extended family system) influenced parents during the stay, their mental health continued to be impacted by their child, as well as other family members not living on the ward.

Several parents expressed that their child's mental health had a strong impact on them:

'I suppose like most mums or parents… if my kids aren't happy, then that really massively impacts on my mental health… whereas at least I feel like everyone's kind of stable and going in the right way. It kind of allows me to… relax and breathe a bit… I mean… we wouldn't be where we are now if it weren't for the [inpatient unit]….because we've made such a big shift in our dynamic…We've kind of been able to kind of free up time between ourselves… (sibling)…is, you know, really pleased that (partner) is around more …it's been really good for their relationship as well I think.' (Robyn)

Thus, while the severity of children's mental health difficulties, understandably had a negative influence on parents, the improvements that children demonstrated over the course of their admission had a positive influence on parents' wellbeing as they were less worried about their child.

Parents felt the impact of the stay '*on everyone's life*' around them (Willow). While some, such as Robyn, appeared to feel a strong sense of gratitude and relief regarding the positive influence of the admission on the whole family, others felt the stay had a negative influence on wider family members. Willow described how the joint-inpatient admission '*was a real*

big struggle for me and I think they struggled with it too…because they were used to me being there', as it was challenging to experience the separation from other family members, she felt responsibility to care for. Dahlia expressed:

> *'So there is support for parents, but there is no support for the siblings…And I think she felt a bit neglected because, you know, she felt that…my mum is always, with (admitted child) and she's paying more attention to her and not me. So I think…(services) need to think about the siblings because it does affect…and you don't of course want those siblings or children to get mentally unwell.'* (Dahlia)

Taken together, these quotes highlight parents' feelings of responsibility for their whole family and a desire for services to consider all the responsibilities they are holding and the needs of all family members. Although some parents felt outside family members were not considered enough, other parents were grateful and reassured by the service maintaining awareness of the whole family:

> *'When I was there, they were very aware that we were a family of four, because at that time we were very much two and two, you know, we were 40 miles apart and… up to an hour apart each way on a journey. And I think... they were very aware that it was a whole family.'* (Rowan)

Discussion

To date, no study has explored parents' experiences of being admitted to a child mental health unit alongside their child (for the duration of the inpatient stay), or of doing therapeutic work during a joint admission. The present study aimed to address this gap in the literature. The findings revealed that parents experienced the joint admission as stressful yet were grateful to be there with their child and learned a lot from the experience and through

therapy. Relationships were perceived to have a key influence on parent wellbeing, including those with staff and parents, on the ward, and other family members, off the ward. The joint admission was perceived to impact everyone in the family: some considered the admission had a positive influence on their whole family, while others regarded the experience as challenging for non-admitted family members.

Intensity and gratitude: tension in parents' experiences

The findings revealed a tension in parents' narratives regarding the joint admission, between gratitude and stress. The perception of the child inpatient admission as stressful is in line with other research on the experiences of parents separated from their child for an inpatient admission (Merayo-Sereno et al., 2023). Considering that inpatient admission is reserved for those experiencing difficulties and psychological distress of the highest severity (Perkes et al., 2019), it makes sense that parents of children requiring this level of intervention would experience distress witnessing their child's mental health difficulties. Moreover, inpatient admission is not something a parent would ever imagine or hope for, and research highlights that it is not uncommon for parents to feel guilt and self-blame in relation to their child's illness or difficulty (Cohen-Filipic & Bentley, 2015; Moses, 2010). Previous research has explored parents' experiences of being admitted to a child mental health unit for the first week of their child's admission only (Shilton et al., 2023). Shilton et al. (2023) found that this one-week stay helped ease the process of separating from their child while fostering trust and communication between parents and staff. Similar to the present study, parents in Shilton et al.'s research reported mixed feelings about the experience. They expressed relief at accessing specialised care but also described anxiety related to the stigma of hospitalisation and fears of being judged. While parents noted that the one-week stay was intense, a potential advantage was that the intensity was limited to just one week. This contrasts with the present study, where parents remained with their child for the full admission. In Shilton et al.'s study,

most parents viewed the one-week duration as ideal, though some highlighted a need for greater flexibility regarding the length of stay. Although parents reported having greater empathy and understanding of their child's struggles, it is possible that a longer period (of joint admission) would provide greater opportunities for parent learning, as well as greater support from staff and peer-support. Nevertheless, for some families an extended joint admission may not be practical, or the stresses would outweigh the potential gains. Comparative studies are needed to evaluate the experiences of parents and children during a full-length joint admission versus the initial one-week period. Such research could help to elucidate the relative merits and costs of different approaches of joint admission, as well as which approaches are most helpful for whom.

Despite the stress and intensity of the stay, most parents expressed deep gratitude for the service: for being able to remain close to their child throughout the admission, for the support they received, and for the positive impact this support had on their families. This finding of parental gratitude for being present with their child is novel and warrants further exploration.

Drawing on Rudi Dallos' (2019) family scripts theory, parents described how family therapy and drama therapy played a crucial role in uncovering the implicit narratives and intergenerational patterns that had shaped their family interactions. According to Dallos, family scripts are the underlying stories and beliefs passed down through generations that influence behaviour and relationships. For some parents, therapy provided the first opportunity to reflect on their own challenges and recognize how these ingrained scripts had shaped their responses and expectations (Dallos, 2019). The therapeutic environment facilitated curious exploration, enabling parents to reframe their scripts through increased

self-awareness and a renewed focus on self-care—marking a significant shift from narratives centred on self-sacrifice or emotional suppression (Vetere & Dallos, 2009).

Parents also emphasised the role of staff in helping them construct more compassionate narratives about their role in their child's difficulties. This approach aligns with Dallos' view on the importance of revising family narratives to support individual well-being and strengthen family relationships. By moving away from self-critical or rigid stories towards more compassionate understandings, parents reported improved well-being, which in turn freed up emotional resources to engage more effectively in their child's care. This shift reflects broader research findings suggesting that adopting a compassionate perspective enhances motivation for self-improvement and builds resilience (Breines & Chen, 2012). Within this context, the joint admission model—which allows parents to remain with their child throughout the entire admission process— appears to provide opportunities to reshape these narratives, potentially benefiting children, parents and families. However, some parents expressed that undergoing therapeutic work during the joint admission was overwhelming, suggesting that some parents may experience doing their own therapeutic work during a joint admission as more destabilising than others. It is possible that parents who have experienced higher levels of trauma, or greater difficulties within their own families of origin may, understandably, experience this work as more stressful, highlighting the need to pace the frequency of therapeutic sessions on an individual case-by-case basis (Courtois, 2004; Ford et al., 2005). Indeed, therapeutic approaches to working with trauma suggest a phased approach is important to avoid feelings of overwhelm (Fisher, 2017; Lee & James, 2012).

Relationships as therapy: the role of relationships in in-patient admissions

Parents described that relationships on and off the ward had a key influence on their wellbeing and this is in line with previous research (Armstrong et al., 2005) and a systemic perspective (Cox & Paley, 1997). During the inpatient admission, the family system extended to encapsulate staff members and other families, as well as non-admitted family members. This is consistent with previous research that indicated the 'family-plus-unit' is a complex system that creates a new set of interconnected relationships (Gross & Goldin, 2008).

In addition to the formal therapy that parents received (i.e. family therapy and drama therapy) relationships on the ward may be considered as a form of informal therapy. Indeed, it is commonly posited that relationships *are* the therapy (Johnson, 2012; Yalom, 2002) and Treisman (2016) suggests 'every interaction is an intervention', highlighting the therapeutic value of both informal and formal interactions. Thus, a joint inpatient admission provides multiple opportunities for therapeutic interactions with parents (as well as children), and informal interactions may be beneficial for formal therapeutic work, as previous research has indicated that casual interactions with staff in an inpatient ward are important for feeling valued and relating human to human (Hartley et al., 2022).

Relationships with staff members were perceived as complex: although many parents felt supported by staff members, several experienced challenges in the parent-staff relationship, and some expressed a need for greater support for their own mental health. This may be understood by the demanding dual role that staff hold: they are, firstly, required to support child mental health (i.e. children are the identified patients) and to provide support for parents. Further, to support child mental health, staff are required to challenge the status quo of family functioning, and to role model alternative parenting behaviours. It is possible that such experiences of parenting children alongside staff, who may, at times, appear more

successful with their child, could understandably lead to feelings of rivalry and hostility (Gross & Goldin, 2008). This points to the importance of delicately balancing power in the parent-staff relationship; some parents expressed a need for their own parental expertise to be valued alongside staff knowledge. Although parents are experiencing challenges with parenting, research highlights that it is helpful for parents to be viewed as the 'experts' regarding knowledge of their child (Bogetz et al., 2021). Given the demanding role that staff members hold in this setting, it is noteworthy that several parents described the deep connections formed with staff. Indeed, relationships with staff appeared to have a pivotal role: where parents felt listened to, supported and accepted by staff the whole experience appeared more contained and manageable, echoing prior research (Hartley et al., 2022; Merayo-Sereno et al., 2023).

Relationships with other parents on the ward were also perceived as extremely valuable. While some parents experienced judgment and isolation on the outside world, they benefitted greatly from the experience of being surrounded by nonjudgmental, accepting others during the admission. Thus, a clear benefit of the joint admission model is the opportunity for parents (and families) to connect with others who understand their struggles in a 'felt' sense. This makes sense in the context of existing literature on peer support models in mental health, highlighting the value of shared experiences in fostering understanding, reducing stigma, and promoting self-efficacy and resilience (Repper & Carter, 2011).The relationship between social support and mental health is well-established; a lack of such support is linked to poorer mental health outcomes (Holt-Lunstad et al., 2010), while a sense of community contributes positively to well-being and stress reduction (Davidson & Cotter, 1991). Although research indicates that peer support can contribute to better adherence to treatment plans, reductions in symptoms and fewer hospitalisations (Chinman et al., 2014), the effectiveness of peer support models can vary significantly, due to factors such as risks of

developing emotional dependency and the potential for inadvertently reinforcing negative experiences (Salzer, 2002). These factors suggest that while peer support can be beneficial, it should be integrated thoughtfully alongside professional interventions to mitigate risks and maintain a balance. Further research is needed to better understand which methods of peer support (e.g. formal, informal, structured or unstructured) may be most helpful to this unique group of parents, both during the admission and in the longer-term, post discharge.

The findings revealed that the joint admission impacted everyone in the family, including those not admitted to the ward. Some parents perceived that the inpatient admission had a positive influence on the mental health of their whole family, while others perceived a more negative influence on outside family members. It is possible that these different experiences may be related to the level of support that parents have. For single parents, or parents with lower levels of partner support, their absence may be experienced as a greater challenge by other family members who, typically, rely more on the admitted parent for support. Further research is needed to better understand the relationships between being parental status (e.g. being a single or a coupled parent), caregiving support and admission to a mental health unit.

Strengths and Limitations

To date, the present study is the first to explore parents' experiences of being admitted to a child inpatient mental health unit for the duration of their child's stay and how parents perceived this to influence their own mental health. The study focused on a unique context, providing an opportunity for rich insights into a phenomenon which is uncommon (e.g. just one UK CAMHS inpatient unit admits parents alongside their children). However, as the study recruited parents from just one UK inpatient ward, findings may not be transferable to

other units employing the joint-inpatient model. The use of a reflexive journal throughout the research process was a strength (Braun & Clarke, 2021) and the reflexive thematic analysis captured complexity and nuance within participants' narratives (Fletcher, 2017). It is noted that, alternative analytical approaches may have afforded different strengths - for example, a narrative analysis (Stephens & Breheny, 2013) may have provided greater insights regarding parents' perspectives within the context of their whole journey, including the long journey to getting support for their child, as well as the journey beyond discharge.

All parents who consented to be contacted for research were invited to participate, and those with all types of experience (positive and negative) were actively encouraged to participate, reducing the likelihood of selection bias – though this cannot be guaranteed as it is possible that parents with particular characteristics may have been more likely to participate. For example, some parents expressed interest in the research but did not participate, and a common reason for this was difficulties finding child care. This may indicate that single parents or those with less caregiving support may have been less likely to participate meaning that the experience of this group of parents is underrepresented.

Future research

The present study provides valuable insights into the experiences of parents jointly admitted to a UK CAMHS inpatient unit alongside their child, including a nuanced understanding of the ways in which parents perceived this admission as both challenging and beneficial to their mental health. However, future quantitative studies are needed to better understand the impact of the inpatient admission on parents' levels of stress, trauma symptoms, depression, anxiety and wellbeing, respectively. The present study investigated parents' experiences within the first three years of being discharged from the service, yet

studies with longer follow-up periods are needed to ascertain how the intensive work done during the admission impacts parents' mental health in the long term.

Moreover, further qualitative studies are required to understand child and staff experiences of this unique treatment model. Given the unique dual role of supporting children and parents within the same admission, it is important to understand staff experiences and needs. It is also key to hear the voices of young people and their views of having a parent admitted alongside them. The study highlighted that parents perceived the joint admission to influence wider family members and their other children in varied ways, thus research with non-admitted family members would also be helpful to gaining a richer understanding of how this model influences the whole family system. Finally, comparison studies are required to assess how the joint admission model compares to the typical CAMHS inpatient model.

Clinical implications

The findings indicate that the joint admission model was valued by parents, and much was gained from the experience, suggesting the practice of admitting parents alongside their children is a valuable addition to CAMHS inpatient services. While some aspects of inpatient admission are inherently stressful (e.g. child distress and ward restrictions), it is important to consider which challenges of the joint admission may be more amenable to change. For instance, several parents reported feeling constantly observed and a need for greater privacy. Hence, the provision of a private space for use after intense meetings/therapy sessions may help to balance parents' immediate needs for privacy alongside the need to be under observation, to improve longer-term family functioning.

The observation that parents found focussing on their own needs difficult highlights the value of spaces like drama therapy, and suggests that more support with self-care may be helpful for parents. Notably, Gross and Goldin (2008) suggest creating self-care groups led

by parents (and supported by staff in the background) may be empowering for parents. The extent to which parents valued the presence of other parents, reveals the need to consider 'common humanity' when designing services, by promoting opportunities to connect with families experiencing similar challenges. Finally, parents' wellbeing was influenced by family members off the ward, suggesting the need for services to consider the responsibilities a parent may hold and all members of the family system (e.g. siblings, partners, grandparents etc.)

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Chapter 3

Discussion and Critical Appraisal

Dr Anja L McConnachie

Discussion

This chapter aims to further discuss and integrate the findings of the systematic review and empirical paper, describing the joint contributions of the papers to the research field considering the strengths, weaknesses and areas for further research.

Overview of findings

Systematic Review

The systematic review aimed to synthesise the available evidence regarding the efficacy of Compassion-focused interventions (e.g. CFT, CMT etc.) for parents on a) parent mental health outcomes and b) child mental health outcomes. Nine studies met the review criteria, covering a wide range of parent samples, including parents of children experiencing an array of mental health and physical health difficulties as well as self-critical parents (irrespective of child difficulties). Quality appraisal and narrative synthesis were conducted.

The findings of most studies indicated improvements in parent mental health outcomes. Compassion-focused interventions were associated with improvements in depression, anxiety, parent wellbeing and trauma symptoms, but findings regarding the impact on parental stress were less consistent. In accordance with the transdiagnostic model, studies suggest compassion-focused interventions may be beneficial for a wide range of parents (e.g. parents of children with an array of mental health and physical health difficulties). However, of the nine included studies, just two had active control groups and bias was identified across all studies. Just two studies included measures of child mental health and both observed significant improvements for children, yet neither study included an

active control group. The high levels of bias, indicated across studies, and the lack of active control groups limits the conclusions that can be made regarding the efficacy of CFT interventions for parents. At best, the available research can be taken as cautious preliminary evidence that CFT interventions may be helpful for parents and children, as further, high-quality research is needed.

Empirical Project

The empirical paper investigated the experiences of parents admitted to a children's mental health ward alongside their child, as well as their perceptions of how the joint admission and therapeutic work influenced their own mental health and wellbeing. Data were gathered through online semi-structured interviews, which were transcribed and then analysed using reflexive thematic analysis (Braun & Clarke, 2021) from a critical-realist perspective (Willig, 2016).

The findings revealed a tension within parents' narratives: on the one hand the joint admission was perceived as intense and stressful, yet on the other hand, parents expressed gratitude for being able to stay with their child and for the support they received. Therapy supported parents to make sense of their own difficulties and intergenerational family patterns, and to develop more compassionate narratives regarding their parenting. Moreover, in accordance with a systemic theoretical orientation, and the research highlighting the influence of family processes and relationships on mental health (Conger et al., 2010; Cox & Paley, 1997), relationships on and off the ward were perceived to have a key influence of parent wellbeing. Hence, the family system appeared to extend during the inpatient admission to encapsulate staff members and other parents and families on the ward. The findings suggested that, overall, parents valued the joint admission and learned a lot from the

experience, yet the perceived challenges of the stay suggest that adaptations could improve the experience of the stay and benefit parental mental health.

Thesis Portfolio

The systematic review and empirical paper both contribute to the broader research field regarding how mental health services can best support parents to support children. Both papers explore novel approaches to working with families, as the research on CFT for parents is in its infancy (Kirby, 2019) as is the research exploring the value of a joint parent-child admission (Cousins & Holmes, 2021). The systematic review covers a specific therapeutic approach which may be helpful for a wide range of parents (i.e. whether there are child mental health difficulties or not). The empirical paper addresses a specific approach to supporting parents where their child has complex and marked mental health difficulties. Taken together these papers provide initial insights regarding the potential of a specific therapeutic approach (CFT), and of a specific treatment model (joint parent-child admission) in supporting parents to support their children.

Both papers indicate a compassionate therapeutic approach may hold potential for working with parents of children with mental health difficulties, where high levels of self-blame, guilt and self-stigma are common (Cohen-Filipic & Bentley, 2015; Moses, 2010). Within the empirical paper this was found to be especially important considering the ways in which parents were supported to make sense of their role within their child's difficulties, which aligns with prior research emphasising the importance of feeling accepted, rather than judged by therapists (Razzaque et al., 2015; Wampold et al., 2017) .

Alongside self-kindness and mindfulness, common humanity is considered one of the three core components of self-compassion (Germer & Neff, 2013). Common humanity may

be defined as ‘seeing one’s experiences as part of the human condition, rather than as personal, isolating and shaming’ (Gilbert & Procter, 2006). The findings of both papers highlighted the value of common humanity for supporting parents. In the systematic review most of the identified studies employed group therapy interventions, whereby common humanity is considered a valuable therapeutic process (Gilbert & Procter, 2006). In the empirical paper, the importance of common humanity was captured by the extent to which parents valued the presence of other parents on the ward who understood their difficulties in a ‘felt’ sense due to having a shared experience.

Notably, compassion is an important component of a wide array of therapeutic approaches (e.g. ACT, CBT and humanistic approaches). Whether or not CFT is the most-suitable intervention for a specific parent, the findings highlight the value of a compassionate therapist orientation (Brill & Nahmani, 2017) and of parents gaining greater self-compassion.

Critical Appraisal

The systematic review was the first to focus on Compassion focused interventions for parents, providing a valuable addition to the research field. Additionally, the protocol was registered on PROSPERO which promotes transparency, reduces likelihood of bias and duplication of reviews (Stewart et al., 2012). However, the review was limited by the small number of studies and the small sample sizes of included studies. The systematic review was also limited by the quality of studies and the lack of studies with active control groups (e.g. ACT, CBT etc).

The empirical paper was the first study to explore the experiences of caregivers admitted to a children’s mental health unit for the duration of the stay. The qualitative methodology permitted a rich and nuanced understanding of parents’ experiences (Denzin &

Lincoln, 2011) and the ninety-minute interviews yielded in-depth accounts from participants regarding their experiences. The PPI involvement, of a caregiver and staff members, in designing the interview was a strength, meeting Yardley's (2000) criteria of impact and importance. The researcher's prior experience of interviewing parents is also considered a strength: familiarity with the process was perceived to facilitate rapport with participants, which may lead to more authentic and detailed data (Glesne, 2016). The reflexive thematic analysis was aligned with the ontological stance of the study, as a critical realist approach considers the researcher as part of the world they are studying (Braun & Clarke, 2021). The study sample may not have been representative, as only those who expressed interest in research took part. It is possible there were meaningful differences between the caregivers who expressed interest and those who did not. Further, the study sample were from one UK inpatient unit, so findings may not be transferable to other mental health units employing the joint admission model.

Clinical Implications

Taken together the findings of the studies indicate the value of supporting parents to support children. Within the systematic review, the small number of studies suggested CFT parent interventions may be beneficial for both parents and their children, but greater, high-quality research is needed. Within the empirical paper, one participant expressed 'you might make more progress with the children if you focused a bit more on the parents' (Aurora). Although this participant perceived they did not receive enough support when admitted alongside their child to an inpatient unit, it nevertheless highlights the importance of supporting parents to support children. This is in accordance with a systemic perspective (Cox & Paley, 1997) attachment theory (Bowlby, 1973) and compassion focused parenting (Kirby, 2019). Arguably the practice of admitting parents alongside children for a CAMHS

inpatient admission may provide more support for parents than traditional approaches which separate parents from their children for the duration of the inpatient stay.

Jointly admitting parents alongside children provides opportunities for direct observations, assessments, formulation, therapeutic(Cousins & Holmes, 2021).pport (Cousins & Holmes, 2021). Indeed, participants expressed gratitude for the support they received during the joint admission and much was gained from the experience of undergoing therapy on the ward. However, findings also highlighted that joint admission was stressful and intense for parents. There are some stressors which may be harder to address, as it makes sense that inpatient admissions would be stressful given these are reserved for those experiencing the highest levels of difficulty (Perkes et al., 2019) and inpatient admission, by definition, involves restrictions to freedom and autonomy. However, it is also important to reflect on the challenges reported by patients and consider which of these may be amenable to change to improve parent experiences and mental health outcomes. For example, the provision of a private space for parents on the ward, particularly after intense meetings or therapy sessions, may help to balance their immediate mental health needs, with the need to complete observations for the longer term functioning of their families. Additionally parental empowerment may be promoted by through running parent-led self-care groups, supported by staff in the background (Gross & Goldin, 2008), and through co-producing family formulations (Farooq et al., 2023). The practice of co-producing formulations may serve as a way to bring greater balance between parental expertise and staff expertise.

The empirical paper revealed complexities within the parent-staff relationship, which may be related to the competing demands that staff face while working to support children and parents during a joint admission. Given the demands of this role, spaces for staff support such as reflective practice are especially important. Indeed, previous research has revealed that

child inpatient admissions are challenging for everyone involved, including staff (as well as children and their parents; Hartley et al., 2022) and the importance of creating a culture of compassion in inpatient settings (Gross & Goldin, 2008).

Future research

The systematic review indicated that more research on compassion-focused approaches for parents (on both parent and child outcomes) is required. In particular, high quality studies including active control groups (e.g. CBT, MBCT, ACT etc.). Further, as the included studies were either group-based, or psychoeducation interventions, there is a need for studies of individual CFT for parents. The emergence of this research may permit more definitive conclusions, regarding the extent to which CFT is effective for parents, as well as whether certain groups of parents are more likely to benefit from CFT, and which formats (i.e. individual, group, psychoeducation etc.) may be most effective for whom.

As the research on the joint admission model is also in its infancy, the empirical paper indicated that quantitative research is required to better understand the impact of this model on parent mental health. Further, qualitative studies of staff and young people's experiences of this novel treatment approach are imperative to gain a better understanding of experiences of everyone within the inpatient system.

Reflections on the Research Process

The critical realist stance emphasises the active role of the researcher across the research process (Maxwell, 2012) and the importance of researcher reflexivity (Watt, 2007). In accordance with this, I will now share my personal reflections on my research process. I found the process of reflecting on my position to be interesting, enjoyable and challenging. I selected the topics for my systematic review and empirical paper as they aligned with my

interests and values. Having grown up with a parent experiencing mental health difficulties I have a longstanding interest in supporting parents, children and families. I was drawn to the project at the service because of my interest in systematic practice and belief in this unique treatment model. I also have an interest in the applications of Compassion Focused Therapy.

I found the process of data collection through online interviews comfortable having previous research experience with parents (including adoptive parents and LGBT parents), yet at times I felt a tension between my role as a researcher and a pull to respond as a clinician to try and alleviate distress. I was mindful of this tension and tried to reassure myself that listening to parents' stories may be experienced as helpful, and that quality research can play a role in preventing longer term suffering. While conducting the interviews I was aware of my position as a Trainee Clinical Psychologist. At times, interviewees appeared to assume I had greater knowledge of the service than I did (i.e. when speaking about different members of staff). However, I made my position as a researcher clear and let participants know that it was helpful to hear about all types of experience (positive and negative), something that was also highlighted on the information sheet. The mixed (positive and negative) experiences that participants shared (as reported in the results) suggests they felt comfortable to open-up during the interview.

After each interview and during the analysis process I found the use of the reflexive diary helpful. For example, after one interview I reflected how my positive orientation towards therapy may have influenced my responses to one participant who expressed they didn't believe therapy was helpful. While I listened with curiosity to the participant's view, after the interview I wondered if I could have asked her more follow-up questions to further understand this experience.

Something I noted across several of the interviews was that participants appeared to find it challenging to focus on their own mental health (despite this being the focus of the interview). For some parents, it took multiple follow up questions to hear their accounts in relation to themselves. I perceived this may be due to the high level of difficulties their children were experiencing and perhaps, understandably, needing to get some of this off their chest, but also potentially a reflection that focusing on their own needs/self-care may not have been something they were in a regular practice of doing.

During data collection, I perceived myself as an outsider as I didn't have any other interactions with the service, however during my data analysis process I began my final clinical placement within the same service. Joining the service was a positive experience for me and had strengths in deepening my understanding of the service. There were also challenges of undergoing my placement in the same service I had researched. For example, I felt anxious and stressed when sharing some of the participants' negative perspectives about the service with my supervisor. I felt a responsibility both in relation to the service and to the participants and we discussed this tension and my supervisor was supportive and understanding regarding my unique position (of being a researcher and on placement in the same service).

As noted above, I personally value the joint admission model, which made the use of my reflexive diary especially important to prevent my own views from having a strong influence on my interpretation of the findings. However, I also felt a key responsibility to ensure participant voices were heard. My personal experience of a family member's mental health difficulties, coupled with my own experiences of therapy challenges, allowed me to stay open to participant experiences and empathise with their perspectives. I believe my personal experiences were a strength, enabling me to balance these alongside my experiences

of providing therapy and working with children and families/the challenges of this work. Additionally, I believe being an LGBT person has shaped my values in representing other marginalised groups (i.e. people experiencing mental health difficulties).

I found the time pressures of the doctorate challenging, and in particular, the extended delays I experienced during the NHS ethical approval process had a knock-on impact on the time available for all other parts of the research process. Additionally, it was demanding to conduct such in-depth qualitative research whilst also completing my placements – having previously completed a research-based PhD, it was a new challenge to balance research and placement work. Despite the time pressures, I found it very rewarding to conduct the qualitative research. I had previously conducted quantitative research and found the critical realist epistemological stance of qualitative research to be more fitting with my own worldview, and I hope to conduct more qualitative research in the future.

Thesis Portfolio Conclusion

The findings highlight the importance of child services (i.e. both physical and mental health services) providing support to parents to support children. More studies are required to better understand the efficacy of CFT for parents, yet the findings of both studies indicate that a compassionate, non-judgemental therapeutic approach may be helpful for a wide range of parents, especially parents experiencing higher levels of trauma, guilt and self-criticism, such as parents of children with mental health difficulties. For parents of children with mental health difficulties that require inpatient admission, a joint (parent-child) admission prevents separation and appears to provide multiple opportunities to support parents. Taken together, the papers provide tentative evidence that a) compassion-focused interventions may hold promise for working with a wide range of parents and b) the joint-inpatient model may be

beneficial for parents of children with complex mental health difficulties (providing greater opportunities to support parents to support their children).

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Appendices

Appendix A: PLOS ONE submission guidelines

Submission Guidelines | PLOS ONE

Style and Format

File format Manuscript files can be in the following formats: DOC, DOCX, or RTF. Microsoft Word documents should not be locked or protected. LaTeX manuscripts must be submitted as PDFs. Read the LaTeX guidelines.
Length Manuscripts can be any length. There are no restrictions on word count, number of figures, or amount of supporting information. We encourage you to present and discuss your findings concisely.
Font Use a standard font size and any standard font, except for the font named "Symbol". To add symbols to the manuscript, use the Insert → Symbol function in your word processor or paste in the appropriate Unicode character.
Headings Limit manuscript sections and sub-sections to 3 heading levels. Make sure heading levels are clearly indicated in the manuscript text.
Layout and Manuscript text should be double-spaced. **spacing** Do not format text in multiple columns.
Page and line Include page numbers and line numbers in the manuscript file. Use continuous line numbers (do not restart the **numbers** numbering on each page).
Footnotes Footnotes are not permitted. If your manuscript contains footnotes, move the information into the main text or the reference list, depending on the content.
Language Manuscripts must be submitted in English. You may submit translations of the manuscript or abstract as supporting information. Read the supporting information guidelines.
Abbreviations Define abbreviations upon first appearance in the text. Do not use non-standard abbreviations unless they appear at least three times in the text. Keep abbreviations to a minimum.
Reference PLOS uses "Vancouver" style, as outlined in the ICMJE sample references. **style** See reference formatting examples and additional instructions below.
Equations We recommend using MathType for display and inline equations, as it will provide the most reliable outcome. If this is not possible, Equation Editor or Microsoft's Insert→Equation function is acceptable. Avoid using MathType, Equation Editor, or the Insert→Equation function to insert single variables (e.g., "a2 + b2 = c2"), Greek or other symbols (e.g., β, Δ, or ′ [prime]), or mathematical operators (e.g., x, ≥, or ±) in running text. Wherever possible, insert single symbols as normal text with the correct Unicode (hex) values. Do not use MathType, Equation Editor, or the Insert→Equation function for only a portion of an equation. Rather, ensure that the entire equation is included. Equations should not contain a mix of different equation tools. Avoid "hybrid" inline or display equations, in which part is text and part is MathType, or part is MathType and part is Equation Editor.

Manuscript Organization

Manuscripts should be organized as follows. Instructions for each element appear below the list.

Beginning section

Middle section

Ending section

Other elements

The following elements are required, in order:

- Title page: List title, authors, and affiliations as first page of the manuscript
- Abstract
- Introduction

The following elements can be renamed as needed and presented in any order:

- Materials and Methods
- Results
- Discussion
- Conclusions (optional)

The following elements are required, in order:

Acknowledgments
References
Supporting information captions (if applicable)

Figure captions are inserted immediately after the first paragraph in which the figure is cited. Figure files are uploaded separately.

Tables are inserted immediately after the first paragraph in which they are cited. T
Supporting information files are uploaded separately.

The introduction should:

- Provide background that puts the manuscript into context and allows readers outside the field to understand the purpose and significance of the study
- Define the problem addressed and why it is important
- Include a brief review of the key literature
- Note any relevant controversies or disagreements in the field
- Conclude with a brief statement of the overall aim of the work and a comment about whether that aim was achieved

The Materials and Methods section should provide enough detail to allow suitably skilled investigators to fully replicate your study. Specific information and/or protocols for new methods should be included in detail. If materials, methods, and protocols are well established, authors may cite articles where those protocols are described in detail, but the submission should include sufficient information to be understood independent of these references.

Supporting reproducibility with protocols

To enhance the reproducibility of your results, we recommend and encourage you to make your protocols public. There are several options:

Protocols associated with Research Articles

Protocol documents may be uploaded as Supporting Information or linked from the Methods section of the article. For laboratory protocols, we recommend protocols.io. Include the DOI link in the Methods section of your manuscript using the following format: http://dx.doi.org.uea.idm.oclc.org/10.17504/protocols.io. [PROTOCOL DOI]. This allows editors and reviewers to consult the detailed step-by-step protocol when evaluating your manuscript. You can choose to keep the protocol private on the protocols.io platform until your article is published—at which time it will be published automatically.

Protocols published in their own right

PLOS ONE offers two options for publishing stand-alone protocol articles: Lab Protocols that describe reusable methodologies and Study Protocols that describe detailed plans and proposals for research projects. Specific guidelines apply to the submission of Lab Protocol and Study Protocol manuscripts. Read the detailed instructions for submitting Lab Protocols and Study Protocols.

Results, Discussion, Conclusions

These sections may all be separate, or may be combined to create a mixed Results/Discussion section (commonly labeled “Results and Discussion”) or a mixed Discussion/Conclusions section (commonly labeled “Discussion”). These sections may be further divided into subsections, each with a concise subheading, as appropriate. These sections have no word limit, but the language should be clear and concise.

Together, these sections should describe the results of the experiments, the interpretation of these results, and the conclusions that can be drawn.

Authors should explain how the results relate to the hypothesis presented as the basis of the study and provide a succinct explanation of the implications of the findings, particularly in relation to previous related studies and potential future directions for research.

PLOS ONE editorial decisions do not rely on perceived significance or impact, so authors should avoid overstating their conclusions. See the *PLOS ONE* Criteria for Publication for more information.

Acknowledgments

Those who contributed to the work but do not meet our authorship criteria should be listed in the Acknowledgments with a description of the contribution.

Authors are responsible for ensuring that anyone named in the Acknowledgments agrees to be named.

Any and all available works can be cited in the reference list. Acceptable sources include:

- Published or accepted manuscripts
- Manuscripts on preprint servers, providing the manuscript has a citable DOI or arXiv URL. Do not cite the following sources in the reference list:

- Unavailable and unpublished work, including manuscripts that have been submitted but not yet accepted (e.g., "unpublished work," "data not shown"). Instead, include those data as supplementary material or deposit the data in a publicly available database.
- Personal communications (these should be supported by a letter from the relevant authors but not included in the reference list)
- Submitted research should not rely upon retracted research. You should avoid citing retracted articles unless you need to discuss retracted work to provide historical context for your submitted research. If it is necessary to discuss retracted work, state the article's retracted status in your article's text and reference list.
- Ensure that your reference list includes full and current bibliography details foevery cited work at the time of your article's submission (and publication, if accepted). If cited work is corrected, retracted, or marked with an expression of concern before your article is published, and if you feel it is appropriate to cite the work even in light of the post-publication notice, include in your manuscript citations and full references for both the affected article and the post-publication notice. Email the journal office if you have questions.
- References are listed at the end of the manuscript and numbered in the order that they appear in the text. In the text, cite the reference number in square brackets (e.g., "We used the techniques developed by our colleagues [19] to analyze the data"). PLOS uses the numbered citation (citation-sequence) method and first six authors, et al. Do not include citations in abstracts. Make sure the parts of the manuscript are in the correct order *before* ordering the citations. **Formatting references**

  PLOS uses the reference style outlined by the International Committee of Medical Journal Editors (ICMJE), also referred to as the "Vancouver" style. Example formats are listed below. Additional examples are in the ICMJE sample references.

Appendix B: Risk of Bias Assessment Tool for Nonrandomised Studies

Study	Selection of participants (selection bias)	Confounding variables (selection bias)	Measurement of exposure (performance bias)	Blinding of outcome assessment (detection bias)	Incomplete outcome data addressed (attrition bias)	Free of selective reporting (selective reporting)	Overall rating
Mitchell et al. (2018)	High	Low	Low	High	High	Low	High
Navab et al. (2019)	High	Low	Low	High	High	Low	High
Khoshvaght et al. (2021)	High	Low	Low	Low	Low	Low	High
A Khoshvaght et al. (2021)	High	Low	Low	High	Low	Low	High
B Bratt et al. (2020)	High	Unclear	Low	Low	High	Low	High
Cwinn & Guillen (2022)	High	Low	Low	High	Low	Low	High
Semsar Yazdi (2023)	High	Low	Low	High	Unclear	Low	High

Appendix C: Risk of bias of RCT studies

Study	Randomisation (selection bias)	Deviations from Intended Intervention (performance bias)	Missing outcome data (attrition bias)	Measurement of the outcome (detection bias)	Selection of the reported result (reporting bias)	Overall rating
(Lennard et al., 2021)	Low	Low	High	High	High	High
(Kirby et al., 2023)	Low	Low	Low	High	Some concerns	Some concerns

Appendix D: NHS REC & HRA Ethical Approval

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

Ariennir gan Lywodraeth Cymru
Funded by Welsh Government

Wales Research Ethics Committee 4
Wrexham

Mailing address:
Health and Care Research Wales
Castlebridge 4
15-19 Cowbridge Road East
Cardiff, CF11 9AB

Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England/ Wales until you receive HRA/ HCRW Approval.

05 September 2023

[redacted]

Dear Ms Lenton

Study title:	**Exploring Parents' Experiences During Joint Admission to a Children's Mental Health Unit: A Thematic Analysis.**
REC reference:	**23/WA/0195**
Protocol number:	**320767**
IRAS project ID:	**320767**

Thank you for your letter of 23 August 2023, responding to the Research Ethics Committee's (REC) request for further information on the above research.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation subject to the conditions specified below.

Good practice principles and responsibilities

The UK Policy Framework for Health and Social Care Research sets out principles of good practice in the management and conduct of health and social care research. It also outlines the responsibilities of individuals and organisations, including those related to the four elements of research transparency:

1. registering research studies
2. reporting results

3. informing participants
4. sharing study data and tissue

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or NHS management permission (in Scotland) should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All research should be registered in a publicly accessible database and we expect all researchers, research sponsors and others to meet this fundamental best practice standard.

It is a condition of the REC favourable opinion that **all clinical trials are registered** on a publicly accessible database within six weeks of recruiting the first research participant. For this purpose, 'clinical trials' are defined as:

- clinical trial of an investigational medicinal product
- clinical investigation or other study of a medical device
- combined trial of an investigational medicinal product and an investigational medical device
- other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice.

Failure to register a clinical trial is a breach of these approval conditions, unless a deferral has been agreed by the HRA (for more information on registration and requesting a deferral see: Research registration and research project identifiers).

If you have not already included registration details in your IRAS application form you should notify the REC of the registration details as soon as possible.

Publication of Your Research Summary

We will publish your research summary for the above study on the research summaries section of our website, together with your contact details, no earlier than three months from the date of this favourable opinion letter.

Should you wish to provide a substitute contact point, make a request to defer, or require further information, please visit: https://www.hra.nhs.uk/planning-and-improving-research/applicationsummaries/research-summaries/

N.B. If your study is related to COVID-19 we will aim to publish your research summary within 3 days rather than three months.

During this public health emergency, it is vital that everyone can promptly identify all relevant research related to COVID-19 that is taking place globally. If you haven't already done so, please register your study on a public registry as soon as possible and provide the REC with the registration detail, which will be posted alongside other information relating to your project. We are also asking sponsors not to request deferral of publication of research summary for any projects relating to COVID-19. In addition, to facilitate finding and extracting studies related to COVID-19 from public databases, please enter the WHO official acronym for the coronavirus disease (COVID-19) in the full title of your study. Approved COVID-19 studies can be found at: https://www.hra.nhs.uk/covid-19-research/approved-covid-19-research/

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

After ethical review: Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study, including early termination of the study
- Final report
- Reporting results

The latest guidance on these topics can be found at https://www.hra.nhs.uk/approvalsamendments/managing-your-approval/.

Ethical review of research sites

[Omit this sub-section if no NHS sites will be taking part in the study, e.g. Phase 1 trials in healthy volunteers]

NHS/HSC sites

The favourable opinion applies to all NHS/HSC sites taking part in the study, subject to confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or management permission (in Scotland) being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS/HSC sites

I am pleased to confirm that the favourable opinion applies to any non-NHS/HSC sites listed in the application, subject to site management permission being obtained prior to the start of the study at the site.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Copies of materials calling attention of potential participants to the research [Study Poster]	2	14 July 2023
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Indemnity Cover]	1	01 August 2022
Interview schedules or topic guides for participants [Interview Schedule]	1	01 May 2023
IRAS Application Form [IRAS_Form_26062023]		26 June 2023
Letter from sponsor [Sponsor Cover Letter]	1	02 June 2023
Other [FW CV]	1	26 May 2023
Other [Permission to share contact details form]	1	26 May 2023
Other [Indemnity Cover]	1	01 August 2022
Other [Debrief form]	2	14 July 2023
Other [Demographic Information Sheet]	2	14 July 2023
Other [Debrief form TC]	2	27 July 2023
Other [Demographic Information Sheet TC]	2	27 July 2023
Participant consent form [Consent Form]	2	14 July 2023
Participant information sheet (PIS) [PIS]	2	14 July 2023
Research protocol or project proposal [Research Protocol]	2	14 July 2023
Response to Request for Further Information [Response to Request for Further Information Following Provisional Opinion]		20 July 2023
Response to Request for Further Information [Response to Request for Further Information]		02 August 2023
Response to Request for Further Information [Response to Request for Further Information Following Provisional Opinion]		23 August 2023
Summary CV for Chief Investigator (CI) [FL CV]	1	26 May 2023
Summary CV for student [AM CV]	1	26 May 2023
Summary CV for supervisor (student research) [FG CV]	1	26 May 2023

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/qualityassurance/

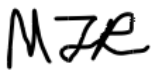
HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at: https://www.hra.nhs.uk/planning-and-improvingresearch/learning/

IRAS project ID: 320767 Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely



pp Mr Martin Rawson- Approvals Administrator
Dr Julie Latchem-Hastings Chair

Email: Wales.REC4@wales.nhs.uk

Enclosures: "After ethical review – guidance for researchers" **Non CTIMP Standard Conditions of Approval**

Copy to: Ms Tracy Moulton

Lead Nation England: approvals@hra.nhs.uk

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

[redacted]

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

06 September 2023

Dear Ms Lenton

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

Study title:	**Exploring Parents' Experiences During Joint Admission to a Children's Mental Health Unit: A Thematic Analysis.**
IRAS project ID:	**320767**
Protocol number:	**320767**
REC reference:	**23/WA/0195**
Sponsor	**University of East Anglia**

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 **320767**. Please quote this on all correspondence.

Yours sincerely,
Gurmel Bhachu

Approvals Manager

Email: HCRW.approvals@wales.nhs.uk

Copy to: *Ms Tracy Moulton*

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*	
Contract/Study Agreement template [PIC Agreement]	1.0	14 July 2023	
Copies of materials calling attention of potential participants to the research [Study Poster]	2	14 July 2023	
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Employer's liability]		01 August 2023	
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Professional indemnity]		01 August 2023	
Interview schedules or topic guides for participants [Interview Schedule]	1	01 May 2023	
IRAS Application Form [IRAS_Form_26062023]		26 June 2023	
Letter from sponsor [Sponsor Cover Letter]	1	02 June 2023	
Other [FW CV]	1	26 May 2023	
Other [Permission to share contact details form]	1	26 May 2023	
Other [Indemnity Cover]	1	01 August 2022	
Other [Debrief form]	2	14 July 2023	
Other [Demographic Information Sheet]	2	14 July 2023	
Other [Debrief form TC]	2	27 July 2023	
Other [Demographic Information Sheet TC]	2	27 July 2023	
Participant consent form [Consent Form]	2	14 July 2023	
Participant information sheet (PIS) [PIS]	2	14 July 2023	
Research protocol or project proposal [Research Protocol]	2	14 July 2023	
Response to Request for Further Information [Response to Request for Further Information Following Provisional Opinion]	1.0	20 July 2023	
Response to Request for Further Information [Response to Request for Further Information]		02 August 2023	
Summary CV for Chief Investigator (CI) [FL CV]	1	26 May 2023	
Summary CV for student [AM CV]	1	26 May 2023	
Summary CV for supervisor (student research) [FG CV]	1	26 May 2023	

Appendix E: Interview Schedule

Parent Interview Schedule v1 May 2023 IRAS Project ID: 320767

PARENT INTERVIEW

ID NUMBER:

INTERVIEWER:

INTERVIEW DATE:

PART ONE: Parent/carer mental health and experience of therapeutic work

I'd like to start by asking you a bit about what you knew about [redacted] before being admitted with your child.

1. A) What were you told about the [redacted] before the admission?
   B) How helpful was this information in preparing you for the admission?
   C) Is there anything that could have been done to better prepare you?

2. Have you ever received any type of therapeutic support before coming to the [redacted]
IF YES: What kind of therapy? What was your experience of this?
[distinguish whether they received therapy for themselves or as part of care for their child (eg family therapy as parent]

The next few questions are about the therapeutic support you received while at [redacted].

3. Can I just check - during your time at the [redacted] did you meet with anyone for 1:1 support? Or did you only receive support alongside your child? (i.e. family therapy)

   IF 1:1: Can you tell me about your experience of this?

   IF no 1:1: Would you have liked to received 1:1 therapy? If so, what would you have liked from this 1:1 therapy?

4. What was it like to explore your own experiences (and challenges?) at the same time as your child's difficulties? (For example in family therapy sessions)

5. What, if anything, did you learn about yourself through the support you received at [redacted]

6. What was *most helpful* and what was *most challenging* about the therapeutic work you did at [redacted] (For example, family therapy or, if applicable, the 1:1 support you received?)

7. Are there any ways that the staff at the [redacted] made this process easier/harder?

8. Are there any ways that the therapy experience could be improved?

For the next couple of questions, I'd like you think about your experience of the admission as a whole (i.e. not just of therapy).

9. What impact do you think the time spent at the [redacted] had on your wellbeing/mental health?
   A) At the time/during the admission
   B) In the longer term/after discharge

10. Has your experience of admission impacted on the wellbeing/mental health on your child? Wider family members? Grandparents? Friends? If so, in what ways?

11. Was your partner involved in the admission? In what ways do you think this has impacted their wellbeing?

12. If I asked your partner/child/family, what might they tell us about how your mental health changed during and after your admission?

The next couple of questions focus on the end of your time at [redacted] and your experience of being discharged from the service.

13. What was the experience of discharge like? What helped with this transition? Is there anything that you think could help support the wellbeing of parents and families during this process?

14. At the end of [redacted] admission, was it suggested to you to seek further/longer-term support (therapeutic) for yourself/for you and your partner?

15. Did you receive therapeutic support (eg family therapy) after you left the [redacted]

If YES: How helpful did you find this support?

IF NO: Would you have liked to access further/longer-term support (therapeutic) for yourself/for you and your partner? What would have been helpful?

16. In what ways do you think CAMHS services (like [redacted]) can best support the wellbeing of parents and families?

PART TWO: The changing relationship between the child and parent from admission to discharge and beyond

I will start by asking a bit about how the [redacted] has impacted your parenting

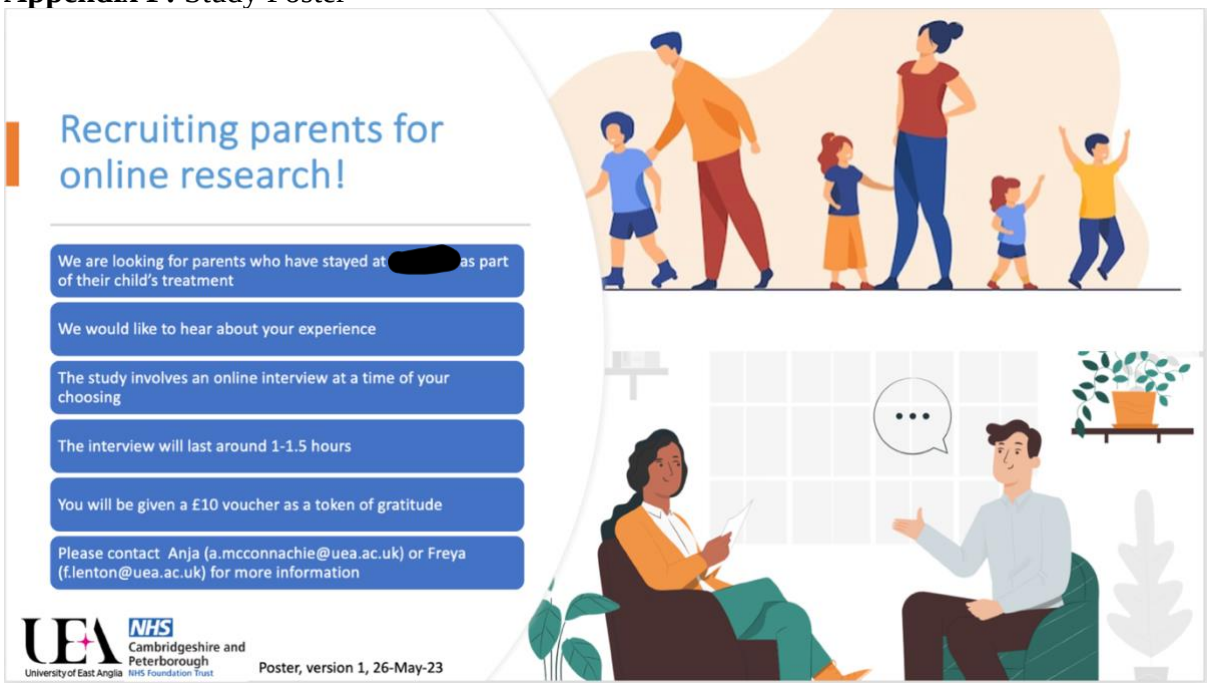
Did you feel that The [redacted] had an impact on your parenting style?

1. Did you feel that [redacted] had an impact on your parenting style?
2. Did you feel that [redacted] had an impact on how you play and have fun with your child?
3. Did you feel that [redacted] had an impact on how you emotionally relate to your child (and when s/he is distressed)?
4. Did you feel that [redacted] had an impact how you show affection with your child?
5. Did you feel that [redacted] had an impact on your behavioural control/ boundaries/ discipline?
6. Did you feel that [redacted] had an impact on how much pressure / expectations of yourself / confidence / acceptance in yourself as a parent?
7. What was the impact, if any, of admission on your child's mental health needs/behavioural needs?
8. Do you feel that [redacted] changed communication between you and your child?
9. How was your experience of parenting your child alongside staff?

I will now ask a bit about others in your life and impact of admission on family life

10. What was the impact of admission at [redacted] on relationships within the family (e.g. partner, siblings, grandparents)
11. What was the impact of admission to reintegration/adjustment back to family life at home?
12. Would others in your family say your relationship with child has changed, and if so, how? What have they observed?

Appendix F: Study Poster



Appendix G: Permission to Contact Form

Template for parents/guardians who have recently been discharged from [redacted] and expressed interest in research, yet contact information are yet to be gained:

Permission to share contact details

I give permission to share my contact details with the University of East Anglia researchers Anja McConnachie and Freya Lenton to find out more about the study on 'parents/guardians experiences of being admitted alongside their child to a children's mental health unit'.

Name: ……

Contact Email: ……..

Contact Telephone Number: ……

Signature:…… Date:……

Template for parents/guardians who have already expressed interest and provided contact details to be contacted for research, yet permission for UEA students to contact needs to be ascertained:

Permission to share contact details

I give permission to share my contact details with the University of East Anglia researchers Anja McConnachie and Freya Lenton to find out more about the study on 'parents/guardians experiences of being admitted alongside their child to a children's mental health unit'.

Name: ……

Signature: …… Date: ……

Appendix H: Information Sheet

University of East Anglia

NHS Cambridgeshire and Peterborough NHS Foundation Trust

Participant Information Sheet

Parents' experiences of being admitted alongside their child to a children's mental health unit

We would like to invite you to take part in our 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 take time to read this information and discuss it with others if you wish. If there is anything that is not clear, or if you would like more information, please ask us.

We would like to thank you, in advance, for taking the time to read through this information and for considering participating in the study.

What is the purpose of the study?

The purpose of the study is to understand the experiences of parents admitted alongside their child to a mental health unit. We want to find out what it is like for parents who have stayed at [redacted] as part of their child's treatment. We are interested in all the ways this might affect parents, including your wellbeing and your relationship with your child.

Who is organising and funding the research?

The research is being conducted by Trainee Clinical Psychologists Freya Lenton and Anja McConnachie, who are carrying out the study as part of their Doctorate in Clinical Psychology, funded by the University of East Anglia (UEA). Freya and Anja are being supervised by Clinical Psychologists Dr Fergus Gracey (UEA) and Dr Francesca Woolgar (CPFT).

This project has been granted ethical approval by the Health Research Authority that assess governance and legal compliance with the independent ethical opinion by a Research Ethics Committee.

Why have I been invited?

You previously expressed interest in involvement in research connected to [redacted] and we would like to invite you to take part in the study.

As [redacted] is the only children's inpatient unit in the UK to admit parents alongside their child, we would like to learn what it is like for parents to be part of the inpatient stay. We hope to speak to around 12 parents, and we would like to hear from parents with a wide range of experiences.

Do I have to take part?

You do not have to take part in the study – participation is entirely voluntary. If you do take part and then later change your mind, you can withdraw from the study without giving a reason until the point of analysis. Whether you decide to take part or not, it will not impact on the clinical care you and your family receive. If you decide to withdraw from the study this will also not impact yours and your family's clinical care.

What will happen if I decide to take part?

If you decide to take part, you will be interviewed at a time of your choosing by one of two Trainee Clinical Psychologists – Anja McConnachie or Freya Lenton. The interview will take place online over Microsoft Teams and will last around 1-1.5 hours. Alternatively, if you prefer, the interview can be carried out over the telephone. All interviews, whether online or via telephone, will be video/audio recorded and transcribed using Microsoft Teams software.

At any point during the interview, you have the right to withdraw. You can withdraw after the interview up until the point of analysis. During transcription, your data will be pseudonymised (i.e., assigned a fictional name, rather than your real name).

The researchers will keep a separate spreadsheet which will link your pseudonym with your participant ID so that we can contact you if you would like to be involved in checking our analyses. Once the data has been analysed, you can receive a summary of the research findings and will have the opportunity to give feedback.

After this, the spreadsheet linking your pseudonym and participant ID will be deleted to ensure your anonymity. The information collected from the interviews will be written up and will be presented in quotes with all identifying information removed.

Are there any disadvantages or risks from taking part?

As the interview will cover topics relevant to mental health and parents' experiences of undergoing therapy, some interview questions may bring up strong emotions for you. If you do feel distressed at any point during the interview, you can take a break or withdraw from the study at any point. If there are any questions you would prefer not to answer you can skip the question. The interviewer will also provide a list of support services that you can contact if you would like further support after taking part.

What are the possible benefits of taking part?

Taking part in the study will help to provide valuable information to wider Child and Adolescent Mental Health Services (CAMHS) about the experiences and support needs of

parents and families. We hope that parents' will find it helpful to have the interviewer listen to their experience, but please note that we cannot guarantee this.

Will I be reimbursed for taking part?

To thank you for your time and participation in the study you will be given a £10 shopping voucher.

Will my taking part in the study be kept confidential?

Your participation in the study will be kept confidential, unless you tell us something which raises a serious concern about your safety or the safety of others. If you tell us something which raises serious safety concerns, we would be required to break confidentiality to ensure the safety of all persons linked to the study.

All information will be kept on the secure network at University of East Anglia (UEA) which only the research team will be able to access. Although one of the supervisors (Dr Francesca Woolgar) works at [redacted] please note that the data is not connected to you or your child's care. All data collected will be kept confidential and cannot be accessed by the clinical team. In any written reports, data will be presented as pseudonymised quotes and all identifying details will be removed.

How will we use information about you?

We will need to use information from you for this research project. This information will include your name and contact details. We will use your name and contact details only to help stay in touch with you while you are in the study. After that we will delete all identifiable information.

We will also gather demographic information and information from you during our interviews. Interviews will be recorded digitally and stored on the UEA secure password-protected encrypted network that only the research team can access. During transcription, all names and identifying information will be changed to protect participant identity. The pseudonymised research data will be stored separately to any identifiable information we have like your name and contact details. We will handle this information and write our reports in a way that no-one can work out that you took part in the study. After publication of the research findings, the anonymised research data will be stored for at least 10 years in line with UEA data management policy.

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 it will not be possible to withdraw the data after the analysis has begun. 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 www.hra.nhs.uk/information-about-patients/
- our leaflet available from www.hra.nhs.uk/patientdataandresearch
- by asking one of the research team
- by contacting the UEA's Data Protection Officer at dataprotection@uea.ac.uk

What should I do if I have any concerns or complaints about the study?

If you wish to make a complaint about the research or investigators, then please contact Professor Sian Coker, Acting Programme Director, Professor of Clinical Psychology, (s.coker@uea.ac.uk). Professor Coker is separate from the research team.

How do I take part?

If you would like to take part in the study, please reply to Anja McConnachie (a.mcconnachie@uea.ac.uk) or Freya Lenton's (f.lenton@uea.ac.uk) email and they will contact you to set up a brief initial telephone conversation to answer any questions, explain consent and set up a convenient interview time.

Appendix I: Consent Form

NHS Cambridgeshire and Peterborough NHS Foundation Trust

University of East Anglia

Participant Consent Form

Participant ID number:

Please initial box

1. I confirm I have read the information sheet. ☐
2. I confirm I have had an opportunity to ask questions and have had them answered satisfactorily. ☐
3. I understand that I am free to withdraw from this study at any stage prior to data analysis without explanation. ☐
4. I understand that what I say will be kept confidential unless something I say raises serious concerns about someone's safety, or raises concerns about professional practice. ☐
5. I understand that my data will be identified only by a code and that my personal details will be kept in a secure file which only the research team can access. ☐
6. I understand that the study results will be presented at conferences and written up in journals. ☐
7. I agree to allow my interview to be audio-recorded. ☐
8. I agree to allow my interview to be video recorded. ☐

The project has received NHS ethical approval.

I agree to participate in the study.

Participant's Signature: ..... Date: .....

Participant's Name in Block Letters: ….....

Researcher's Signature: …… Date: .....

When completed: 1 for participant; 1 for researcher store on OneDrive

NHS Cambridgeshire and Peterborough NHS Foundation Trust

University of East Anglia

Demographic Information sheet

Participant ID number:

We ask everyone who takes part in the study for some demographic information. This is to help us better understand who participants are and how inclusive/representative our sample is.

We would be grateful if you could provide as much information on this sheet as you feel comfortable to share. If there are any questions you prefer not to answer you can leave these blank.

In the table below, please provide details about everyone who lives in your household (including yourself).

Name	**Age**	**Relationship to parent (e.g., child, partner)**

If you have any questions about the study please contact Anja McConnachie (email: a.mcconnachie@uea.ac.uk) or Freya Lenton (f.lenton@uea.ac.uk).

Demographic Information continued

Please answer the following questions in your own words. If there are any questions you prefer not to answer you can leave these blank.

1. How would you describe your gender?

2. Is your gender different to the sex you were assigned at birth? Y/N (circle)

3. Would you consider yourself to have a disability? If so, please describe:

4. How would you describe your ethnicity?

5. How would you describe your sexual orientation?

6. How would you describe your social class?

If you have any questions about the study please contact Anja McConnachie (email: a.mcconnachie@uea.ac.uk) or Freya Lenton (f.lenton@uea.ac.uk).

Appendix K: Debrief Form

NHS Cambridgeshire and Peterborough NHS Foundation Trust

University of East Anglia

Debrief Form

Thank you for your participation in this research. As a token of our appreciation for your time and involvement we would like to offer you a £10 voucher. You will receive this following your interview via email.

What happens now?

The results of this research will be written into a full research report, which will be submitted to the UEA as part of a thesis for the Doctorate in Clinical Psychology programme. After submission, if you have expressed an interest in receiving the findings of the research, we will send you a summary of the results by email. The researchers intend to submit this report to a peer reviewed journal for publication.

Contact information

If you have any questions or concerns regarding this research, you may raise them with one of the researchers:

Freya Lenton: f.lenton@uea.ac.uk
Anja Mcconnachie: a.mcconnachie@uea.ac.uk

Further support

If you feel affected by any of the issues addressed in your interview, please seek further support from your **GP** or **care team**. If you have concerns about your child's mental health, please contact their **CAMHS Team**.

IAPT (Improving Access to Psychological Therapies): Adults NHS talking therapy service providing support for common mental health conditions. Find your local IAPT and self-refer here: https://www.nhs.uk/service-search/mental-health/find-an-nhs-talking-therapies-service

The Samaritans offer free confidential support on **116 123**, or email: jo@samaritans.org for a reply within 24 hours.

Young Minds offer a Parents Helpline (Mon-Fri 9:30m - 4pm; **0808 802 5544**), Webchat and Email Service: https://www.youngminds.org.uk/parent/parents-helpline-and-webchat/

If you require more urgent mental health support, please call **111, 999** or go to **A&E**.

Thank you again for your participation!

Appendix L: Coding excerpt sample

Staff compassionate formulation and psychoeducation – helping parents to understand it's not their fault/they aren't responsible for everything

- Takes the pressure off (lifting a weight)

if anything… I would say it took pressure off of me.

I think when we went in, all I felt very much responsible for it was for me to sort these things out.

It was for me to fix these things, and if I did the right things, we wouldn't be in this place in the first place and you know the staff sort of explained to me that actually that wasn't the case, that…I'm not responsible for everything and… you know, things happen and…you know, I haven't got to fix everything sort of thing and and that's sort of thing so.

So I would say in a sense, it took pressure off of me and allowed me to think this is this is how it is for (child)

And and I have to work with how it is for (child) rather than I'm responsible for it.

I've got to fix it. I've got to make it right, that sort of thing.

Took pressure off of me rather than adding any.

Yeah, because I think I, I don't know if it's just me, but but to me it feels natural as a parent that if your child is suffering that you feel that you need to you, you need to make that right somehow.

So I think to understand that you can't always just make it right?

I mean, I remember (staff member) telling me that. Umm, now I wasn't doing things wrong and I sort of said to her.

Also, the nursing staff would say things about how, you know, mental health problems and not, you know, it's not like somebody has just created them because if they don't the wrong thing, they, they they they're quite sort of complex and and so it's just those things.

- Compassion from staff: it's not your fault

It is like that constant reassurance that actually and you know things can go wrong and… it's not just your sole responsibility to have stopped it, to have, you know, try and fix it.