MONASH University

Applying Different Therapeutic Modalities to Support Parents with Mental Health Challenges: Experiences of Australian Therapists who use Schema Therapy, Acceptance and Commitment Therapy and Narrative Therapy

Ciara Louise Hart

BA (Psych), BA (Hons)

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Abstract

Parents make up almost one third of mental health service users (Maybery et al., 2009) and due to the parenting responsibilities have their own support needs (Reupert & Maybery, 2016). While some parents with mental health challenges manage well (Aram et al., 2017), others find it difficult to balance the demands of parenting and looking after their own mental health needs (Carpenter-Song et al., 2014; Montgomery et al., 2006). Children of parents with mental health challenges have an increased risk of developing psychological difficulties themselves (Reupert et al., 2022), especially if their parents do not receive adequate support (Leverton et al., 2003; Park et al., 2003). Initial research suggests that standard manualised treatments such as cognitive therapy and psychopharmacological remedies, may not be adequate for addressing the specific needs of parents with mental illness and their children (Coiro et al., 2012; Weissman et al., 2016). In relation to therapeutic modalities, it remains unclear and under-researched in the literature which individual therapeutic approaches best support parents.

Just as certain therapeutic modalities are better suited to treat particular psychological conditions and presenting problems (Carry & McCulley, 2016), it may be that certain modalities are better suited to support parents who experience mental health challenges. There appears to be a dearth of research into the effectiveness of different therapeutic modalities for working therapeutically with parents who have a mental illness what specific aspects of the modalities might be helpful and the experiences of therapists. This project will investigate the utility of three commonly used therapeutic modalities, schema therapy, acceptance and commitment therapy (ACT) and narrative therapy, for those who care for dependent children, and simultaneously experience mental health challenges. As there are few studies examining the perspectives of therapists working outside public and inpatient psychiatric services, the aim of this PhD is to examine the use of different therapies with parents who have mental health challenges, from the experiences and perspectives of therapists working in private and/or community settings with parents. More specifically, this PhD will examine the following questions:

- What are the experiences of therapists using different modalities when working with parents with mental health challenges? Do therapists using different modalities, have different experiences working with parents?

- From the perspective of therapists, what elements of the various therapeutic strategies and approaches appear to respond to the needs of parents who experience mental health challenges? Are there common strategies or tools across the three modalities that therapists find work best for parents with mental health challenges? If so, what are these?
- What enablers and barriers have therapists found when working with these therapeutic modalities with parents? How do these compare between the different modalities?

This PhD will be completed as a thesis with published work, including three publishable studies. All studies involved interviews with therapists about their experiences with, and views of, working therapeutically with parents; the first study with schema therapists, the second study with acceptance and commitment therapists and the third study with narrative therapists. The final chapter of this thesis is a general discussion that integrates all of the research findings and explores the implications of these for parents, children, therapists and the mental health system. Further, it will include a discussion on how therapist can better support parents with mental illness, the thesis limitations and possible future research directions.

Declaration

The following declarations are made in accordance with Monash University Doctor of Philosophy Regulation:

This thesis is an original work of my research and contains no material which has been accepted for the award of any other degree or diploma at any university or equivalent institution and that, to the best of my knowledge and belief, this thesis contains no material previously published or written by another person, or any use of generative artificial intelligence technologies, except where due reference is made in the text of the thesis.

Student signature:

Print Name: Ciara Hart

Date: 25/08/2024

Thesis Including Published Works Declaration

The following declarations are made in accordance with Monash University Doctor of Philosophy Regulation:

I hereby declare that this thesis contains no material which has been accepted for the award of any other degree or diploma at any university or equivalent institution and that, to the best of my knowledge and belief, this thesis contains no material previously published or written by another person, or any use of generative artificial intelligence technologies, except where due reference is made in the text of the thesis.

This thesis includes three original papers submitted for publication in peer reviewed journals. This core theme of the thesis is the views and experiences of therapists across schema therapy, acceptance and commitment therapy and narrative therapy who work with parents with mental health challenges. The ideas, development and writing of all the papers in the thesis were the principal responsibility of myself, the candidate, working within the Faculty of Education under the supervision of Professor Andrea Reupert and Dr Rochelle Hine who is from the Monash School of Rural Health.

For the three papers that are included in this thesis, the inclusion of co-authors reflects the fact that the papers came from active collaboration between researchers and acknowledges the respective input from the research team. Chapters 4, 5 and 6 present these papers alongside the contribution of each researcher to the paper. The contributions of each researcher can also be found in Table 0.1.

Table 0.1.

Outline of the Candidate's Contribution to Publications in the Thesis

Thesis Chapter	Publication Title	Publication Status	Nature and % of candidate contribution	Co-author(s) names, nature and % contribution	Co-author(s) is a Monash Student?
5	What are Schema Therapists' experiences and perceptions of working with parents with a mental illness	Accepted in the *Australian Counselling Journal*	**70% -** Candidate led the study conceptualisation and design, participant recruitment, data collection, recording and transcription, analysis and interpretation of results and the preparation of the manuscript	**Dr Phillip Tchernegovski 20%** - Co-led the study conceptualisation and design, assisted with participant recruitment, data collection, recording and transcription. Was involved in the analysis and interpretation of results and provided feedback on the manuscript	No
				Prof Andrea Reupert 5% - Provided feedback on the manuscript	No
				Dr Rochelle Hine 5% - Provided feedback on the manuscript	No
6	Acceptance and Commitment Therapy for parents who have mental health challenges: Therapists' Perceptions	Returned for revisions from *Clinical Psychologist*, edited and resubmitted	**70% -** Candidate contributed to the study conceptualisation and design, led the participant recruitment, data collection, recording and transcription, analysis and interpretation of results and the preparation of the manuscript	**Prof Andrea Reupert 10%** - Assisted with the study conception and design, provided feedback on the manuscript	No
				Dr Rochelle Hine 10% - Assisted with the study conception and design, involved in analysis and interpretation of results, provided feedback on the manuscript	No
				Irene Martin 10% - Input into data analysis and manuscript preparation	Yes

7	Narrative Therapy for parents who have mental health challenges: Therapists' Perceptions	Submitted for publication with the *International Journal of Narrative Therapy and Community Work*	**80% -** Candidate led the study conceptualisation and design, led the participant recruitment, data collection, recording and transcription, analysis and interpretation of results and the preparation of the manuscript	**Prof Andrea Reupert 10%** - Assisted with the study conception and design, provided feedback on the manuscript **Dr Rochelle Hine 10% -** Assisted with the study conception and design, involved in analysis and interpretation of results, provided feedback on the manuscript	No No

Student name: Ciara Hart

Student signature:

Date: 25/08/2024

I hereby certify that the above declaration correctly reflects the nature and extent of the student's and co-authors' contributions to this work. In instances where I am not the responsible author I have consulted with the responsible author to agree on the respective contributions of the authors.

Main Supervisor name: Andrea Reupert

Main Supervisor signature:

Date: 25/08/20

Manuscripts

Hart, C., Tchernegovski, P., Reupert, A., & Hine, R. (in press). What are Schema Therapists experiences and perceptions of working with parents with a mental illness. *Australian Counselling Journal.* (In press 14th June 2024).

Hart, C., Reupert, A., Hine, R., & Martin, I. (under review). Acceptance and Commitment Therapy for parents who have mental health issues: Therapists' perceptions. *Clinical Psychologist.*

Hart, C., Reupert, A., & Hine, R. (under review). Narrative Therapy for parents who have mental health issues: Therapists' perceptions. *International Journal of Narrative Therapy and Community Work.*

Acknowledgments

There are many people I want to thank for supporting me and helping me get through the past few years of this PhD.

Firstly, I want to acknowledge and thank my amazing supervisors beginning with Phillip Tchernegovski, my first supervisor who brought many ideas to this thesis and got me started on this journey four years ago. Thank you for your structured guidance and support as I was getting my head around post-graduate research whilst also undertaking placement and coursework.

To Andrea Reupert and Rochelle Hine, thank you both for your ongoing supervision, prompt email replies, and positivity over the past three years. You never failed to ease any anxieties I have had over the course of the thesis and logging onto a Zoom call to hear your insights and enthusiasm about my work will always mean so much. I am very grateful for the hours you have invested in reviewing my work, providing feedback, and discussing ideas. This thesis would not have been possible without Andrea and Rochelle's exceptional support - thank you for showing me what great leadership looks like.

To my parents, who always encouraged me to not shy away from a challenge and pursue my interests and passions which indeed led me to undertake this thesis. I am beyond lucky to have grown up with you both as my parents and thank you for all your love and support over the years.

Another thank-you must go my amazing friend and fellow PhD Candidate Irene Martin. Irene has been a source of motivation and encouragement from the beginning, providing not only academic feedback and assistance with coding interviews, but also much needed emotional support during more challenging times. Our Zoom study sessions, text messages of support and practice milestone reviews with one-another helped bolster my motivation over the years. Above all, Irene has brought so much fun and enjoyment into undertaking my PhD candidature, and ensured I never felt alone throughout the thesis process.

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And to my wonderful friends, and biggest cheerleaders – thank-you. Having the daily support from my housemates, Tristan and Tas, was a massive motivator for getting me over the line in the final few months of the candidature. Tristan's frequent comments including: 'wait you're still writing that PhD? you were working on it last week so I thought you'd be done by now' will always make me laugh. Jokes aside, thank you for being so supportive about me spending my weekends at the kitchen table plodding along with writing my thesis. Having my friends cheer me along the way has made the process all the more enjoyable.

This research was supported by an Australian Government Research Training Program (RTP) Scholarship.

Authors' Note

This thesis is formatted as a thesis including published works, meaning that particular chapters include papers that have been prepared and submitted for publication in peer-reviewed journals during the candidate's enrolments. The Faculty of Education at Monash University specifies that articles included in a thesis with publications need to have been submitted for consideration of publication at a minimum. Papers do not have to have been accepted and can be under review by peer-reviewed journals at the time of thesis submission.

A thesis including published works contains chapters that introduce the research and explain how the research fits within the thesis's overall aims. The first three chapters of this thesis (Chapter 1 - Introduction, Chapter 2 – Literature Review and Chapter 3 – Methodology) frame the subsequent research studies presented in chapters 4, 5 and 6. Additionally, a thesis including published papers should provide a cohesive and sustained discussion of the central themes. The final chapter (Chapter 7 – Discussion) brings together the findings from each of the three studies discusses the central themes that arose across the papers.

Whilst I have tried to minimise repetition throughout, some overlap of information is required in order to clearly introduce the research and discuss key themes that arose from the research findings, and to simultaneously have three manuscripts that function as stand-alone papers. For instance, there is some repetition of previous research pertaining to this field that is discussed in the literature review as well as each of the three studies.

All three studies included in this thesis have been submitted for publication; however, at the time of thesis submission, only one has been accepted to publication (Study 1 – accepted for publication in the Australian Counselling Journal, in press in 2024). Study 2 has been submitted for publication with Clinical Psychologists. I have received a recommendation for revisions from peer-reviewers, and these have been addressed in the revised submission to the journal. Study 3 has been submitted to the International Journal of Narrative Therapy and Community Work and is currently under review.

Monash University Graduate Research guidelines indicated that research papers included in theses should be presented as they are published. Whilst the three studies are awaiting publication, I have included the three studies in the format they were submitted for

publication. Each journal I submitted my papers to has different styles and requirements which explains the varied formatting of each paper.

List of Abbreviations used in the Thesis

FFP	Family Focused Practice
GP	General Medical Practitioner
IPA	Interpretative Phenomenological Analysis
ST	Schema Therapy
ACT	Acceptance and Commitment Therapy
RFT	Relational Frame Theory
NT	Narrative Therapy
CBT	Cognitive Behavioural Therapy
DBT	Dialectical Behavioural Therapy
AIHW	Australian Institute of Health and Welfare
ISST	International Society of Schema Therapy

Chapter 1 Introduction

1.1 Parents with Mental Health Challenges

Many parents experience mental health challenges (Maybery et al., 2015) and many adults who use mental health services are parents (Maybery & Reupert, 2018). However, across the literature, definitions of 'parents with mental health challenges' vary, as do prevalence estimates of mental health challenges among parents. The introduction to this thesis will explore the various definitions and prevalence estimates, followed by a summary of the literature outlining the experiences of parents with mental health challenges. The experiences and outcomes of children who have parents with mental health challenges will also be discussed. The epistemological and ontological frameworks that underpin the research approach will then be outlined. Chapter 1 will conclude with a description of how reflexivity was demonstrated throughout the research process of the thesis.

1.1.1 Who are Parents with Mental Health Challenges?

In the field of parental mental health, definitions of 'parents with mental health challenges' vary. Some authors recognise parents who do not live with their children (Diaz-Caneja & Johnson, 2004; van der Ende et al., 2016) and/or have adult children (Awram et al., 2017). Other studies focus exclusively on parents who have full-time custody of dependent children (Afzelius, Plantin & Östman, 2018; Stallard, Norman, Huline-Dickens, Salter & Cribb, 2004). Additionally, much of the research to date conducted with parents who have mental health challenges has focused on mothers (Dolman et al., 2013; Halsa, 2018; Perera, Short & Fernbacher, 2014). Within this thesis, a parent is considered to be any person who identifies with this role, regardless of gender, custodial status, biological relationships, or the age of the child.

When recruiting parents with mental health challenges, some studies encompass mental health challenges broadly, relying on participants' self-reporting (Gladstone et al., 2011; Jones et al., 2016), while others focus specifically on diagnosed disorders such as schizophrenia, bipolar disorder, and personality disorders (Diaz-Caneja & Johnson, 2004; Dolman, Jones & Howard, 2013; Howard & Hunt, 2008), and/or depression (Solantaus, Paavonen, Toikka, & Punamäki, 2010). Substance use disorders have been included as mental health challenges in some investigations with parents (Edwards, Eiden & Leonard, 2006; van der Ende, van Busschbach, Nicholson, Korevaar & van Weelghel, 2016), while other studies excluded participants with such diagnoses (Drost, van der Krieke, Sytema & Schippers, 2016; Goodman et al., 2011). Throughout this thesis, parental mental health

challenges are defined broadly, to encompass any parent who self identifies experiencing challenges with their mental health, regardless of whether they have been diagnosed with a mental health disorder or not.

This thesis focuses on parents with mental health challenges who present for one-on-one psychotherapeutic counselling to address their mental health challenges in a private practice setting. Psychotherapy refers to the treatment provided for mental health challenges and/or emotional and behavioural disturbances (Freedman et al., 1985). This thesis explores the experiences and perceptions of therapists who undertake psychotherapeutic counselling with parents with mental health challenges. The term 'therapists' will be used throughout this thesis to refer to mental health professionals who practice the delivery of psychotherapeutic counselling interventions with clients. Therapists may obtain professional training from a number of fields, including psychology, social work and counselling (Clarkson, 1991; Osagu et al., 2013). Regardless of their discipline, the three studies in this thesis involved interviewing therapists who work with parents with mental health challenges.

As therapy can be accessed by parents with any type of mental health challenge, there was no exclusion criteria for therapists regarding whether their clients who are parents have a diagnosable mental illness or not. Further, there was no assessment of, or exclusion based on the severity of the mental health challenges therapists worked with. The author of this thesis acknowledges that not all parents who have mental health challenges have a diagnosable mental illness, that some people chose not to identify with any diagnostic label and that the severity and duration of mental health challenges vary enormously. Within this thesis, mental health challenges are broadly considered to be any psychological difficulties which may lead to engagement with therapy.

1.1.2 Prevalence of Mental Health Challenges Amongst Parents

The prevalence of mental health challenges among parents is not definitively estimated due to variations in sampling and assessment techniques. Maybery et al., (2015) outlined two main methods for estimating the prevalence of parental mental illness: a top-down and a bottom-up approach. The top-down approach involved analysing existing data on both mental illness and parental status from general populations, such as national surveys (e.g., Luciano, Nicholson & Meara, 2014) or census data (e.g., Maybery et al., 2009). However, this method is limited because the measures used are not always specifically designed to accurately identify parents who experience mental health difficulties (Maybery et al., 2015). The 'bottom-up' approach, involves using data collected within public mental

health services, such as intake assessments, surveys completed by service users (Handley, Farrell, Josephs, Hanke & Hazelton, 2011) or audits of case files (Gatsu et al., 2016) to estimate the proportion of adults accessing mental health services who identify as parents. While this method provides tailored information, data integrity can be problematic as not all mental health services rigorously collect these data. Furthermore, the samples obtained are not necessarily representative of larger populations including parents with mental health challenges who are not engaged with a mental health service, thus limiting the applicability of the findings (Maybery et al., 2015).

Given the strengths and limitations of both the top-down, and bottom-up approaches, Maybery et al., (2015) combined the two approaches to report and estimate the prevalence of parental mental illness in Australia. Top-down data, drawn from Australian Bureau of Statistics (1998; 2003), showed that 23.3% of Australian families have at least one parent with a mental illness. Another estimate, derived from a substantial community survey, suggested a slightly lower prevalence of 14.4% of families have a parent who has a mental illness. Discrepancies between these figures were attributed to methodological differences in the data collection methods (Maybery et al., 2015). The bottom-up estimate used by Maybery et al., (2015) was drawn from adult mental health service records across the state of Victoria. The data was then extrapolated to the broader population, suggesting that around 1.3% of Australian families have a parent receiving support from adult mental health services at any one time. Maybery et al., (2015) noted that this figure is inherently conservative, as it specifically pertains to parents with mental illness who are engaged in clinical mental health services.

A systematic literature review found that between 12 and 45% of all clients attending adult mental services were parents (Maybery & Reupert, 2018), with four of the studies included in the review found to have prevalence rates from 36 to 38% (Hearle et al., 1999; Gatsou et al., 2016; Benders-Hadi et al., 2013; Ostman & Eidevall, 2005). However, these audit-style studies are limited in that they often concentrate on a single regional adult mental health service, typically with small sample sizes (Howe et al., 2012; Benders-Hadi et al., 2013). In contrast, a recent study by Rudd et al., (2019) was conducted with a larger sample size, of 23,167 outpatients, to estimate the prevalence of parents in Norwegian adult mental health outpatient clinics. It was found that 36% of outpatients had children under 18 years (Ruud et al., 2019).

Although there is a significant variation between the prevalence estimates of parents with mental health challenges receiving support from clinical and adult mental health

services, the research conducted to date suggests that parental mental health challenges are commonplace around the globe, including in Australia. The higher, top-down estimate suggests that one in five families have a parent with a mental illness (Maybery et al., 2015). However, the bottom-up estimates suggest that many of these parents are not receiving clinical support for their mental illnesses. Given the high prevalence of families where a parent has mental health challenges, it is important that adequate support and resources are available for these parents and their families. The private mental health sector plays an important and potentially preventative role in this endeavour.

1.1.3 Experiences of Parents with Mental Health Challenges

Experiences of parental mental health challenges are unique to each individual and family. However, throughout the last 30 years of research in this field, common experiences amongst parents with mental health challenges have been identified, including some positive (Abrams & Curran, 2011; van der Ende et al., 2016; Maybery & Reupert, 2018a, 2018b) as well as negative experiences (Awram et al., 2017; Dolman et al., 2013; Montgomery et al., 2011). The literature investigating these experiences is summarised below.

Parenting plays a central role in people's lives and has the potential to bring joy (Abrams & Curran, 2011; Diaz-Caneja & Johnson, 2004) and meaning (Dolman et al., 2013; Evenson et al., 2008) for those living with mental health challenges. Thus, for some, a parenting identity brings positive elements that help them to manage their mental health challenges. For example, some parents report that caring for their children has facilitated social engagement with other adults, including the parents of other children, building social connectedness which in turn acts as a protective factor (van der Ende et al., 2016). Further, parenting responsibilities may contribute to providing structure to one's daily routine (van der Ende et al., 2016), another factor that may promote recovery (Maybery & Reupert, 2018a, 2018b). Finally, motivation for parents to commit to mental health recovery goals (Evenson et al., 2008; Reupert & Maybery, 2009) and engage in mental health services (Diaz-Caneja & Johnson, 2004) can be driven by wanting to maintain positive wellbeing to appropriately care for children.

Notwithstanding the various positive experiences reported by parents who experience mental health challenges, a range of negative experiences have also been described. Numerous studies have highlighted difficulties associated with individuals attempting to balance the demands of parenting with addressing their mental health needs (Awram et al., 2017; Montgomery et al., 2011). Whilst parenting responsibilities can promote a structured

daily routine, some parents who have mental health challenges may find it difficult to plan activities and maintain a routine (van der Ende et al., 2016). Similarly, some parents have described how their mental health challenges prevent them from providing adequate structure and care for their children (Diaz-Caneja & Johnson, 2004; Dolman et al., 2013) compromising their ability to respond appropriately to their children's needs (Diaz-Caneja & Johnson, 2004). This could lead to a sense of inadequacy and/or an awareness of being judged. For instance, some mothers felt stigmatised, guilty or labelled as "non-compliant" when their children missed day care or appointments (Diaz-Caneja & Johnson, 2004). Diaz-Caneja and Johnson (2004) found societal expectations and judgments could impact mothers' mental health when they perceived themselves as failing to meet these expectations. Other parents with mental health challenges found it difficult to be empathetic and form a nurturing bond with their children (Abrams & Curran, 2011; Hine, Maybery & Goodyear, 2017). Possibly because of these attachment difficulties, another study, which investigated the parenting experiences of fathers with psychosis, described stressful parent-child interactions, which in turn, can aggravate mental health difficulties (Evenson et al., 2008).

Other research has highlighted the concerns some parents have about their children's welfare. Many parents share concerns regarding their children experiencing bullying or associative stigma, due to their parent's mental health challenges (Halsa, 2018; Jones et al., 2016). This in turn can lead families to conceal parental mental health challenges which inhibits help seeking (Reupert et al., 2015; Reupert et al., 2021). Other studies have described parents' concerns about losing custody of their children (Dolman et al., 2013; Jones et al., 2016; Montgomery et al., 2011). These fears appear to be substantiated as research shows that between 30-70% of mothers with schizophrenia experience at least temporary custody loss of children (Nicholson & Miller, 2011). Thus, for many, intermittent parenting is the norm, bringing extra challenges (Nicholson & Miller, 2011). Likewise, parents have described how their mental illness has been used against them in custody and/or access disputes over their children (Jeffery et al., 2013; Holford et al., 2023). Given these difficulties, it is crucial that mental health support is available, to alleviate the challenges facing parents and their families and to enhance the overall well-being of both parents and children.

1.1.4 Children of Parents with Mental Health Challenges

Just as parents with mental health challenges have diverse experiences, so do their children. The following section exploreses some of the experiences children may have and discuss potential outcomes children may face.

An experience common to children of parents with mental health challenges is the caring responsibilities they assume when or if parents are unable to support the family, care for themselves and/or participate in everyday routines and responsibilities (Maybery et al., 2005; Pölkki et al., 2005). Children have described valuing the bond created through engaging in caring activities with their parents and family, reporting an increased sense of maturity, empathy and pride in their caring role (Ahlström et al., 2009). Maybery and Reupert (2019) found that some children who have a parent with mental health challenges, develop resilience and empathy at a young age, learning to navigate complex emotions and situations. These children may demonstrate a deepened capacity for compassion and a heightened sensitivity to the needs of others, stemming from their experiences with their parent. Likewise, some children may have strong problem-solving, adaptability and coping mechanisms developed in response to their family life experiences (Maybery & Reupert, 2019).

Children can experience various emotional and psychosocial challenges associated with their parents' mental health challenges (Bee et al., 2014; Dam & Hall, 2016; Grove et al., 2015). These challenges may include family conflict stemming from the stress and instability associated with a parent's mental health struggles (Bee et al., 2014). This conflict can manifest in various ways, such as heightened tension, frequent arguments or breakdowns in family communication (Aldridge, 2006). Moreover, for some parents, erratic parenting, inconsistent boundary setting and high emotional expression (such as anger towards their children) have been described (Bee et al., 2014). Some children of parents with a severe mental illness have described feeling targetted by their parents' hostile behaviour (Bee et al., 2014). Issues with family communication, family disruptions, transient lifestyles, and children assuming onerous caregiving roles, have likewise been raised in several studies (Aldridge, 2006; Ballal, 2018; Brockington, 2011; Gopfert, 1996; Maybery et al., 2015; Nicholson, 2001).

Parents and children may want to keep the parent's mental health challenges a secret and avoid talking about it to others outside of the family (Dam & Hall, 2016; Grove et al., 2015) in order to avoid stigma (Reupert et al., 2020). Likewise, children have reported hiding

their parents' mental health challenges from friends, to avoid social ostracization and being stigmatised (Fjone et al., 2009; Gladstone et al., 2011). This in turn inhibits help seeking from services. In addition, children who keep parents' mental health challenges a secret, may experience internalising symptoms such as self-blame, self-stigma, and negative self-identity (Dam & Hall, 2016; Murphy et al., 2016). When services are aware of a family's circumstnaces, children and young people describe a general lack of understanding and support from those services (Backer et al., 2017). These aforementioned experiences may negatively impact children's behaviour and mental health outcomes across their lifespan.

Just as the experiences of children who have parents with mental health challenges are varied, so too are their outcomes. Children's outcomes can vary based on the severity and chronicity of their parents' mental health challenges, the support available to the family and other environmental and socioeconomic and cultural factors (Hjen et al., 2013); Goodman et al., 2011; Webb et al., 2016). Nonetheless, compared to their same aged peers, children of parents with mental health challenges may have more school problems including lower grades, more absenteeism and expulsions, and have been reported to fall asleep in class due to exhaustion (Hjen et al., 2013; Mordoch & Hall, 2008; Straussner, 2011). Children of parents with mental health challenges tend to have relatively poor cognitive development and a high incidence of learning disabilities, which can exacerbate school difficulties (Gladstone et al., 2011). A large, nationwide cohort study in the UK found children of parents with mental health challenges had lower educational attainment, including lower rates of achieving expected educational milestones and qualifications, compared to their peers (Webb et al., 2016). The study found variations in child education outcomes were based on the type and severity of their parent's mental health challenges, with children of parents with severe mental disorders (e.g., schizophrenia, bipolar disorder) tending to fare worse academically compared to children of parents with less severe mental health challenges (Webb et al., 2016).

Children of parents with mental health challenges may encounter difficulties with self-regulation, emotional and behavioural problems and show an increased risk of developing mental health challenges themselves (Lam & O'Farrell, 2011; Nicholson et al., 2009; Weitzman et al., 2011). A meta-analysis examining the strength of the association between mothers' depression and children's emotional functioning and behavioural problems, found maternal depression was significantly related to higher levels of negative affect and behaviour, general psychopathology and internalising and externalising in children (Goodman et al., 2011). Maternal depression was also found be significantly related to lower

levels of positive affect in children (Goodman et al., 2011). Children of parents with mental health challenges are two-to-three times more likely to develop a mental health problem themselves compared to the general population (Maybery et al., 2009; Rasic et al., 2014). This increased risk is likely transmitted through an interplay of genetics and social determinants (Maybery et al., 2009).

Genetic risks, such as temperamental features, increase the likelihood of mental illnesses, and can be transmitted from parents to child (Hosman et al., 2009; van Santvoort et al., 2015). For example, research has identified genetic evidence for the heritability of generalised anxiety disorder based on family and twin studies (Gottschalk & Domschke, 2017). The transmission of genetic risks is influenced by interactions between genetic factors and environmental conditions (Mullins et al., 2016).

Mental health outcomes in children are often linked with social determinants, such as socioeconomic status, poverty, isolation, access to healthcare, stigma and discrimination, education, and support networks (Reupert et al., 2022). These social determinants are adversely impacted by parents' mental health challenges (Reupert et al., 2022) as these factors significantly influence the resources available to assist individuals to navigate and manage mental health challenges (Beardslee et al., 2011; Powell et al., 2020). Moreover, social disadvantages contribute to the transgenerational nature of mental health challenges (Powell et al., 2020; Power et al., 2016). Social disadvantages including insecure housing, poverty, stigma, isolation, family violence, racism, substance use and addiction, have all been found to exacerbate the likelihood of transgenerational mental illness (Beardslee et al., 2011; Hosman et al., 2009; Powell et al., 2020; Power et al., 2016). When social disadvantage is faced by families, problems are often cumulative, for example parental mental health challenges leading to unemployment, which in turn might lead to financial and housing insecurity (Reupert et al., 2022). There is a strong need to create policies, social structures and mental health support systems that mitigate and prevent the impacts of these problems and improve mental health outcomes for parents and their children (Hine & Jewell, 2024).

1.2 Epistemological and Ontological Framework

This thesis has been informed by various epistemological and ontological frameworks. Epistemology is the philosophical study of knowledge that aims to define what knowledge is, differentiate its main types, identify its sources, and determine its boundaries (Bullock and Trombley, 2000). Ontology refers to the theory of reality (Bullock and Trombley, 2000) and what it means to be a person, either as researcher or participant in the

research (Guba, 1990). For this thesis I have chosen to apply a constructivist epistemological framework, a phenomenological ontological framework and to undertake person-centred research, all of which align with my worldview.

A person-centred approach implies recognition of the broad social, biological, psychological, cultural and spiritual dimensions of each person, their families and communities (Titchen et al., 2017). Key assumptions underpinning person-centeredness include respect, self-determination, reciprocity and mutuality (McCormack & McCance, 2010). Epistemological and ontological assumptions also underpin person-centred research including how 'reality' is embedded in shared meanings, behaviours and practices (Titchen and Ajjawi, 2010). Collectively, these assumptions form the foundation of person-centred research, and shape the research outcomes (Titchen et al., 2017). Titchen et al. (2017) described how epistemology and ontology permeate every aspect of the research process, from research design; the skills researchers must acquire, the roles and relationships they establish, and the methodologies they employ during the research.

A constructivist epistemological framework focuses on how individuals construct understandings of their world through experiences and social interactions (Packer et al., 2000). This perspective acknowledges that knowledge is not merely 'discovered but actively created by individuals through social interactions and experiences (Packer et al., 2000). Constructionism rejects the notion of a single ultimate truth, instead proposing there are multiple realities equating to multiple truths (Braun & Clarke, 2013). In the context of psychotherapy, which this thesis investigates, clients and therapists collaboratively build new understandings and insights during their interactions during psychotherapy, which is aligned with my constructivist epistemological worldview. In a constructivist approach to psychotherapy, clients construct their realities and therapeutic interactions to help them reconstruct their perceptions and beliefs. Therapists actively collaborate with clients to explore and reconstruct their personal meanings and beliefs, tailoring their methods to fit each client's unique perspective (Neimeyer, 2009). This constructivist framework emphasises flexibility, ongoing adaptation, client empowerment, and positions therapists as facilitators of personal insight and growth (Neimeyer, 2009).

A phenomenological ontology framework focuses on the lived experiences and subjective realities of individuals (Hammarberg et al., 2016; Peat et al., 2019; Smith, 2009). A phenomenological approach allows deep exploration of participants' experiences, emotions, and perceptions to understand their unique perspectives and meanings. The epistemological and ontological frameworks used throughout, emphasise the richness of

personal narratives which is well suited for psychotherapy research (Guba, 1990; Packer et al., 2000; Smith et al., 2009).

1.3 Reflexivity

Throughout the research process it was crucial I demonstrated reflexivity. Reflexivity involves acknowledging and critically examining my own values, experiences, beliefs, and social identities, and understanding how these factors influence the research undertaken (Eatough & Smith, 2008). Reflecting on my position as a young, early-career psychologist and researcher, who grew up in a family where a parent had a mental illness, was important in the current project which focuses on therapists working with parents with mental health challenges.

My interest in exploring psychotherapy to support parents with mental illness is personal and rooted in my own experiences. Growing up with a parent who struggled with mental health challenges, I witnessed firsthand the impact parental mental illness has on family dynamics and children, including my own emotional well-being. The experience of having a parent navigate mental health support whilst simultaneously being the primary caregiver in my family, fuelled my desire to understand and improve the ways in which therapeutic interventions can support families in similar situations. This personal connection drove my commitment to the thesis topic, with the goal of enhancing the quality of care and support available to parents and their children. I believe my background and experience provides a unique perspective to the research as I can empathise with and appreciate the nuanced needs of those affected by parental mental illness.

Throughout the research process, I was acutely aware of how my personal history living with a parent with mental illness would influence my perspective. Consequently, I implemented measures to manage this influence effectively. I engaged in regular self-reflection and supervision to explore and account for the the ways that my personal experiences might influence the research findings or introduce bias into the interpretation of data. I also kept a research journal to document my thoughts and emotions after each interview with therapists. An excerpt from the research journal can be found in Appendix A. I referred back to the journal entries prior to and during analysis of the data to remind myself of how I felt when conducting the interview, ensuring I had a critical awareness of my own emotional responses to and perceptions of the interview data.

Reflecting on my position as a young, early-career psychologist, with limited training and practical experience using the three psychotherapeutic modalities selected for

investigation (schema therapy, acceptance and commitment therapy [ACT] and narrative therapy) was also important throughout the research process. My training in psychotherapy, through my psychology master's coursework, placement experience, professional development and work as a provisional psychologist, equipped me with theoretical knowledge about a variety of therapeutic approaches. Over approximately two years, I have gained practical experience working with children and adults, which has allowed me to apply different therapeutic modalities with clients in contexts including private practice and school settings. While I have training in a range of psychotherapies, I feel most confident and well-versed in Cognitive Behavioral Therapy (CBT). However, I wanted to investigate therapies besides CBT due to there already being initial research investigating the effectiveness of CBT for parents with mental health challenges (Coiro et al., 2012; Cuijpers et al., 2015) as well as satisfying a personal interest to explore other therapies.

I have had exposure to training in schema therapy, ACT, and narrative therapy, although my training in these modalities was not extensive. Additionally, I have limited personal experience using techniques from these modalities with clients. As I have not specialised in any of the three modalities investigated in this thesis, I have few preconceptions of, or preferences for, the modalities. I believe this facilitates an objective viewpoint in researching them and comparing similarities and differences between the experiences described by schema therapists, ACT therapists and narrative therapists. I do not consider myself to have any professional biases in my approaches to or preferences for any of the three modalities.

Although I have had limited experience conducting schema therapy, ACT and narrative therapy with clients prior to undertaking this thesis, the exposure to these modalities that I gained through university training and professional development opportunities, sparked my interest in these modalities. Additional factors that contributed the selection of these three modalities, included their theoretical underpinnings, which will be further discussed in subsequent chapters.

Throughout the development of this thesis, it was critical that I continuously reflected on my limited professional background using these three modalities, alongside my growing interest in the modalities. Being an early-career psychologist brought both benefits and challenges when interviewing experienced therapists who have undertaken specialised training in the modalities and for most participants, have many years' experiences practicing them in therapy with clients who are parents. In contrast to my inexperience with the therapies, the therapists interviewed had significant experience practicing either schema

therapy, ACT or narrative therapy. Accordingly, I entrusted the therapists interviewed to provide rich, insights about working with parents across the modalities. My youth and professional inexperience were at times an advantage, as they allowed me to approach the research with genuine curiosity, an open mind and a fresh, 'naïve' perspective. This helped build open dialogue between myself and the participants I interviewed, as I may have been seen as eager to gain insights into their experiences and understand their views without having preconceived notions. However, my limited experience practicing therapy could have also make it harder to establish credibility and rapport with experienced therapists. They might have seen me as lacking the depth of knowledge needed to fully understand their insights and experiences regarding their work with parents. Further, I may have missed opportunities to explore certain aspects of the participants' responses more deeply due to a lack of nauced understanding of the modalities and providing therapy to parents with mental health challenges. In my attempts to address this, I familiarised myself with relevant literature and theoretical frameworks prior to conducting any interviews with participants, showing my commitment to the research topic and respect for their expertise. I sought regular supervision to improve my understanding of the therapies I investigated and to enhance my data collection and analytical skills. Moreover, I collaborated with my supervisors and a peer PhD candidate to ensure my interpretations and analysis reflected participants' experiences.

Chapter 2 Literature Review

The previous chapter introduced the definition and prevalence of mental health challenges among parents, the experiences of these parents, and the impact on their children. It also outlined the epistemological and ontological framework guiding the research and discussed my reflexivity process throughout the thesis. In this chapter, I will begin by providing an overview of the Australian mental health system. Following this, I will explore the relationship between parenting and recovery, considering how mental health challenges can impact both the parent and the child, and how recovery processes may intersect with parenting responsibilities. The chapter will then describe various support options available for families where a parent experiences mental health challenges include an analysis of organisational approaches, community-based support strategies, family intervention approaches, and child-only interventions designed specifically to support the children of parents with mental health challenges. Additionally, I will review individual approaches

tailored to supporting these parents. Finally, the chapter will conclude with a discussion of the rationale and aims of this thesis.

2.1 The Australian Mental Health System

As the data for the set of studies within this thesis were collected from therapists practicing in Australia, the literature review commences with a description of the Australian mental health system. For many Australians with mental health challenges, the first point of engagment in professional mental health support is primary care settings, where people are typically seen by their general medical practitioner (GP) (Baulderstone et al., 2012; Spooner et al., 2024; Welfare, 2013). Depending on the presenting mental health issues, GPs may prescribe medication and/or refer the client to a mental health service to access a psychotherapeutic intervention (Baulderstone et al., 2012; Spooner et al., 2024). In an Australian context, one-on-one psychotherapeutic counselling services occur in the public and private mental health systems.

The public mental health system is primarily funded by the government and provides services through hospitals, community health centres, and specialised mental health facilities (Australian Institute of Health and Welfare (AIHW), 2023). These services are accessible to the public, often at low or no cost, and are designed to offer comprehensive care, including crisis intervention, inpatient treatment, and outpatient support. Examples of mental health supports provided in the public sector include publicly funded programs such as Keeping the Body in Mind (Curtis et al., 2016); public hospital inpatient and outpatient services, and services funding through the National Disability Insurance Scheme (NDIS; an Australian government initiative designed to support people with disabilities by providing funding for necessary services and support). The private mental health sector includes private practices and private hospitals, where services are funded through out-of-pocket payments, or covered fully or partially under Medicare (AIHW, 2023). Private mental health services often cater to individuals seeking more immediate or specialised care that may not be readily available in the public sector (Williams & Doessel, 2008). Additionally, the insurance mechanisms and out-of-pocket costs within the private sector can influence accessibility to this mental health support (Finlay & Looi, 2020).

Professionals providing mental health services in Australia come from diverse disciplines, including psychiatry, psychology, social work, occupational therapy and mental health nursing (AIHW, 2023). In 2022, there were approximately 4,300 psychiatrists; 33,000

psychologists; 2,900 accredited mental health social workers; 2,800 mental health occupational therapists and 25,000 mental health nurses working in Australia (AIHW, 2023). According to AIHW (2023) approximately half (49%) of psychologists work in private practice settings. In a study investigating accredited mental health social workers in 2024, 85% of participants surveyed reported they worked in private practice (AIHW, 2024). Indeed, a significant amount of the Australian mental health workforce works within private practice settings, therefore this is an important environment to conduct research.

In Australia, potential clients can either directly approach a private practice setting for mental health support, such as one-on-one counselling, or be referred by their GP. Commonly in Australia, when specialised mental health care is required, a GP will refer a client to a therapist for individual psychotherapeutic treatment, typically cognitive behavioural therapy (CBT), as this is covered under Medicare (Baulderstone et al., 2012). Australia's Medicare system (the national universal health insurance scheme, which gives people access to a range of health and hospital services, including mental health services, at a low or no cost; Department of Health and Human Services, 2024). Currently, clients in Australia who are referred by their GP for mental health treatment such as one-on-one counselling can be eligible for ten psychotherapeutic sessions each year covered under Medicare each year however this varies depending on government policy.

It is important to note that there has been criticism highlighting the limitations of the Australian mental health system. Firstly, Australia's Medicare system (Department of Health and Human Services, 2024) is very much focused on the individual, rather than the family. As such, GPs will typically refer only individual clients for further treatment, such as counselling, and not additional family members, such as carers of the family for family therapy, as this is not covered under Medicare. Within the Australian context, it has been argued that more could be done by GPs to recognise and support the role of client's partner, children or other family members or their family role, when clients present with mental health challenges (Reupert et al., 2015). In one study, Reupert et al., (2015) interviewed Australian GPs to ascertain whether and how they work with clients who are parents experiencing mental health challenges. The authors found that GPs do not commonly engage with parents about family issues, some questioned whether being family-focused was part of their role and some identified a need for training in providing family-focused support for parents. Thus, whilst GPs are often the first line of support to parents with mental health

challenges, they commonly miss opportunities to offer preventative support that takes into consideration the parenting role of their clients and the needs of the whole family (Reupert et al., 2015).

2.2 Parenting and Recovery

Since the emergence of consumer and carer advocacy movements in the 1980's, there has been a shift in how mental health settings have conceptualised recovery, transitioning from clinical to personal constructions of recovery from mental health challenges (Anthony, 1993). A systematic review and narrative synthesis by Leamy et al., (2011) produced a conceptual framework for personal recovery in mental health. The review developed the CHIME framework which outlined five key elements essential for personal recovery; Connectedness, Hope and optimism about the future; developing a positive Identity; finding Meaning in life; and Empowerment. The framework highlights the importance of holistic mental health support that goes beyond symptom reduction and focuses on enhancing well-being and quality of life (Leamy et al., 2011). It provides a comprehensive approach to mental health recovery, emphasising the need for interventions that support individuals in these five areas to promote sustainable recovery.

However, parenting remains a less prominent topic in the personal recovery and CHIME framework discourse (Maybery et al., 2015; Reupert et al., 2017). The CHIME framework is relevant for personal recovery for parents with mental health challenges, as it addresses not only mental health challenges but also one's role as a parent (Maybery et al., 2015). The following section will explore the literature on parenting with mental health challenges as it pertains to each of the five CHIME elements.

The element of Connectedness refers to the importance of relationships and social support in recovery (Leamy et al., 2011). It involves building and maintaining supportive relationships with family, friends, peers, and mental health professionals, fostering a sense of belonging and community. The role of Connectedness in the recovery process for parents has been reviewed in the literature. Maybery et al, (2015) described how families provide a support network that helps people maintain social connections, which is key for emotional health, offers a sense of belonging and reduces feelings of isolation. Other literature has found that experiencing connectedness with one's children positively influenced personal recovery for mothers (Ackerson, 2003; Carpenter-Song et al., 2014). Further, mothers have described that feeling safe to disclose their mental health problems to others, including family

members, friends and support groups, positively influences their personal recovery (Cremers et al., 2014).

Hope and optimism about the future refers to providing the motivation and belief that a positive future is possible and is a fundamental aspect of recovery (Leamy et al., 2011). Optimism about the future encourages individuals to set and pursue personal goals, envisioning a life beyond mental illness. In regard to parental mental health challenges, families can be a source of hope and engagement, especially during challenging times (Maybery et al., 2015).

In the CHIME framework, Identity refers to developing a positive identity and overcoming the negative self-perceptions often associated with mental illness (Leamy et al., 2011). It includes forming a new, positive sense of self that is not defined by the illness, allowing individuals to reclaim their lives and roles. Family relationships contribute significantly to a person's sense of identity, offering shared experiences, traditions and values (Maybery et al., 2015). Maternal identity has an important role to play in personal recovery, with research suggesting that when a mother sees her role as central to her identity, it can provide a strong motivation for recovery (Hine et al., 2018). The responsibilities and meaning derived from motherhood as one component of a multifaceted identify, can become a driving force in a mother's desire to improve her mental health and well-being (Hine et al., 2018).

The element of Meaning refers to finding purpose and meaning in life, often through engaging in activities that are personally meaningful, such as work, hobbies, or volunteering (Leamy et al., 2011). It helps individuals understand their experiences and find a sense of direction and fulfillment. For many parents with mental health challenges, their role as a parent can provide a profound sense of purpose and meaning in life (Reupert et al., 2015).

The fifth element in the CHIME framework, is Empowerment which refers to gaining control over one's life and making independent choices (Leamy et al., 2011). It involves building confidence, self-efficacy, and the ability to advocate for oneself, leading to greater autonomy and participation in decision-making regarding one's treatment and life. According to Hine et al., (2018) there remains scope for mental health professionals to find ways to empower parents with mental health challenges through acknowledging and validating the strengths in their parenting capacity.

Integrating parenting roles into personal recovery for individuals with mental illness, can improve the wellbeing of parents, children, and families (Reupert et al., 2017). Reupert et al., (2017) emphasised the need for mental health professionals to consider parenting responsibilities as a central aspect of recovery, advocating for more tailored support for

parents with mental health challenges. However, this research focused on the experiences of parents with mental health challenges within psychiatric settings (Reupert et al, 2017). There remains limited research into the experiences of parents receiving mental health support from other settings, such as private therapy settings (Cooper et al., 2023). The following section will provide an overview of the different support options available in Australia for families (parents and children) where a parent has mental health challenges.

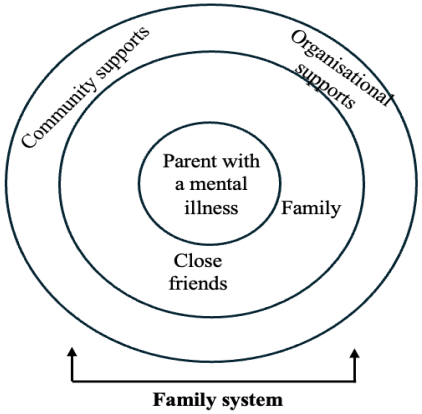
2.3 Support Options for Families where a Parent has Mental Health Challenges

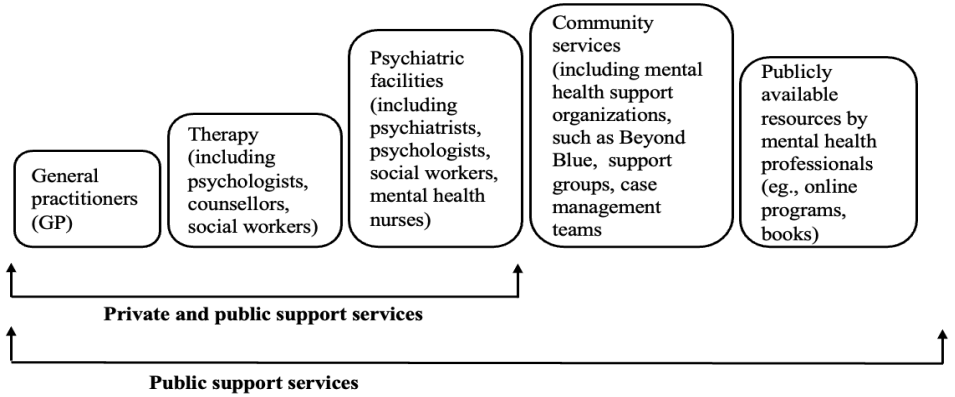
Families with a parent with mental health challenges need timely and appropriate support (Reupert & Maybery, 2009). For families where a parent experiences mental health challenges, the most effective support is provided through Family-Focused Practice (FFP), a holistic approach within mental health services that emphasises the interconnected nature of individual and family well-being (Foster et al., 2016). FFP aims to support not only the individual with mental health challenges but also their family members, acknowledging the critical role families play in the recovery and care process. FFP should be inclusive, ensuring that the needs of both the parent and other family members, including children, are addressed through coordinated care (Goodyear et al., 2015).

There are many settings, both private and public, where parents, and other family members, can receive support, including primary care (Hooper et al., 2012; Rishel, 2012), and public mental health facilities (Reupert et al., 2012; Reupert et al., 2015). Across these different sectors, various approaches have, or could be, employed to support families where a parent has a mental health challenge. FFP approaches to supporting families may include community and organisational supports, family systems approaches, child focused approaches and parent-focused approaches. Opportunities to ensure parents' unique needs are met in services include focusing on strengths (Hine & Jewell, 2024), integrating parenting skills training into psychiatric rehabilitation programs and implementing supported employment programs specifically tailored for parents (Cook & Mueser, 2014). Figure 1 depicts the different support models for families where a parent has a mental health challenge, with further detail provided in the paragraphs below.

Figure 1

Model of support and approaches available for families where a parent has a mental health challenge





Support approaches:

Community approaches
- Community mental health services
- Policy advocacy and awareness campaigns (eg., for reducing stigma)
- Informal community supports (eg., family, friends, church groups, neighbours)

Organisational systems approaches
- Infrastructure that captures parenting status
- Training and professional development for practitioners

Family systems approaches
- Couples or family counselling
- Community case management and support services

Child-only approaches
- Peer-support programs (eg., camps)
- Online programs

Parent focused approaches
- Individual counselling
- Parenting programs
- Peer support groups
- Online resources for parents
- Parenting books

2.3.1 Community Approaches

Community approaches to parental mental health challenges can offer support to families (Bee et al., 2014; Sherman et al., 2018). Examples include community mental health services, targeted parenting programs and policy advocacy and awareness campaigns for reducing stigma (Corrigan et al., 2012). Targeted community interventions, including parenting programs and policy advocacy for reducing stigma are designed to educate, promote understanding, and reduce negative attitudes towards mental health challenges (Corrigan et al., 2012). Corrigan et al., (2012) highlight the importance of community approaches for fostering a more supportive and inclusive society and improving the quality of life of individuals with mental health challenges.

Beyond community interventions, 'natural' or informal community supports may be available to parents and families (Sherman et al., 2018). For instance, extended family and friends, neighbours, churches, and community groups with inclusive, non-judgemental cultures can provide support for parents with mental health challenges and their families (Sherman et al., 2018). Nicholson et al., (2009) explored the complex role of family support for parents with mental health challenges finding that that while family support can offer crucial assistance, it can also present challenges depending on family dynamics and delivery of the support. For instance, the involvement of grandparents in childcare can be highly beneficial, providing essential respite and stability for parents managing mental health challenges (Nicholson et al., 2009). However, the study also highlights instances where such support can become intrusive rather than helpful for example if grandparents take over caregiving responsibilities in ways that undermine the parents' authority or preferences, thereby creating conflicts and additional stress. This dichotomy underscores the importance of a balanced approach to family support that respects the autonomy of the parents while providing meaningful assistance (Nicholson et al., 2009). Beyond the role of families, there is limited research into the role of other community supports such as neighbours and church groups specifically for supporting parents with mental health challenges (Bee et al., 2015).

2.3.2 Organisational Approaches

There are various ways that organisations can provide an environment that supports parents. For example, mental health intake forms might include items around parenting status which can signal to parent service users that parenting and their child's wellbeing is relevant to adult mental health services (Tchernegovski et al., 2017). In addition to forms, intake procedures may include interviews, standardized assessments, behavioural observations, and risk evaluations to gain a comprehensive understanding of clients' parenting competencies and family dynamics (Goodyear et al., 2015). This holistic approach ensures that interventions are tailored to the unique needs of each family.

Organisations can also support parents with mental health challenges through investing in training and professional development for their staff. By equipping mental health professionals with specialised knowledge and skills tailored to the unique needs of parents, organisations can enhance their team's confidence and competence in working with this population. Within Australia, there are organisations, such as Emerging Minds, that specialise in developing mental health training, programs and resources in response to the needs of families and mental health professionals working with parents, children and families (Emerging Minds, 2024). Organisations can foster an environment that supports the unique needs of parents with mental health challenges through investing in such training and ensuring ongoing professional development for staff.

2.3.3 Family Intervention Approaches

Family interventions may include family therapy or interventions directed to the family unit (Rivett, 2017). Family therapy entails working with families to address psychological issues and improve family mental health and relational dynamics (Minuchin, 2018; Rivett, 2017). There are numerous types of family therapy such as structural family therapy (Minuchin, 1974), strategic family therapy (Haley, 1976; Madanes, 1981), Bowenian Family Therapy (Bowen, 1978), systemic family therapy (Selvini-Palazzoli et al., 1980), and narrative family therapy (White & Epston, 1990) among others. Despite the different theoretical frameworks and techniques that underpin the different types of family therapy, they all view the family as an interconnected system where members influence each other (Carr, 2012). Family therapy has a focus on improving interpersonal dynamics often through targeting communication patterns (Carr, 2012).

A meta-analysis by Cluxton-Keller and Bruce (2018) analysed multiple studies across different types of family therapy approaches and found that family therapy significantly

reduced depressive symptoms in mothers with perinatal depression. Further, they found that family therapy improved family functioning and parent-infant relationships (Cluxton-Keller & Bruce, 2018). Another meta-analysis by Doss et al., (2019) found couple and family therapy for adults with depression led to improvements in individual symptoms, relationship satisfaction, and overall family functioning. Indeed, the effectiveness of different family therapy approaches for parents with mental health problems has been well established in the literature (Carr, 2009; Cluxton-Keller & Bruce, 2018; Doss et al., 2019).

There are also several family interventions designed for parents with mental health challenges (Moltrecht et al., 2024; Mulligan et al., 2021; Orte et al., 2016; Solantaus et al., 2010). Examples of these family interventions include the Family Competence Program (Orte et al., 2016), Family Talk Intervention (Beardslee et al., 2013; Mulligan et al., 2021) and Let's Talk about Children (Solantaus et al., 2010).

Within Australia, the Let's Talk about Children (LTC) program (Solantaus et al., 2010) has been delivered and evaluated (Allchin et al., 2022; Maybery et al., 2019). Originally developed in Finland, the intervention consists of three structured sessions which explore the parenting role of service users where one or more parents experience a mental illness and have dependent children aged under 18 years (Maybery et al., 2019; Foster et al., 2016). Although, parents with a mental illness are the primary participants of LTC, it can be considered a family intervention as the focus of the program is on their parenting role and how they can strengthen the family unit. The children of parents with a mental illness can be considered as indirect participants, as LTC aims to support these children by enhancing their understanding of the parent's mental health condition and helping them cope with associated challenges (Solantaus et al., 2010). Moreover, in some cases, other family members will be involved in the program, such as partners, or extended family members who play a significant role in the child's life or the parent's support system (Solantaus et al., 2010). In the first session, the parent completes a developmental log for each child to identify their child's strengths and areas requiring further support. In the second and third sessions, the mental health professional and parent work collaboratively to increase the family's understanding of the parent's mental health challenges, its impact, and appropriate supports to strengthen their parenting skills and address their children's needs (Maybery et al., 2019; Solantaus et al., 2010). An evaluation of LTC found the program can provide parents with a sense of hope and self-determination (Solantaus et al., 2010). Additionally, LTC was found to decrease psychosocial distress in both parents and children (Solantaus et al., 2010), which helps protect children from negative health and social outcomes (Cooper & Reupert, 2016).

Alongside the growing body of research investigating the benefits of family interventions (Goodyear et al. 2015a; Hosman et al. 2009; Maybery et al., 2019; Reupert & Maybery 2007; Solantaus et al., 2010), there is other research highlighting the difficulties implementing them and sustaining family interventions as part of standard service delivery. Difficulties can arise from various sources, including barriers related to mental health professionals' practices, supervision oversights, organisational constraints, policy limitations and challenges within the client or family dynamics themselves (Allchin et al., 2022; Dixon et al. 2001; Goodyear et al. 2015b; Kavanagh et al. 1993; Lauritzen et al. 2014, 2015; Maybery & Reupert, 2009; Tchernegovski et al., 2017).

2.3.4 Supporting the Children of Parents with Mental Health Challenges: Child-Only Approaches

There are several support options purposefully designed for children of parents with mental health challenges, including online programs and peer-support programs (Reupert et al., 2013). Online interventions generally target older children and young adults, aged between 12 and 25 years, whose parent or siblings have a mental illness (Pitman & Matthey, 2004; Reupert et al., 2022). These online interventions are typically focused on providing psychoeducation, informing children about the mental health challenges their parent may have, and are available for children to complete in their own time and at their own pace (asynchronous) (Pitman & Matthey, 2004; Riebschleger et al., 2009). Peer-support programs can also be delivered as online interventions, such as the mi.spot (mental illness; supportive, preventive, online, and targeted) which is a professionally moderated online intervention for young adults aged 18 to 25 years who have a parent with a mental health challenges (Reupert et al., 2020). The mi.spot intervention was found to improve the mental health and wellbeing of young adults with parents with mental health challenges (Reupert et al., 2020).

In addition to online peer-support programs there are also in-person peer-support groups which are child focused, and may be offered as camps, school holiday programs, or after-school programs (Goodyear et al., 2009; Hargreaves et al., 2008; Pitman & Matthey, 2004). These peer-support programs aim to increase children's understanding of mental health challenges, foster peer connections, and improve children's adaptive coping abilities, by employing a group-based, strengths-focused, preventative approach (Hargreaves et al., 2008; Reupert et al., 2013). Previous research has shown positive impacts from participation in peer support programs for children of parents with mental health challenges. For example, the PATS (Paying Attention to Self) peer support program (Hargreaves et al., 2008) provided

children of parents with mental health challenges opportunities to realise that they were not alone; to make friends with shared experiences and to better understand how mental challenges can impact families. Children who undertook the SMILES (Simplifying Mental Illness plus Life Enhancement Skills) program had improved knowledge of mental health challenges and improved self-rated life skills (Pitman & Matthey, 2004). Additionally, Goodyear et al., (2009) found that peer support programs for children in families where there are parental mental health challenges can make a positive difference to the health and well-being of children (Goodyear et al., 2009). However, some parents reported that their children had more problematic behaviours after completing the peer support program, including asking 'difficult' questions (Goodyear et al., 2009). Such research suggests that child-only programs may need to be supplemented with simultaneous support for parents to ensure that they are prepared for the changes in their child's improved mental health literacy.

2.3.5 Parent-Focused Approaches

There are a range of different parent-focused approaches available to parents with mental health challenges. Examples include parenting programs, online or web-based psychological interventions and psychotherapeutic counselling.

Peer-Support Groups

Peer-support groups are another approach for parents with mental health challenges. These groups involve parents as peer specialists who have lived experience of mental health challenges, experience with service supports, and a positive, realistic orientation to recovery and family life (Nicholson & Valentine, 2018). Parent peer-support groups often have a unique ability to empathise with the specific concerns of parents with mental health challenges. These concerns may include difficulties balancing parenting responsibilities with mental health needs, the impacts of parental mental health challenges on children, combating stigma, and managing treatment challenges such as medication side effects (Lacey et al., 2015; Nicholson & Valentine, 2019). Evaluations of peer-support groups show a sense of belonging, empowerment and engagement for the parents involved (Farkas & Boevink, 2018). Other research has found that peer-support for adults with mental health challenges can increase health-promoting behaviours, and reduce the utilisation of emergency services (Bellamy et al., 2017). Further, research has highlighted how peer-support services have a positive impact on levels of hope, empowerment and quality of life (Bellamy et al., 2017), all recovery promoting factors. However, the benefits of peer-delivered services on clinical outcomes are not as strongly supported (Lloyd-Evans et al., 2014; Pitt et al., 2013) suggesting

that parents with mental health challenges may need additional support to treat their mental health concerns, beyond peer-support groups.

Parenting Programs

There are numerous parenting programs which may be offered to parents who have mental health challenges, that aim to enhance their parenting skills (Cooper et al., 2018; Phelan et al., 2012; Pickering et al., 2015). Parenting interventions are usually manualised programs including but not limited to Circle of Security (Hoffman et al., 2006), Triple P Parenting Program (Pickering et al., 2015) and Mental Health Positive Parenting Program (Phelan et al., 2006).

Circle of Security is a manualised program delivered to either groups of parents or individuals. It is designed for parents of children aged between 4 months to 6 years (Hoffman et al., 2006). The Circle of Security program introduces parents to their child's relational needs through a combination of guided reflections, video content and handouts (Bowlby, 1988) whilst also supporting parents in setting boundaries as appropriate (Hoffman et al., 2006). While the standard Circle of Security program is relevant for all parents, it has been shown to improve parents' emotional functioning and has utility for parents with mental health challenges (Huber et al., 2016).

Triple P Parenting Program aims to promote warm, responsive, and consistent parenting that offers boundaries (Pickering et al., 2015; Sanders & Turner, 2018). The Stepping Stones Triple P Parenting Program is an adapted version of the original program that is tailored to address the unique needs and challenges faced by parents with mental health concerns, providing additional support and strategies for managing both parenting and mental health (Pickering et al., 2015). The program aims to offer practical parenting strategies while considering the additional stresses and barriers that mental health issues may create. The Triple P Parenting Program and adapted Stepping's Stones version caters for five different developmental stages in children: infants, toddlers, pre-schoolers, primary schoolers, and teenagers (Pickering et al., 2015).

Another adapted version of the Triple P Parenting Program is the Mental Health Positive Parenting Program (MHPPP; Phelan et al., 2006). The MHPPP introduced additional sessions including 'The impact of mental health on parenting' and 'Children's fears, friendships and schooling'. The program aims to enhance parental insights and encourage participants to plan parenting strategies to manage future periods of mental health challenges (Phelan et al., 2012). An evaluation of pre and post program measures found that MHPP can lead to parents having a greater understanding of children's behaviour, increased parental

self-control and motivation, and improved communication skills, all of which create a responsive and nurturing environment for children (Phenlan et al., 2012; Suarez et al., 2016).

Parenting programs can build parents' capacity by improving knowledge and skills related to meeting the needs of their children. These programs can assist parents in taking actions such as setting boundaries, improving communication and planning parenting strategies which support their mental health.

Online or Web-Based Psychological Interventions

Online or web-based psychological interventions are another type of individual approach for parents with mental health challenges. Online or web-based psychological interventions are typically self-guided interactive programs. Examples of these manualised mental health interventions for parents include online self-guided programs, such as CBT-based living-life-to-the-full (LLTF; Palmer et al., 2012); Parenting Internet Education (PIE; Kaplan et al., 2014) and the Parenting with Success and Satisfaction program (PARSS; van der Ende et al., 2010). Evaluation findings have shown improvements in anxiety and depression levels in participants of LLTP (Elison et al., 2017), suggesting this online psychological intervention may be useful in supporting parents with mental health challenges. The PIE program has been found to significantly reduce parental stress and have lasting effects at 18-months follow-up for mothers with mental health challenges who participated in the online program (O'Shea et al., 2019). Additionally, research into the effectiveness of PARSS for parents receiving ongoing mental health support, found one-year after the intervention, parenting satisfaction and quality of life increased, indicating that PARSS has the potential to function as a useful tool (van der Ende et al., 2010). Online programs are relatively low-cost interventions and have the advantage of accessibility, which is important for busy parents experiencing mental health challenges (van der Ende et al., 2014).

Although there is a growing evidence base for online psychological interventions, a meta-analysis by Beatty and Binnon (2016) highlighted issues with low adherence and participation of online self-guided psychological interventions. Although this meta-analysis was not specific to parents with mental health challenges, the findings suggest that parents, who are typically time poor and have to balance their own mental health needs whilst upholding caring responsibilities may have difficulty with program adherence. Therefore, whilst self-guided online programs may overcome some of the previously outlined access issues, additional supports or interventions may also be required to boost engagement and address retention issues.

Psychotherapeutic Counselling

In Australia and elsewhere, parents with mental health issues may also obtain support from counselling. The term 'counselling' covers a broad field of helping services, including having a skilled professional work with a client to support them to develop new ways of thinking, feeling, behaving and decision-making (Osagu et al., 2013). Counselling aims to facilitate self-knowledge, emotional acceptance, and personal growth (Osagu et al., 2013). People may seek out counselling for a variety of reasons, such as when experiencing grief and loss, difficulty in relationships, managing a lifestyle change, or when experiencing a mental health challenge (Carr & McNulty, 2016). Some subspecialties of counselling are psychotherapeutic counselling, career counselling, couples counselling, school counselling and family counselling (Osagu et al., 2013). Psychotherapeutic counselling, involving treatment by a therapist for mental health challenges and/or emotional and behavioural disturbances (Freedman et al., 1985) is the focus of this PhD.

From the 1950s to the 1980s debates over the effectiveness and benefits of psychotherapy engrossed the psychotherapy community (Smith et al., 1980). However, after the first meta-analysis of psychotherapy outcomes (Smith & Glass, 1977), was published, the nature of the debate changed as psychotherapy was demonstrated to be beneficial to clients. Since the 1980's, the efficacy of psychotherapy and its long-terms positive outcomes for a variety of disorders has been further established (Cosci et al., 2020; Lambert, 2013; Leichsenring et al., 2022; Wampold & Imel, 2015). As of May 2024, a search of PubMed (an international database of biomedical literature) shows that around 233,000 academic articles have been published on psychotherapy research between 1980 and 2024. Further, around 11,000 meta-analyses and systematic reviews on psychotherapy have been published over this timeframe, with approximately 1300 papers in 2023 alone (PubMed, 2024), demonstrating a significant evidence base supporting the utility of psychotherapy for a range of conditions.

2.3.6 What Makes Psychotherapeutic Counselling Effective

There are numerous factors associated with effective psychotherapeutic counselling, including the therapeutic alliance, client related factors, therapists related factors and the therapeutic approach employed (Duncan et al., 2015; Hill & Norcross, 2023; Miller & Rollnick, 2019).

The relationship between the therapist and the client, characterised by trust, empathy and agreement on goals and methods, is generally regarded as one of the most important determinants of therapy outcome (Duncan et al., 2015; Wampold & Imel, 2015). For

example, a strong alliance is predicative of client engagement, treatment adherence and treatment success (Horvath & Symonds, 1991; Martin et al., 2000). This positive impact is seen across different psychotherapeutic modalities and client populations (Flückiger et al., 2018). Further, the quality of this alliance has been shown to be a more reliable predictor of treatment success than the specific type of therapy employed (Norcross & Lambert, 2018). Thus, establishing and sustaining a strong therapeutic alliance is essential for effective counselling and achieving positive therapeutic outcomes.

The therapeutic relationship can be impacted by the culture of client and therapist in several ways, including different cultural communication styles, nonverbal behaviour and cultural sensitivies (Sue & Sue, 2016). For example, some cultures may value direct eye contact as a sign of respect and engagement, while others may view it as confrontational or disrespectful (Sue & Sue, 2016). Misunderstandings in these areas can create barriers to establishing a strong therapeutic relationship. Cultural misunderstandings between client and therapist can undermine the therapeutic alliance and reduce positive counselling outcomes (Zhang and Burkard 2008). Therapists' own cultural competence, and their awareness and understanding of cultural differences, is essential for building a strong therapeutic relationship (Choi et al., 2015; Pedersen et al., 2008). Some research suggest that clients may feel more understood and comfortable with therapists who share their ethnic or racial background (Cabral et al., 2011). Clients who feel culturally misunderstood, are more likely to terminate counselling early (Zhang & Burkard, 2008). However, cultural competence can compensate for a lack of ethnic matching, allowing for a strong therapeutic alliance even in cross-cultural settings (Cabral et al., 2011; Chang & Berk, 2009).

There are numerous client factors that impact the effectiveness of therapy, including motivation, readiness for change (Miller & Rollnick, 2019), their current level of distress (Robinson & Rickard, 2018) and supports available to them (Holt-Lunstad et al., 2010). Clients who are motivated to change are more likely to actively engage in therapy, complete therapeutic tasks, and adhere to treatment plans, resulting in better outcomes (Miller & Rollnick, 2019). Additionally, clients' expectations and beliefs that counselling will help, play a significant role in therapy outcomes (Constantino et al., 2018; Wampold & Imel, 2015). Similarly, clients' positive expectations about counselling are associated with better therapeutic outcomes (Constantino et al., 2018). Clients' level of distress also has been shown to impact therapy outcomes (Robinson & Rickard, 2018; Borkovec & Castonguay, 2018). Across different therapeutic modalities, clients with higher distress levels tend to have greater improvements, although higher initial severity can also pose challenges in therapy

engagement (Robinson & Rickard, 2018). Additionally, availability of supports for clients has been shown to influence their outcomes (Holt-Lunstad et al., 2010). For example, having social supports can assist with the adaptive coping skills clients learn in counselling, and improve the overall effectiveness of therapeutic intervention (Holt-Lunstad et al., 2010).

The confidence, attitude, skills and knowledge of the therapist all contribute to the effectiveness of therapy (Borders & Brown, 2022; Elliott et al., 2018; Hill & Norcross, 2023). Therapists who demonstrate self-assuredness and competence can positively influence therapeutic outcomes (Baldwin & Imel, 2013). Confidence in delivering interventions helps therapists build trust and credibility, enhancing the therapeutic alliance and fostering client engagement (Baldwin & Imel, 2013). Additionally, therapists' attitudes can influence the effectiveness of therapy (Elliott et al., 2018). Therapists who display warmth and empathy, including being non-judgmental and open-minded, create strong therapeutic bonds, which are associated with better client outcomes (Elliott et al., 2018). Others have found that clients feel respected and understood by therapists who maintain a non-judgmental curiosity in their approach with clients from diverse backgrounds (Elliott et al., 2018). Accordingly, therapists who demonstrate a genuine interest in their clients' wellbeing are typically more therapeutically effective (Elliott et al., 2018). The skill and knowledge of the therapist also determines how well interventions are delivered and how effectively questions are asked (Hill & Norcross, 2023). For example, psychotherapeutic outcomes are enhanced through therapists' tailoring interventions to each individual client's needs, such as by showing cultural competency and considering cultural factors in the lived experiences of clients (Day-Vines et al., 2018). Each therapist will have different areas of competencies, shaped by their educational backgrounds, professional development, supervision and past experiences (Borders & Brown, 2022; Corey et al., 2020).

Finally, outcomes are impacted by the therapeutic modality provided. Therapists practice psychotherapy from different 'umbrella' theoretical approaches, including Cognitive Behavioural Therapy, Humanistic Psychotherapy, Systems or Family Therapy and Psychodynamic Psychotherapy (Carr, 2009). Within these 'umbrellas' there are numerous different types of modalities of psychotherapy which therapists may specialise in (Sharf, 2019) and the number of types of effective psychotherapy modalities has risen over time (Cuijpers, van Straten, van Oppen, & Andersson, 2008; Wampold & Imel, 2015). For example, Cognitive Behavioural Therapy encompasses cognitive therapies such as Dialectical Behavioural Therapy (DBT), Acceptance and Commitment Therapy (ACT), and Schema Therapy. A Humanistic Psychotherapeutic approach encompasses person-centred therapy,

Gestalt Therapy, Existential Therapy and Solution-Focused Therapy (Sharf, 2019). This preceding list of psychotherapies is not exhaustive and there are many variations and subtypes within each modality (Smith & Jones, 2018). Additionally, new psychotherapy modalities may emerge as research and clinical practice continues to evolve (Sharf, 2019). Nonetheless, the specific techniques of various therapeutic approaches are estimated to contribute to approximately 15% of the variance in therapy outcomes (Wampold, 2013). This suggests that while techniques are important, they are not the primary drivers of successful therapy.

Despite the therapeutic approach not being the most critical factor in therapy outcomes (Wampold, 2013), the current study, which investigates how different therapies work with parents who have mental health challenges, is still valuable. Understanding which modalities are engaging and accessible for parents and how they might accommodate parents' needs can improve treatment adherence and reduce dropout rates (Flückiger et al., 2018). Additionally, having an understanding about which modalities and techniques are effective and engaging for parents can enable therapists to tailor treatments to meet their clients' specific needs. Tailoring treatment modalities and techniques is likely to enhance the therapeutic alliance and improve therapeutic outcomes (Day-Vines et al., 2018). Further, investigation of how different therapies work with parents who have mental health challenges, may help to simultaneously address mental health needs in the context of complex family dynamics (Tchernegovski et al., 2018).

Private practice counsellors comprise a significant part of the mental health workforce in Australia (Australian Government Department of Health, 2019). As of 2023, there were 30,700 people employed as counsellors in Australia (Australian Government,2023). These counsellors mostly have a background in psychology, social work or occupational therapy, and as highlighted by AIHMW (2023) a vast majority of them (approximately 49%-85%) work in private practice settings. Thus, in terms of availability to mental health support, counsellors in private practice can be considered to be one of the most widely available options for parents with mental health challenges. Nonetheless, within the Australian context, clients may experience financial barriers in accessing counselling, (Kingston & Morgan, 2018). Further, there may be other barriers to seeing a counsellor, including lengthy waitlists and geographical distance (Naccarella & Loh, 2021).

Although counsellors may be one of the most widely available options for parents with mental health challenges, very few studies to date have investigated the outcomes of one-on-one-counselling for parents with mental health challenges. Instead, most research

related to parents' experiences of mental healthcare has focused on the practices of multidisciplinary teams within public rehabilitation and psychiatric settings (e.g., Dolman et al., 2013). To date, there are limited studies investigating the cohort of parents with mental health challenges who undertake private therapeutic counselling (Cooper et al., 2023).

There are some studies that have explored different counselling modalities for parents with mental health issues for example, Interpersonal Therapy (IPT) which has been shown to reduce psychological distress in perinatal women (Bright et al., 2020). IPT is a short-term, time limited psychotherapy intervention that conceptualises depression from a biopsychosocial perspective and specifically addresses problems that are interpersonal in nature, such as interpersonal conflicts and social role transitions, including the transition to motherhood (Klerman et al., 1984; Bright et al., 2020). A meta-analysis by Bright et al., (2020) found IPT was effective in reducing symptoms of depression and anxiety as well as improving social support, relationship satisfaction, and adjustment, in women during their pregnancy and postpartum period. Previous research had highlighted how IPA is well-suited to the needs of perinatal women due to the modalities focus on role transitions, interpersonal disputes and interpersonal deficits (Stuart & O'Hara, 1995).

A meta-analysis conducted by Cuijpers et al., (2015) demonstrated the effectiveness of various psychotherapies, including Cognitive Behavioral Therapy (CBT), psychodynamic therapy, and interpersonal therapy, in significantly reducing depression levels among mothers facing mental health challenges. The psychotherapies reviewed in this meta-analysis were conducted in various settings, including outpatient mental health clinics, hospitals, and community-based facilities. Cuijpers et al., (2015) found that various therapeutic interventions were effective in alleviating maternal depression alongside showing potential benefits for the mental health of their children and in reducing overall parental distress. Despite these promising findings, the authors emphasized the need for further research into the field of psychotherapy for supporting parents, to investigate the specific mechanisms through which these therapies impact both parent and child mental health outcomes. Additionally, Cuijpers et al., (2015) highlighted the importance of assessing the long-term effectiveness of these interventions, particularly in diverse populations, and called for more rigorous study designs to strengthen the evidence base.

By contrast, other research has found less promising evidence on the effectiveness of psychotherapeutic interventions for meeting the needs of parents and their children (Coiro et al., 2012). Coiro et al., (2012) explored the use of Cognitive Behaviour Therapy (CBT) with 60 mothers with major depression (Coiro et al., 2012). They offered mothers experiencing

depression either CBT, medication, or a referral to existing community services. Corio et al., (2012) aimed to examine whether treating mothers' depression though CBT could reduce or eliminate the negative effects of maternal depression on children's behaviour problems and adaptive skills. Results found no significant differences in children's behavioural or adaptive functioning as rated by the mother participants, between the community services, CBT or medication groups at six or twelve-months post treatment. The researchers posited that CBT treatment alone for mothers with depression was not associated with improvements in children's outcomes. Further, Coiro et al., (2012) compared the children of mothers who remained depressed and the children of mothers in remission from depression, regardless of treatment option. They found that the children of mothers in remission showed fewer behavioural problems, compared to the children of mothers who remained depressed. No significant difference in children's adaptive functioning were found between children of mothers in remission and with depression (Coiro et al., 2012). The conclusions drawn by the authors was that CBT was effective for some but had limited benefits for mothers with depression who were in remission. The researchers noted that further research is needed on the long-term effects of treating parental depression on families to determine whether the benefits of remission persist (Coiro et al., 2012).

Rather than examining specific therapeutic modalities, such as what was done by Bright et al., (2020) and Coiro et al., (2012), a recent study by Cooper et al., (2023) focused on the experiences and perceptions of parents receiving mental health support from psychologists in private practice. The research focused on how parents experience private practice psychology services in relation to their parenting role. It also explored what support parents believe they need from private practice psychologists in their parenting, which included the needs to feel understood and heard as a parent. Parents also expected their psychologist to provide targeted support for parenting difficulties including practical parental supports (Cooper et al., 2023).

2.3.6 Barriers

Across the different approaches to supporting parents with mental health challenges, there are common barriers to implementing family-focused practice (FFP). Some barriers relate to mental health professionals' practices or organisational barriers, whilst other barriers stem from parents themselves.

Barriers Related to Mental Health Professionals' Practices

Deficits in confidence, skills and knowledge are reported as the major barriers for adult mental health professionals delivering family interventions (Biebel et al. 2014; Cook &

Mueser 2014; Tchernegovski et al., 2018; Tuck et al., 2023). For instance, some adult mental health professionals described their lack of education in child focused or family orientated work (Foster & Isobel, 2018; Hjärthag et al., 2017; Lauritzen & Reedtz, 2013; Leenman & Arblaster, 2020), viewing this as a specialised skill set. Similarly, skill and knowledge deficits in working with clients on parenting issues has also been raised, with some professionals feeling unsure how to respond to parenting needs and child welfare concerns (Tchernegovski et al., 2017). Mental health professionals have described finding it difficult to talk with clients about the potential impacts of their mental health challenges for their children, noting that clients were often anxious to discuss parenting problems, fearing judgement and potential custody loss (Leenman & Arblaster, 2020; Radley et al., 2021; Skundberg-Kletthagen et al., 2020; Strand & Rudolfsson, 2018).

Ambiguity in the scope of mental health professionals' roles may also hinder the implementation of FFP (Maybery & Reupert 2009). Some mental health professionals have expressed that they do not believe that working with clients on parenting and family issues is their responsibility, with some suggesting that working with children was outside the scope of their role as an adult mental health professional (Foster & Isobel, 2018; Hjärthag et al., 2017; Maddocks et al., 2010; Radley et al., 2021; Slack & Webber, 2008). Likewise, some mental health professionals who work with parents with a mental illness, see working with children beyond their expertise, and instead refer to specialist children's services (Foster & Isobel, 2018; Hjärthag et al., 2017; Krumm et al., 2019; Maddocks et al., 2010; O'Brien et al., 2011; Radley et al., 2021; Slack & Webber, 2008; Tchernegovski et al., 2018a). Across numerous studies, a common feeling of uncertainty prevails, regarding the boundaries of mental health professionals' roles when discussing parenting issues and meeting the needs of children of parent clients (Foster & Isobel, 2018; Lauritzen & Reedtz, 2013; O'Brien et al., 2011; Pfeiffenberger et al., 2016; Radley et al., 2021; Strand & Rudolfsson, 2018; Sunde et al., 2021; Tchernegovski et al., 2018a).

Despite the benefits of identifying the parenting status of clients, mental health professionals do not routinely do so, or even when collected, they may not use this information in their care planning and practice (Maybery et al., 2016; Pfeiffenberger et al., 2014). Barriers that hinder mental health professionals asking about the parenting status and working with parents in a family orientated manner include problems related to organisational policy, resourcing, and management (Maybery et al., 2016). For example, inadequate resource allocation, including having large client workloads (Byne et al., 2000) and lacking dedicated time for family-focused practice (Maybery & Reupert, 2006, Korhonen

et al. 2008a; Maybery & Reupert 2009) may hinder mental health professionals' ability to support families. Other organisational barriers to working in a family orientated manner with parents includes a lack of funding and financial barriers (Conway et al., 2006), such as the extra costs associated with the time required for collaborative practice with other services, something that families often require (Darlington et al., 2005; Maybery et al., 2016). Many organisations have not invested in family-focused training to ensure all mental health professionals feel confident and competent practicing in a family orientated manner (Allchin et al., 2022).

Not being a parent can also be perceived as a barrier for professionals when working with clients on family issues (Gran et al., 2019; Tuck et al., 2023). As it is outside their experience, mental health professionals who are not parents have described working with parents on parenting issues as difficult (Grant et al., 2019). Conversely, mental health professionals who are parents are able to draw on their own experiences of caring for their children to effectively and authentically identify and address the worries and needs of clients who are parents as well as the needs of their children (Foster & Isobel, 2018; Grant et al., 2019; Krumm et al., 2019; Leenman & Arblaster, 2020; Tchernegovski et al., 2018a, 2018b). Mental health professionals who were able to draw on their own parenting experiences, including self-disclosing their own parenting challenges, found this helped to combat parents' anxiousness to discuss parenting conversations (Tchernegovski et al., 2017).

Mental health professionals' training and discipline can also impact their attitudes towards supporting clients in a family sensitive manner. Seminal research conducted by Bernheim and Switalski (1988) found differences between professionals in terms of how often they worked with families. Their research showed that from a sample of 350 inpatient and outpatient staff, psychiatrists and social workers spent more time with families, compared to psychologists surveyed (Bernheim & Switalski, 1988). However, the psychiatrists and social workers surveyed had less favourable attitudes towards FFP compared to the psychologists (Bernheim & Switalski, 1988). Additionally, they found that psychologists, administrators and team leaders were supportive of the concept of family-focused practice, although they spent little time with the families in their practice (Bernheim & Switalski, 1988).

Previous research has highlighted the need for, and the importance of, training and resources for mental health professionals supporting families where a parent has mental health challenges (Golden et al., 2020; Whitman et al., 2009). Training of mental health professionals who work in various healthcare settings, including paediatricians, nurses, social

workers and psychologists should include working and communicating with families using a strengths-based approach, identifying family needs and priorities, and planning for collaboration in service delivery (Whitman et al., 2009). A study in Ireland found that mental health professionals, from a range of professional backgrounds and who work with children, adolescents and families, experienced heightened knowledge and awareness of mental illness and its effects on children and families following specialised training (Golden et al., 2020). Mental health professionals noted barriers to the implementation of FFP stemming from legislation and national mental health policies.

Another barrier to working with parents on family issues is the challenge of holding the respective needs and perspectives of both parents and children in mind (Tchernegovski et al., 2018; Tuck et al., 2023). Tchernegovski et al., (2018), investigated the experiences of Australian mental health professionals, including social workers, psychologists, psychiatrists, mental health nurses and occupational therapists, who worked with parents with mental health challenges across various mental health, and/ or welfare settings. The study found that some professionals experienced difficulty maintaining a 'dual focus,' the act of concurrently holding both the parents and their child in mind and focusing on the child's wellbeing and outcomes at the same time as adults. In contrast to a dual focus, a singular focus targets either the parent or the child exclusively, but not both concurrently (Tchernegovski et al., 2018). Previous literature investigating the experiences of mental health professionals has found that being able to balance attention on the needs of both parents and children can be challenging (Leen- man & Arblaster, 2020; Maddocks et al., 2010; Sjöblom et al., 2005; Strand & Rudolfsson, 2018; Sunde et al., 2021; Tchernegovski et al., 2018a, 2018b). Strategies to overcome this difficulty include using a strengths-based approach, debriefing with colleagues and seeking supervision with other professionals who specialise in working with families where a parent has a mental illness (Tchernegovski et al., 2018).

Related to having a dual focus, is the need for mental health professionals to navigate heightened emotions when supporting clients in their parenting role (Tuck et al., 2023). Australian mental health professionals indicated that it can be difficult to raise the sensitive topic of parenting as some clients experience shame and guilt about their parenting or feel judged (Tchernegovski et al., 2017). Parental reluctance makes mental health professionals resistant to raise the topic of parenting, in case the rapport between themselves and their client may be ruptured (Tchernegovski et al., 2017). Mental health professionals can overcome this by using a supportive, strength based and non-judgemental approach and by disclosing their own parenting experiences (including aspects they struggle with) to

normalise the difficulty of the role (Tchernegovski et al., 2017). Other studies have shown that mental health professionals have found that talking to clients about their children could strengthen rapport if managed appropriately (Lauritzen & Reedtz, 2013; Maddocks et al., 2010; Strand & Rudolfsson, 2018; Tchernegovski et al., 2018a, 2018b).

Barriers for Parents in Engaging in Support and Intervention

There are numerous barriers parents with mental health challenges face when engaging in support and intervention. Financial barriers can pose significant challenges for parents and families seeking mental health support (Coombs et al., 2021; Moroz et al., 2020; Knapp & Wong, 2020). In Australia, many people are left with out-of-pocket costs for mental health services, as the Australian medical insurance program, Medicare, typically often only covers mental health support for individuals and no other family members (Australian Institute of Health and Welfare, 2022). Further, Medicare only covers a portion of the total cost of a support service for an individual, if any at all (Australian Institute of Health and Welfare, 2022). Families who struggle to afford these costs, may forgo treatment or have a limited range of service options (Coombs et al., 2021; Moroz et al., 2020; Knapp & Wong, 2020). Geographical barriers, including a lack of public transport can impact access to support services, particularly in rural and remote areas (Kavanagh et al., 2023; Newman et al., 2022; Vayro et al., 2020). Overall, compared to urban areas, people from rural areas in Australia are less likely to engage in mental health care (Kavanagh et al., 2023; Reupert et al., 2021; Vayro et al., 2020). They also face long waiting lists for the limited services available (Kavanagh et al., 2023; Reupert et al., 2021; Harding et al., 2023). The Australian culture of stoicism and confidentiality concerns can also prevent those living in rural and remote areas from seeking help (Cremers et al., 2014; Newman et al., 2022; Reupert et al., 2021).

Some family members may not be able to attend treatment or support services. For example, some families may have children in out-of-home care who are unable to participate in family-focused supports and interventions (Maybery & Reupert, 2009). The child's age can be a barrier as young children may not have the capacity to understand what is happening in treatment (Bibou-Nakou, 2003). Further, coordinating numerous family members to be involved in a parent's mental health treatment, and coordinating with numerous mental health professionals can be difficult and timely to organise, and not a feasible treatment option for families.

Fear around the consequences of disclosing mental health challenges and /or parenting may also prevent parents and children from engaging in support. For some parents, reluctance to engage in mental health support for themselves or their children may be driven by fears of

the involvement with child protection (Cooper et al., 2023; Jones et al., 2016). Conversely, in some families, children themselves may not be willing be involved in their parents' treatment. Stigma may contribute to this, as may uncertainty about what the intervention entails (Maybery & Reupert, 2009; Moltrecht et al., 2024).

Indeed, there any many reasons why it can be challenging to engage multiple family members in the treatment of parents with mental health challenges. As such, rather than engage in a whole-family approach, parents may often seek support for just their child (child-only approach) or just themselves (parent-focused approach).

2.4 PhD Rationale and Aims of the Thesis

There are numerous approaches to supporting parents with mental health challenges, across community, organisational systems, family systems, child-only and parent-focused approaches. Barriers to implementing FFP have been identified (Tchernegovski et al., 2018; Tuck et al., 2023). However, practice standards for family-focused care in the adult mental health sector have also been developed by Goodyear et al., (2015) to aid mental health professionals working with parents with mental health challenges. Despite these developments, there remain gaps in understanding the effectiveness of the different approaches, including parent-focused approaches, for supporting FFP and meeting the unique needs of parents with mental health challenges and their children.

Parents present for therapy for a range of different reasons, sometimes related to parenting issues, but more often for their own mental health concerns (Cooper et al., 2023). Regardless of the primary presenting issue, there is evidence that acknowledgeing a client's parenting identity and strengths and addressing parenting challenges in the therapeutic interaction, is beneficial to both the parent client and their children. Research has only very recently begun to investigate the experiences and perceptions of parents receiving mental health support from psychologists in private practice (Cooper et al., 2023). Additionally, the effectiveness of using different psychotherapies with parents remains unclear. Some previous research has demonstrated reduced mental health problems for parents (Bright et al., 2020) alongside potential benefits for the mental health of their children and in reducing overall parental distress (Cuijpers et al., 2015), whilst other studies have found psychotherapeutic treatment alone (CBT) was not associated with improvements in children's outcomes (Coiro et al., 2012). Therefore, it is unclear whether various psychotherapeutic modalities meet the needs of parents with mental health challenges, including offering support for parenting issues.

The thesis compares three different therapeutical approaches for working with parents with mental health challenges, from the perspectives of therapists. The three psychotherapeutic modalities selected for investigation were schema therapy, acceptance and commitment therapy (ACT), and narrative therapy. These three therapeutic modalities come from different philosophical approaches and offer distinct perspectives and techniques for addressing psychological concerns compared to modalities from the same approach (Martin, 2015). By selecting three different philosophical backgrounds to investigate, a broad range of perspectives and techniques are investigated and compared for their utility in meeting the needs of parents with mental health challenges and their families. The distinct perspectives and techniques of each modality are outlined in the Literature Review of Therapeutic Modalities (Chapter 3) and in the three papers (Chapters 5, 6 and 7).

The aim of this PhD is to examine the use of three different psychotherapeutic modalities with parents who have a mental health challenge from the perspectives of therapists who undertake one-on-one counselling with those parents. More specifically, the following research questions will be investigated with schema therapists, acceptance and commitment therapists and narrative therapists':

- What are the experiences of therapists using different modalities when working with parents with mental health challenges? Do therapists using different modalities, have different experiences working with parents?
- From the perspective of therapists, what elements of the various therapeutic strategies and approaches appear to respond to the needs of parents who experience mental health challenges? Are there common strategies or tools across the three modalities that therapists find work best for parents with mental health challenges? If so, what are these?
- What enablers and barriers have therapists found when working with these therapeutic modalities with parents? How do these compare between the different modalities?

Gaining insight into schema therapists', ACT therapists' and narrative therapists' experiences and perspectives of working with parents, can refine and enhance the protocols within each therapeutic approach. Understanding which techniques and interventions therapists find most effective in their chosen modality can be used to inform further iterations of the therapeutic models for working with parents with mental health challenges. Likewise, insights into the barriers that therapists face when working with these therapeutic approaches

with parents may be used to inform further iterations of schema therapy, ACT and narrative therapy models. Additionally, considering the support and resources therapists require can inform the development of supervision and professional development opportunities.

Chapter 3 Overview of Therapeutic Modalities

The Introduction to this thesis (Chapter 1) has provided an overview of parents with mental health challenges, including prevalence, experiences, and the impact of mental health challenges on their children, as well as the epistemological and ontological frameworks guiding this thesis. The Literature Review (Chapter 2) has examined the Australian mental health system and various support options available for families, such as community, organizational, family intervention, child-only, and parent-focused approaches. Together, these chapters established the rationale and aims of the thesis, setting the foundation for the subsequent exploration of therapeutic modalities.

This current Chapter will provide an overview of the three therapeutic modalities investigated in this thesis: schema therapy, acceptance and commitment therapy (ACT), and narrative therapy. Each therapeutic modality will be described, including an overview of key techniques of the modality. A review of the literature into the effectiveness of these therapeutic modalities for treating different psychological conditions will also be provided, followed by research into the modalities use with different population groups, including parents.

3.1 Schema Therapy

Schema therapy integrates elements from cognitive-behavioral therapy (CBT), psychoanalysis, attachment theory, and emotion-focused therapy to address chronic and complex psychological disorders (Young, 1994). This approach has demonstrated efficacy in treating a range of conditions, including personality disorders, chronic depression, and complex trauma (Jacob et al., 2018). In schema therapy, there is a collaborative and empathetic therapeutic relationship between therapist and clients, a significant emphasis is placed on the quality of therapeutic relationship as a catalyst for change (Young, 1999). Central to schema therapy is identifying and adapting early maladaptive schemas (EMS) and modes (Young, 1999).

3.1.1 Schemas

EMS can be defined as the beliefs we hold about ourselves, others and the world, which result from interactions between unmet core childhood needs, early environmental conditions and innate temperament (Young et al., 2003; Farrell et al., 2014). Five schema domains have been identified relating to the five areas of core emotional need. These five domains are: Disconnection and Rejection; Impaired Autonomy and Performance; Other-Directedness; Impaired Limits; Over-vigilance and Inhibition. Eighteen EMS have been identified, each of which falls under one of the schema domains as can be seen in Table 2.1 (Young et al., 2003). Schemas help children to make sense of their early life experiences, however when EMS are carried into adulthood, they can become problematic, inaccurate, and limiting as they may distort perceptions and interactions and lead to rigid thinking patterns (Farrell et al., 2014). EMS in adults can lead to difficulty adapting to changing circumstances or affect personal growth and wellbeing (Farrell et al., 2014).

Table 3.1

Schema Domains and Schemas

Disconnection and Rejection	**Impaired Autonomy and Performance;**	**Other-Directedness**	**Impaired Limits**	**Over-vigilance and Inhibition**
Emotional Deprivation	Dependency/ Incompetence	Subjugation	Entitlement	Negativity
Abandonment	Vulnerability to Illness/ Harm	Self-Sacrifice	Insufficient self-control	Emotional Inhibition
Mistrust/ Abuse	Enmeshment	Attention-Seeking		Unrelenting Standards
Defectiveness	Failure			Punitiveness
Social Isolation				

3.1.2 Modes

When EMS are activated, intense emotional, cognitive and behavioural states can be triggered, which are referred to as modes (Young et al., 2003; Farrell et al., 2014). There is no complete consensus about the range of modes and these may be individualised to the client, however four main categories of modes have been theorised (Bach et al., 2018). The four basic categories of schema modes are: innate child modes, dysfunctional critic modes, maladaptive coping modes and healthy modes (Farrell et al., 2014).

Innate Child Modes

Innate child modes are characterised by intense negative emotions and urges that were felt in childhood or early adolescence and are activated by schemas (Young et al., 2003; Young et al., 2010). Forms of innate child modes are the Lonely Child, Abandoned Child, Angry Child and Impulsive Child.

Dysfunctional Critic Modes

Dysfunctional critic modes encompass a negative internalised parental 'voice' and reflect aspects of inattentive or critical attachment figures (e.g., parents, teachers, etc) during childhood and adolescence (Young et al., 2010). The Dysfunctional critic modes are broken down into the Punitive Parent, whose 'voice' denigrates, and the Demanding Parent, whose 'voice' places almost impossible demands on the person (Young et al., 2010). Activation of dysfunctional critic modes often amplifies the distress of innate child modes. Initially the dysfunctional critic modes were referred to as dysfunctional parent modes, but terminology has changed and now referred to as critic modes.

Maladaptive Coping Modes

Maladaptive coping modes refer to parts of the self that overuse unhealthy coping styles to dampen the felt distress of innate child modes (Young et al., 2003). There are three broad coping styles that people use to cope with schema activation: schema overcompensation (fight), schema avoidance (flight) and schema surrender (freeze) (Young et al., 2010). Coping through schema overcompensation looks like doing the opposite of one's schema (Young et al., 2003). An example of overcompensation to the abandonment schema is someone pushing their partner away and telling themselves that they do not need the closeness that their innate child mode desires. Coping through schema avoidance may include avoiding situations or people that trigger one's schema (Young et al., 2003). An example of avoidance to abandonment is avoiding intimate relationships, to prevent any possible break-ups or future abandonment. Coping through schema surrender looks like

giving into one's schemas (Young et al., 2003). An example of a surrender to abandonment might be selecting partners who cannot make a commitment to remain in the relationship and vigilantly fixating on signs that their partner is likely to leave. Coping styles are individual, and different people have different coping styles. It is theorised that the purpose of maladaptive coping styles is to protect oneself from experiencing pain and fear although they do not ultimately meet core unmet needs and instead tend to perpetuate difficult feelings (Young et al., 2003). One may not be consciously aware of their maladaptive coping modes operating. Therefore, a goal of schema therapy is to help the client become aware of their maladaptive coping modes, and learn more adaptive, healthier coping styles.

Healthy and Functional Modes

Healthy and functional modes can help regulate and counter the effects of other modes (Young et al., 2010). They represent an aspect of one's healthy and functional self. Healthy and functional modes are broken down into the Healthy Adult Mode and Happy Child Mode. The Healthy Adult Mode is characterised by functional thoughts and behaviours and is the part of the self that is capable, strong, and well-functioning in adult life (Young et al., 2010). In schema therapy, the therapist forms an alliance with the Healthy Adult of clients and a goal of therapy is to enhance the Healthy Adult mode to promote capacity for self-parenting (Young et al., 2010). It is thought that strengthening the Healthy Adult mode will have a positive impact on parenting competence. The Happy Child Mode is considered to be a helpful resource that promotes playful and enjoyable activities, especially in social networks (Arntz et al., 2012). People with personality disorders tend to have underdeveloped healthy modes (Arntz et al., 2012).

3.1.3 Goals of Schema Therapy

Schema therapy aims to help clients get their core emotional needs met in an adaptive manner by counteracting dysfunctional critic modes and caring for innate child modes so that adaptive coping strategies can replace the default maladaptive coping modes that people tend to rely on (Farrell et al., 2014). Underlying schemas are also addressed, with EMS being identified, challenged and modified into more functional representations of the world and self (Farrell et al., 2014).

3.1.4 Schema Therapy Techniques

Schema therapy involves the use of cognitive, behavioural, and experimental techniques (Young, 2003; Young et al., 2010). Cognitive techniques are used to evaluate the

validity of schemas and advantages and disadvantages of maladaptive coping styles (Farrell et al., 2014). Behavioural techniques may be used to discourage maladaptive coping styles and encourage adaptive behaviour (Farrell et al., 2014). Experimental techniques play a key role in schema therapy, and many of the techniques are unique to the therapy (Young et al., 2003). Experimental techniques can provide clients with corrective emotional experiences, by encouraging clients to express emotions related to EMS and by meeting clients unmet core emotional needs in session (Young et al., 2003; van Vreeswijk et al., 2012). Key experimental techniques are outlined below.

Imagery Rescripting

Imagery rescripting involves the therapist asking the client to imagine a past scenario that is associated with negative emotion (Farrell et al., 2014). Often, an attachment figure will have played a negative role in the scenario. The schema therapists seek permission to enter the scenario, before the client describes the negative experience that occurred. The therapist then provides a corrective experience by standing up for the client, advocating for their needs and calling out any unfair or upsetting behaviour enacted by others. Often this involves the therapist talking to the attachment figure in the scenario about their unacceptable treatment towards to the client. The therapist then turns their attention to the child version of the client in the scenario to offer reassurance and comfort or whatever is necessary to meet their previously unmet emotional need, thereby taking on the role of a nurturing carer.

Chair Work

'Chair work' involves using chairs to represent different aspects of the client, such as a mode (Farrell et al., 2014). The client moves between chairs to speak from the perspectives of different modes and also speaks to other modes. This dialog leads to insights about conflicts between the modes and facilitates resolution towards meeting the needs of innate child modes.

Limited Reparenting

Limited reparenting involves the therapist taking on a 'parental role' with the client, to help address unmet core needs (Farrell et al., 2014). Limited reparenting draws on the intimate therapeutic relationship established in schema therapy between therapist and client. In providing limited reparenting, the therapist starts by providing co-regulation support to the client, whilst demonstrating the Healthy Adult mode, until the client has developed their own Healthy Adult enough to take on this role for themselves (Young et al., 2010). Where a client lacks reasonable limits, the therapist may help to set these limits through a process called empathic confrontation (Farrell et al., 2014). This is when the therapist recognises the client

is behaving in a particular way but points to the negative consequences and suggests an alternative adaptive behaviour.

3.1.5 Effectiveness of Schema Therapy for Different Psychological Conditions

There is growing research into the effectiveness of schema therapy for different psychological conditions (Spinhoven et al., 2007; Hawke & Provencher, 2011; Klerk et al., 2017; Köruk & Özabaci, 2018; Peeters et al., 2021). Klerk et al., (2017) facilitated through in-depth semi-structured interviews with therapists and clients presenting with a range of personality disorders. They found the highly collaborative therapeutic relationship and the focus on modes in the schema therapy model was helpful for understanding and improving clients' symptoms of their personality disorders (Klerk et al., 2017). Conversely, unhelpful aspects of the schema therapy model were also described, including how clients desired more clear, practical targets to work towards; therapists noted that they had difficulty performing schema therapy when clients were not ready to focus on specific problems (Klerk et al., 2017). This study built upon a previous investigation of the schema therapy for clients diagnosed with Borderline Personality Disorder (BPD) which found schema therapy led to significant improvements in symptoms and functioning for clients (Spinhoven et al., 2007). The study also highlighted that schema therapy was effective in reducing overall psychopathology, improving interpersonal and emotional regulation skills and was rated positively by both clients and therapists (Spinhoven et al., 2007). Furthermore, schema therapy has been found to have a high level of efficacy in the treatment of depression for adults (Hawke & Provencher, 2011; Köruk & Özabaci, 2018). A recent systematic review described how schema therapy is effective for treating anxiety, obsessive-compulsive disorder (OCD) and Post-Traumatic Stress Disorder (PTSD) in adults (Peeters et al., 2021). Therefore, the literature into the effectiveness of schema therapy has established the model to be a useful mental health treatment for a range of psychological conditions.

3.1.6 Effectiveness of Schema Therapy for Different Population Groups

Research has begun to investigate the use of schema therapy for different population groups, beyond populations of clients with certain psychological conditions (Legra & Verhey, 2017; Khasho et al., 2019; Videler et al., 2018). For example, research has investigated the effectiveness of schema therapy for older adults (Legra & Verhey, 2017; Khasho et al., 2019; Videler et al., 2018). Further, recent research has explored the effectiveness of schema therapy in offenders with intellectual disabilities and found

significant improvements in emotional states (Klerk et al., 2021). Beyond the forementioned studies, there remains limited research into the experiences of other population groups who undergo schema therapy such as cross-cultural groups, populations with diverse genders and sexualities.

3.1.7 Effectiveness of Schema Therapy with Parents

There is limited research investigating the use of schema therapy with parents who have a mental illness. Research by Solan et al., (2021) into the utility of schema therapy, did not focus on parents with mental health challenges, but the parents of children with attention deficit hyperactivity disorder (ADHD). They found that 'schema parenting behaviour training' (SPBT) for parents of children with ADHD led to greater ADHD symptom reduction in children compared to standard 'parenting behaviour training' (a first-line treatment for children with ADHD). This finding suggests potential utility of schema therapy strategies to support parents of children with ADHD (Solan et al., 2021). However, this study involved parents undertaking schema therapy to support their child's condition and did not collect data on whether the participating parents had mental health challenges themselves or not. The impact schema therapy has on supporting parenting roles, and parents mental health remains under-researched. It is important to address this gap in the literature to examine whether schema therapy addresses needs specific to parents, and how the practice of schema therapy could be better adapted when working with parents with mental health challenges.

3.1.8 Schema Therapy Selection for Investigation

Schema therapy was selected as a modality to be investigated in this thesis for several reasons. Firstly, schema therapy targets deep-seated patterns (schemas) that develop early in life and influence behaviour, emotions, and relationships (Young et al., 2003). I hypothesised that for parents, addressing these core issues could lead to lasting changes that benefit both parents' mental health and parenting abilities and subsequently have a positive impact on their children. Additionally, I thought that other theoretical foci of schema therapy would be related to parentings capability and assist parents to meet the wellbeing needs of their children. For example, schema therapy has a focus on developing self-parenting skills, through building clients Healthy Adult Mode (Young et al., 2003) and addressing core childhood emotional needs. Given these theoretical foci, I was interested to investigate how therapists perceived schema therapy for parents with a mental illness and whether it could build parenting capacity and capability.

Moreover, schema therapy integrates elements from cognitive-behavioural, psychoanalysis, attachment theory and emotion-focused therapies. This comprehensive approach suggests that it is a versatile model. Further, schema therapy not only targets maladaptive schemas but also promotes emotional healing and resilience (Young et al., 2011) which are crucial for effective parenting (Louis et al., 2021). Due to its versatility, I reasoned that it may be effective in supporting clients who are balancing their own mental health needs alongside their parenting responsibilities. Additionally, schema therapy has been shown to be effective in treating a range of complex psychological conditions (Jacob et al., 2018). As such, schema therapy could potentially help parents manage the dual challenges of addressing parents' mental health needs while simultaneously fulfilling their parenting roles. Therefore, investigating the application of schema therapy for parents could offer valuable insights into its efficacy in supporting both parental mental health and child well-being.

3.2 Acceptance and Commitment Therapy (ACT)

Acceptance and commitment therapy (ACT) is commonly referred to as a 'third wave' behavioural therapy that aims to enhance psychological flexibility, encourage acceptance of uncomfortable thoughts, and foster behavioural changes that align more closely with one's personal values (Hayes et al., 2006; Hayes et al., 2011). Considering the title of this approach, 'acceptance and commitment therapy', acceptance refers to the therapeutic focus of inviting clients to accept unwanted private experiences, including emotions, thoughts and memories, as well as external events that are not directly controllable (Hayes et al., 2004). Commitment refers to the process of the client choosing a set of meaningful values to guide their life direction and bring purpose; followed by committing to and implementing actions that are consistent with these values. In sum, ACT does not attempt to change or eliminate symptoms or unwanted private experiences, but rather focuses on building acceptance and orienting them towards undertaking actions (behaviours) that are consistent with their personal values (Hayes et al., 2012).

The ACT model centres around six core processes: acceptance, cognitive defusion, self as context, contact with the present moment, values, and committed action (Hayes et al., 2006). Combined, these six core processes all promote psychological flexibility and reduce experiential avoidance (Hayes et al., 2006). The theory that underpins ACT prescribes psychological flexibility; the ability to act in accordance with one's values, regardless of inner experiences, as the central construct of good psychological functioning (Hayes et al., 2012). Throughout ACT, therapists work to improve psychological flexibility in clients by

leveraging the influence of mindfulness practice and behaviour change strategies (Hayes et al., 1999).

Relational Frame Theory (RFT) is a central construct in ACT. RFT is a contextual theory of human language and cognition (Hayes et al., 2011). RFT aims to provide a psychological account of language and cognition, by considering human evolutionary success. Further, RFT seeks to understand the cognitive roots of both human achievement and suffering (Hayes et al., 2011). According to the theory that underpins ACT, human language plays a central role in psychopathology, and ACT deals with the language produced by the mind that exacerbates psychopathology.

3.2.1 Goals of ACT

According to ACT, the core of human psychopathology and unhappiness is inflexibility (Luoma et al., 2017). ACT does not aim to remove negative thoughts and feelings but rather to help clients learn to experience negative thoughts and feelings in a way that is less distressing and more flexible. By managing negative thoughts and feelings more effectively, individuals are afforded more time to focus on what truly matters to them. Thus, ACT also aims to move clients from a 'stuck' and unsatisfying life to a more fulfilled one (Hayes et al., 2011).

3.2.2 Techniques and Processes of ACT

As outlined by acceptance and commitment therapy theory, there are six sets of inflexible processes that get in the way of living a fulfilled life (Hayes et al., 2004). The six core processes are: Present-moment awareness; Dimension of self; Defusion; Acceptance; Connecting with values and Committed action. Collectively, these six processes define the acceptance and commitment therapy intervention model (Hayes et al., 2004). The techniques used in acceptance and commitment therapy centre around these six different inflexible processes and work to make them more flexible through the use of experiential exercises, metaphors, behavioural tasks and home-based exercises (Strosahl et al., 2004).

Contact with the Present Moment

ACT recognises that much distress derives from negative thoughts about events or relationships from the past and/or anticipatory thoughts about events yet to take place. A role of the therapist is to discourage the client from dwelling in either the past or future, and instead to encourage them to live more in the present moment (Hayes et al., 2004). There is a

large focus on staying present, becoming aware of sensory perceptions and noticing what's happening in the moment as it occurs.

Acceptance

ACT seeks to move from experiential avoidance; basing actions on avoiding 'bad' or difficult emotions, and from constantly striving for emotional control, and instead towards acceptance and willingness to experience whatever shows up emotionally, no matter how uncomfortable, and to be present and curious about bodily sensations, thoughts and emotions.

Cognitive Defusion

As clients progress through ACT, the treatment works to undermine the language-based processes that promote 'fusion'. In this context, fusion refers to having an unclear distinction between thoughts and reality – such as whereby one believes every thought to be 'true' and thereby sees the world through those difficult thoughts. Rather, ACT promotes defusion from thoughts, whereby one can notice their thoughts, be curious and reflective about where they come from and what they might mean, and through this process the power of the thoughts to influence behaviour is diminished and the person can then make a choice about how they respond.

Self-as-context

Another process in ACT involves distinguishing between one's conceptualised self and self-as-context and provides a position from which acceptance of events is less threatening (Hayes et al., 2004). Self-as-context (SAC) is typically taught as an extension of mindfulness, which encourages people to focus on an enduring sense of self that has a flexible perspective, in which thoughts, emotions and sensations arise and pass.

Connecting with Values

Throughout the ACT process, clients identify values, valued outcomes and gain awareness of what matters to them most in life. In doing so, ACT moves clients towards conscious awareness of how they want to behave and what sort of person they want to be, aligning their values and behaviours in tangible and satisfying ways.

Committed Action

Another key process is committed action, which describes going from being on 'autopilot,' reacting, feeling trapped or taking the line of least resistance (and least emotional discomfort), towards building patterns of committed actions that are consistent with their values; doing what it takes to live the life they want to have, even when that is difficult.

There is no stipulated order for addressing the six core processes. The processes are highly interdependent and focusing on one process in ACT can activate another process. For example, focusing on developing contact with the present moment, and increasing mindfulness can naturally lead to greater cognitive defusion, as individuals become more adept at observing their thoughts without automatically reacting to them.

3.2.3 Effectiveness of ACT for Different Psychological Conditions

A growing number of systematic reviews and meta-analyses have attested to the efficacy of ACT for a range of psychiatric disorders and chronic health conditions including mood and anxiety disorders, psychosis, chronic pain, cancer, diabetes, epilepsy, obesity, and substance use disorders (A-Tjak et al., 2015; Hayes et al., 2011; Oest, 2014; Powers et al., 2009; Ruiz, 2012; Zhenggang et al., 2020; Gloster et al., 2020; Munawar et al., 2021). For example, results of a recent review of meta-analyses investigating the efficacy of ACT for a range of conditions, - including anxiety, depression, substance use, pain, and transdiagnostic groups, found that ACT was generally superior to inactive controls (e.g. waitlist, placebo), treatment-as-usual, and other active intervention conditions (including psychodynamic therapy, behavioural therapy and mindfulness-based interventions) (Gloster et al., 2020). Additionally, a review of the benefits of ACT for individuals with ADHD highlighted how the flexibility of acceptance and commitment therapy enabled it to be adapted to the treatment of general psychosocial issues as well as targeted ADHD treatment (Munawar et al., 2021). A meta-analysis found that ACT significantly reduced depressive symptoms compared with the control group, especially at three months of follow-up, for adults with mild depression (Zhenggang et al., 2020). However, it was noted that more research is needed to investigate the different effects for minor, moderate and severe depression and the long-term outcomes (Zhenggang et al., 2020). In sum, there is a growing body of research into the effectiveness of ACT for treating a variety of psychological conditions.

3.2.4 Effectiveness of ACT for Different Population Groups

Studies have recently investigated the effectiveness of ACT for different population groups, including for adults, adolescents, children, family caregivers and parents (Fang et al., 2020; Gloster et al., 2020; Prudenzi et al., 2021; Zhenggang et al., 2020). For instance, research investigating the effectiveness of ACT for children and adolescents with a range of different psychological disorders has found ACT is effective for symptom improvement in adolescents with OCD (Armstrong, 2011), autism and learning disorders (Cook, 2008), depression (Hayes et al., 2011), anorexia (Heffner et al., 2002) and chronic pain (Wicksell et

al., 2009). Other papers reported that adolescents undertaking ACT experienced improvements on various measures of functioning, for example school attendance and performance (Hayes et al., 2011; Sabaini, 2013; Wicksell et al., 2005, 2009). A recent meta-analysis involving 14 randomized controlled trials on the efficacy of ACT for children found that compared to waitlist and treatment-as-usual (e.g., psychoeducation, treatment-as-usual and pastoral care), ACT significantly improved symptoms of depression and anxiety (Fang & Ding, 2020).

There has also been research investigating the effectiveness of ACT for family caregivers. Han et al., (2021) found that using ACT with people who provide unpaid assistance for a relative with a chronic disease or a disability, had moderate effects on improving depressive symptoms, small to moderate effects on stress reduction and small effects on anxiety reduction). Previous research found that accepting the losses of relatives' abilities and care demands helps family caregivers to better adapt to their changing roles and relationships (Brodaty & Donkin, 2009).

There has been research into the effectiveness of ACT for primary caregivers who are parents of children with severe disabilities or health conditions. As early as 1989, there was literature suggesting the utility of treatment consistent with an ACT approach for parents of children with severe disabilities (Biglan, 1989; Singer & Irvin, 1989). Although this literature pre-dates the use of the term 'acceptance and commitment therapy' the treatments proposed by the authors for parents are highly consistent with the theory and processes in ACT. Biglan (1989) focused on behavioural family therapy for parents of children with severe disabilities and discussed the application of behavioural principles to help parents manage the challenges associated with raising children who have significant disabilities. The paper emphasized the importance of teaching parents strategies for coping with stress, improve their parenting practices, and enhance the overall family environment (Biglan, 1989). Particularly, Biglan's (1989) work helped parents develop psychological flexibility, manage distressing thoughts and emotions, and engage in values-driven behaviours. This early literature suggested the utility of interventions that would later be recognised as consistent with the ACT approach ((Biglan, 1989; Singer & Irvin, 1989). A recent systematic review and meta-analysis of ten studies found that ACT may help improve psychological flexibility in parents of children with special health care needs (Parmer et al., 2021).

Studies have also investigated ACT with parents of children with autism. Blackledge and Hayes (2006) invited parents of children with autism to participate in a two-day, group-based, experiential ACT workshop and found statistically significant (although not large)

improvements in measures of depression, psychological distress and psychiatric symptomatology at three months follow-up. A recent systematic review found that ACT was effective in managing distress when working with parents of children with autism (Juvin et al., 2022). Whilst ACT appears promising for working with parents of children with autism, Juvin et al., (2022) noted that the field of research into ACT with parents is still relatively new.

3.2.5 Adaptations of the ACT Model for Parents

Whittingham and Coyne (2019) adapted the ACT model specifically for parents of children with a disability. The goal of the adapted therapy was to help parents better manage difficult thoughts and emotions and to take meaningful, values-based action which supports their parenting role (Whittingham & Coyne, 2019). Adaptations by Whittingham and Coyne (2019) include altering the core processes to include parenting values clarification, mindfulness for parents, acceptance of parenting challenges, defusion for unhelpful thoughts about parenting and commitment action that support their role as a parent. There is however no evaluation published on this adapted model and it is unclear whether Australian ACT therapists are familiar with Whittingham and Coyne's (2019) adapted model and whether they practice it when working with parents of children with a disability.

Although the traditional ACT model has been specifically adapted for parents of children with a disability (Whittingham & Coyne, 2019) and research has begun to investigate the experiences of specific groups of parents who undergo ACT, as far as the researchers are aware, no study to date has qualitatively examined counsellors' experiences of using ACT with parents who have mental health challenges.

3.2.6 ACT Selection for Investigation

ACT was selected as a modality to be investigated in this thesis for several reasons. It was hypothesised that the six core processes of the ACT model could be applicable to parenting needs. For instance, the process of contact with the present moment, which incorporates mindfulness techniques, could help parents stay present and engaged in the moment (Whittingham & Coyne, 2019). This could increase their ability to respond thoughtfully rather than reacting impulsively (Guendelman et al., 2017), which is an important strategy for parenting (Siegal & Hartzell, 2014). Mindfulness can enhance the quality of parent-child interactions, helping parents to be more attentive, patient, and responsive to their children's needs (Cohen, 2010) and aware of their own internal reactions

and responses (Kabat-Zinn & Kabat-Zinn, 2014). Additionally, it is hypothesised that the acceptance process of ACT, may help parents reduce avoidance behaviours, and encourage them to accept difficult thoughts and feelings rather than trying to suppress or escape them. This would be especially helpful for parents who experience stress, anxiety, or depression. Another core process of ACT, cognitive defusion, could be useful for parents by helping them change their relationship with their thoughts, leading to more adaptive responses in challenges situations (Hayes et al., 2006). Previous research has highlighted the importance of parents demonstrating emotional and cognitive flexibility (Flujas-Contreras, 2022) and thus there is utility in investigating whether ACT for parents with mental health challenges enhances cognitive flexibility in clients' parenting roles. The self-as-context process in ACT could help parents view their thoughts and feelings from a broad perspective (Hayes et al., 2004), which could reduce self-judgment and support more self-compassionate parenting. Other processes of ACT involve clients connecting with their core values and committing to actions that align with these values (Hayes et al., 2004). For parents, this could mean identifying what kind of parent they want to be and making decisions that reflect those values.

As such, the ACT model could potentially address both parenting needs and mental health challenges. Hence, investigating the application of ACT for parents could offer valuable insights into the efficacy of ACT techniques and process that work well with parents, and what needs to be adapted, if anything, to better suit practice with parents.

3.3 Narrative therapy

Narrative therapy is a non-pathologizing and collaborative type of psychotherapy that focuses on individual's stories and experiences to help them identify and challenge limiting beliefs and behaviours (Payne, 2006). Developed by White and Epston (1990) narrative therapy theory asserts that as our experiences are complex ambiguous, we construct narratives to make sense of them. Narrative therapy stems from Systemic Family Therapy and shares many of its methods, including the extensive use of questioning, reflecting teams and attention to social and familial influences on persons' perceptions (Payne, 2006). A key feature of narrative therapy is that it views problems as separate from the person and instead sees them as a result of their interactions with the environment and society. A narrative therapy approach recognises that each person is an expert in their own lives and is capable of change, consistent with a strengths-based approach (Morgan, 2000).

The therapeutic relationship between client and therapist in narrative therapy is cooperative with the client experiencing their own discoveries and then deciding how these discoveries can be used (Payne, 2006). The therapist's role in narrative therapy is to create a context for clients to recognise and accept self-knowledge, skills and capacities (Payne, 2006). Throughout narrative therapy, the therapist maintains a position of curiosity, and stays 'decentred' in sessions, asking questions which influence what becomes visible in the session whilst also emphasizing the person's strengths and abilities (White, 2000). The therapist's role is to facilitate this process of recognition, rather than to impose assumed expert professional knowledge about the person's motives or needs (Payne, 2006).

3.3.1 Goals of Narrative Therapy

The goal of narrative therapy is to help clients reshape their identities and experiences by exploring and re-authoring the stories they tell themselves (White & Epston, 1990). The aim is to make client's life stories more satisfying, and less problem saturated (White & Epston, 1990). Therapists work to help clients understand and reframe their experiences in alternative ways, and develop more empowering and liberating narratives, leading to a greater sense of agency and personal growth (White, 2000). This is done through externalising problems, re-authoring narratives and deconstructing dominant narratives.

3.3.2 Key techniques

Externalising Problems

A key technique in narrative therapy is to externalise problems. This refers to regarding problems as distinct from the person (Payne, 2006). In other words, people are not viewed as the problem, rather problems are viewed as products of interpersonal relationships or broader social and cultural contexts (White, 2000). Externalising the problem helps the person see it as something they can change rather than something that defines them. Externalising the problem involves naming, objectifying, and personifying the problem (Payne, 2006). Through externalising the problem, clients are encouraged to adopt a critical stance towards problems, questioning how these issues have come to exert influence in their lives without attributing personal fault or inherent deficiencies (Payne, 2006). Externalising problems can also involve externalising conflicts and viewing them as separate from personal identities which allows individuals to explore how these problems have influenced their relationships without attributing blame or fault to each other (Nicholas, 2013; White & Epston, 1990).

Re-authoring Narratives

Re-authoring narratives is another technique which involves reframing clients' beliefs, experiences and behaviours, to assist them in finding alternative perspectives and creating new meanings about beliefs, experiences and behaviours (Payne, 2006; White, 2007). This could involve the therapist and client constructing alternative narratives about relationships and conflicts by exploring and amplifying instances of positive interactions, to promote a more balanced understanding of the relationship.

Deconstructing Dominant Narratives

The deconstruction of dominant narratives involves critically examining prevailing stories that individuals or families hold about themselves and their experiences (White & Epston, 1990). These narratives often contribute to misunderstandings or conflicts within relationships. Deconstructing these narratives also entails exploring moments in a person's life that diverge from the dominant, problem-focused narratives that the client may overlook in their life narrative, but which hold significant meaning (Payne, 2006). Through this process of deconstruction, clients gain a holistic understanding and develop a more comprehensive and enriched life story (Payne, 2006; Brown & Augusta-Scott, 2006).

Cultural and Contextual Sensitivity

Narrative therapy interventions are sensitive to cultural backgrounds and contexts, acknowledging how cultural beliefs, traditions, and social norms influence relationship dynamics (Wendt & Gone, 2017; Vromans et al., 2016). This awareness enables therapists to customise interventions that honour and integrate cultural responsiveness into the therapeutic process.

The aforementioned techniques represent only a subset of the methods employed in narrative therapy. Therapists adapt their techniques based on the individual needs and objectives of each client (White, 2007).

3.3.3 Effectiveness of Narrative Therapy for Different Psychological Conditions

The research into the effectiveness of narrative therapy has covered a range of different psychological conditions, substance use disorders, and other presenting problems. For example, narrative therapy has been found to improve depressive symptoms (Lopez et al., 2014a) and contribute to long-term benefits (Lopez et al., 2014b). Enhanced interpersonal outcomes have also been found in adults from diverse cultural and socioeconomic backgrounds who undertake narrative therapy (Vromans & Schweitzer, 2011). Research has also shown efficacy of narrative therapy on treating anorexia and bulimia (Lock et al., 2005;

Heywood et al., 2022); specific phobias (Tadros et al., 2022); and in supporting positive health outcomes for people with intellectual disabilities (Wark, 2012). Further, research has found that group-based narrative therapy interventions may reduce depression and anxiety symptoms in adults with amphetamine addiction (Shakeri et al., 2020). However, no significant difference in quality of life was found after ten group narrative therapy sessions (Shakeri et al., 2020).

3.3.4 Effectiveness of Narrative Therapy for Different Populations

Narrative therapy has been found to have utility for a range of different population groups, including children and adolescents (White, 2006), adults, couples and families (White & Epston, 1990), and people with chronic illnesses (Smith & Sparkes, 2008). Narrative therapy has been applied with children and adolescents to help them reframe their experiences and develop a sense of agency (White, 2006). Additionally, narrative therapy has also been found to reduce behaviour problems in children and improve their self-perceptions after undertaking 12 sessions of narrative therapy (Fatahi et al., 2021). There have also been applications of narrative therapy for adults who, as children, experienced childhood abuse and interpersonal trauma (Cloitre et al., 2020). An adapted version of narrative therapy, specifically for individuals who experienced childhood trauma and abuse, was found to reduce post-traumatic stress disorder (PTSD) symptoms and improve overall functioning in trauma survivors (Cloitre et al., 2020).

Narrative therapy has shown utility in supporting individuals with chronic illnesses by helping them reframe their experiences and construct more empowering personal narratives (Frank, 2023; Langdridge, 2007; Smith & Sparkes, 2008). Research indicates that this narrative therapy can enhance psychological well-being, improve coping strategies, and reduce the emotional burden associated with chronic conditions (Smith & Sparkes, 2008). By externalising the illness and separating it from the individual's identity, narrative therapy fosters a sense of agency and resilience, encouraging clients to envision a life not entirely defined by their illness (Langdridge, 2007).

3.3.5 Effectiveness of Narrative Therapy with Parents

The seminal literature by White and Epston (1990) highlighted how narrative therapy principles and techniques could be applied in family therapy settings. More recent literature has demonstrated that narrative therapy can be used to support a range of issues for parents and families.

Narrative family therapy for women has been found to help them deconstruct unhelpful narratives they may have created during the pregnancy and postpartum period (Banker & Goldenson, 2023). Using a case study, Banker and Goldenson (2023) highlighted how narrative therapy could be used to help clients emotionally re-author their 'mothers stories,' referring to the narratives they have formed about themselves as a mother. Narrative therapy could be used to and create new meanings through separating their identity as a mother from their postpartum mood anxiety disorder (PMAD) symptoms (Banker & Goldenson, 2023).

Additionally, narrative therapy has been used to assist blended families (Gold, 2016; Shalay & Brownlee, 2007), to address adoption issues within families (Stokes & Poulsen, 2014), to support homeless families (Fraenkel et al., 2009), and to improve the family functioning of couples (Suddeath et al., 2017). Besa (1994) found that narrative therapy was effective in reducing parent-child conflicts. More recent literature by Suddeath et al., (2017) described how narrative therapy techniques can be applied in family therapy including externalising the problem from the family, re-authoring narratives and recognising cultural discourse and its impact on family narratives.

McQueen and Hobbs (2014) described how using a narrative approach with parents can address the power differentials between mental health professionals and parents, and lead to a sense of collaboration. They found that this technique can provide parents with an opportunity to examine, reflect and recognise their resources and skills (McQueen & Hobbs, 2014).

There is a growing body of research demonstrating the utility of practicing narrative therapy with parents to address a range of issues (Besa, 1994; Gold, 2016; McQueen & Hobbs, 2014; Shalay & Brownlee, 2007; Suddeath et al., 2017. However, literature into therapists' experiences and perspectives of using narrative therapy with parents who experience mental health challenges remains under-researched.

3.3.6 Narrative Therapy Selection for Investigation

Narrative therapy was selected as a modality to be investigated for its use with parents for numerous reasons. Firstly, narrative theory stems from Systemic Family Therapy, (Payne, 2006) and has a focus on understanding how social and familial influences shape individuals' perceptions and experiences. It was hypothesised that this focus on social and familial influences would be particularly relevant for parents with mental health challenges, as it emphasizes the importance of examining the broader context in which their struggles occur.

By acknowledging the impact of social and familial narratives on their mental health, parents could have a better understanding of how these social and familial influences across generations may have shaped their current challenges, thereby opening the door to alternative, more empowering narratives.

This approach empowers parents to reframe their experiences, allowing them to move away from problem-saturated narratives and toward more positive, strengths-based understandings of their lives. By encouraging parents to recognize that their problems are not inherent to them but rather separate entities, narrative therapy fosters a sense of agency and control, which can be critical for parents struggling with mental health issues.

Additionally, it was hypothesised that the narrative therapy techniques of externalising problems, re-authoring narratives, and deconstructing dominant narratives would be useful for parents with mental health challenges. Externalising problems could help parents view their mental health issues as challenges they face rather than as defining aspects of themselves. This could reduce self-blame and guilt, which are common feelings among parents with mental health challenges (Dolman et al., 2013; Halsa, 2018). Re-authoring narratives could enable parents to reconstruct their life stories, involving other family members, by identifying and emphasizing moments of strength, resilience, and positive change, promoting a more hopeful and empowered self-identity. Deconstructing dominant narratives could help parents critically examine societal or familial expectations and allowing them to challenge and rewrite these narratives in a way that better aligns with their values and lived experiences. These techniques collectively could support parents in developing a more constructive and empowering narrative of their lives, which is crucial for their mental health and overall well-being and could potentially support parenting confidence.

3.4 Summary and Aims of the Thesis

The prevalence of parents caring for children with a mental illness is significant (Reupert & Maybery, 2016). Parents with mental health challenges face unique and often complex challenges when navigating parenthood and managing their illness (Dolman et al., 2013). While negative experiences and poor health outcomes for their children are not inevitable (Maybery & Reupert, 2019), children of parents with mental health challenges are at an increased risk of adverse outcomes including emotional difficulties and developing a mental illness themselves (Hjen et al., 2013; Goodman et al., 2011; Maybery et al., 2009; Rasic et al., 2014; Webb et al., 2016). Therefore, it is crucial that adequate care be provided for parents and their families.

As previously described in the literature review, there are numerous support options for families where a parent has a mental illness, including organisational, community, family and individual (either to the parent or the child) approaches. The majority of research relating to parents' experiences of mental healthcare has focused on the practices of multidisciplinary teams within public rehabilitation and psychiatric settings (Dolman et al., 2013). Few studies have investigated individual approaches for parents with mental health challenges, including the approach of one-on-one counselling; this represents a large proportion of the Australian mental health sector (Australian Government Department of Health, 2019) and one of the most common and accessible mental health supports for parents in Australia.

As per section 2.4 (PhD Rationale and aims of the thesis) within this literature review chapter, the aim of this thesis is to examine the use of three different psychotherapeutic modalities with parents who have mental health challenges, from the perspectives of therapists who undertake one-on-one counselling with those parents. More specifically, the following research questions will be investigated with schema therapists, acceptance and commitment therapists and narrative therapist:

- What are the experiences of therapists using different modalities when working with parents with mental health challenges? Do therapists using different modalities, have different experiences working with parents?
- From the perspective of therapists, what elements of the various therapeutic strategies and approaches appear to respond to the needs of parents who experience mental health challenges? Are there common strategies or tools across the three modalities that therapists find work best for parents with mental health challenges? If so, what are these?
- What enablers and barriers have therapists found when working with these therapeutic modalities with parents? How do these compare between the different modalities?

Chapters 5, 6 and 7 will detail and include the studies undertaken with schema therapists, ACT therapists and narrative therapists including their insights and experiences of using each specific therapeutic modality with parents with mental health challenges. The following chapter (Chapter 4) will outline the methodology used across each study in this thesis.

Chapter 4 Methodology of Phenomenological Studies

This chapter will provide an overview of the methodology used in each study of this thesis. The use of qualitative methods in mental health research will firstly be discussed and an overview of the analysis method used in the three studies in this thesis: Interpretative Phenomenological Analysis (IPA), will be provided. Participant demographics will be outlined, as will the research procedures for the studies followed by participant information and finally a discussion of ethical considerations and research rigour.

4.1 Qualitative methods in mental health research

Both quantitative and qualitative research methodologies play a role in psychological research yet address distinct questions. Quantitative research focuses on numerical data and statistical analysis and is adept at answering questions related to the prevalence, correlations, and causality of psychological traits and behaviours (McBeath et al., 2022). Quantitative methods provide a broad, generalisable overview of patterns across large populations (McBeath et al., 2022). Conversely, qualitative research delves into the nuanced, subjective experiences of individuals, making it ideal for exploring the meanings, perspectives, and contexts behind psychological phenomena (McBeath et al., 2022). The choice of quantitative or qualitative methods for conducting the studies that comprise this thesis was driven by the research aim. As this thesis aimed to investigate the lived experiences and perceptions of therapists working with parents with mental health problems, qualitative methods were selected for the research.

The use of qualitative methods in mental health research have increased in recent years (Gough & Lyons, 2016). Within the field of psychological research, the 1970s and 1980s saw heated debates about the dominance of quantitative research (Harper & Thompson, 2011). Over time, acceptance of qualitative research and its utility has grown (Henwood et al., 1998). Qualitative methods are now routinely practiced and published in international journals and are growing in popularity for mental health research (Harper & Thompson, 2011). Qualitative methodologies can be used to investigate a range of issues related to psychology and counselling, such as understanding the lived experiences of individuals, uncovering the coping mechanisms of individuals with mental health challenges, or interpreting interpersonal dynamics within therapeutic settings (McBeath et al., 2022).

Qualitative research encompasses many different methodological practices (Gough & Lyons, 2016) such as Interpretative Phenomenological Analysis (IPA: Smith et al., 2009),

narrative analysis (Crossley 2000), psychosocial approaches (Hollway & Jefferson, 2000) and discourse analysis (Potter 2007). Across the different methodologies, there is a common interest in generating rich qualitative data and increasing understanding of social and psychological experiences and processes, rather than quantifying something (Harper & Thompson, 2011). Qualitative methods are well suited for investigating complex phenomena (Gough & Lyons, 2016) such as the views and lived experiences of mental health professionals and clients regarding treatments of mental health challenges (Salle & Flood, 2012; Silverstein et al, 2006). Thus, qualitative methods are congruent with the aim of this thesis to examine the views and experiences of mental health professionals, specifically therapists, when working with parental mental illness.

4.2 Introduction to Phenomenological methodology

All three studies were conducted within a Phenomenological Analysis (IPA) framework. IPA is a type of qualitative analysis that requires researchers to draw on their own understanding of the participants' experience as part of the analysis (Smith & Shinebourne, 2012). IPA was chosen as it allows for in-depth exploration of participants' subjective and unique lived experiences and derives meaning from how these experiences are expressed by participants which was ideal to explore therapists' views and experiences of conducting therapy with parents (Eatough & Smith, 2007; Hammarberg et al., 2016; Lincoln & Denzin, 1998; Peat et al., 2019; Smith et al., 2009). IPA draws on the theoretical underpinnings of phenomenology, hermeneutics, and idiography, which are outlined below.

Phenomenology

Phenomenology is a philosophical movement focused on lived experiences (Husserl, 1983). Phenomenological psychology is concerned with an individual's account of an event or object, rather than an objective statement of the event or object itself (Smith, 1996). When developing IPA, Smith (1996) drew on the works of phenomenologists to create IPA analysis, which is designed to examine participants' experiences and how they view their experiences (Peat et al., 2019; Smith et al., 2011).

Hermeneutics

Hermeneutics is a theory of interpretation that also underpins IPA methodology (Smith, Flowers & Larkin, 2009). More specifically, it has been posited that IPA is founded on *hermeneutics of understanding* referring to a form of hermeneutics which seeks to interpret how participants understand phenomena through their own unique, subjective

experiences (Davidsen, 2013). By contrast, other forms of hermeneutics seek to interpret phenomena from a specific theoretical perspective such as feminism or psychodynamic theory (Davidsen, 2013). Hermeneutics is used in many areas of psychological research as most psychological processes cannot be directly observed, but rather can only be related through participants' subjective accounts of their experiences and views, which requires a process of interpretation by the researcher. Thus, IPA is strongly underpinned by hermeneutics as it centres around participants describing their experiences which then requires a process of engagement and interpretation of the data from the researcher (Smith, 2011).

Idiography

IPA is ideographic, meaning it focuses on an in-depth investigation of single cases, rather than seeking to identify norms across populations (Smith, Jarman & Osborn, 1999). Idiography can be seen utilised within an IPA framework as it is considered applicable for corpus analysis of single case investigations (Smith, Jarman & Osborn, 1999). Additionally, IPA has been recommended for studies of up to approximately ten participants (Smith, 2004; Smith, Flowers & Larkin, 2009). IPA research involves an in-depth exploration and analysis of each participant case, before attempting to identify commonalities across the sample (Smith, 2004). In the later phase of the analysis, high-quality IPA studies include a search for patterns across the cases, including areas of convergence or divergence between cases, which may eventually form a theme (Smith, 2011).

4.3 Interpretative Phenomenological Analysis (IPA)

IPA is a relatively recently developed form of qualitative inquiry (Smith, 1996) which has rapidly become one of the most commonly used and well-known qualitative methodologies for psychological research (Hammarberg et al., 2016; Lincoln & Denzin, 1998; Peat et al., 2019; Smith et al., 2009; Smith, 2011). IPA aims to examine participants' lived experience, and how they make sense of, and give meaning to, any given experience (Smith et al., 2009). It involves an intensive qualitative analysis of participants' personal accounts (Peat et al., 2019). Most commonly, semi-structured interviews are the data collection method used for IPA analysis (Larkin et al., 2008). Participant interviews are audio-recorded and transcribed verbatim before being analysed. Due to the intensity and in-depth nature of each interview case, IPA studies usually involve relatively small sample sizes (Smith, 2011).

There is a substantial body of research in psychological settings using IPA methods (Smith, 2011). IPA has been used in a range of subject areas including clients' illness experiences, carers' experience, clients' experience of therapy and health professionals' experience of delivering therapy (Smith, 2011). IPA research has been growing exponentially and has appeared in many academic outputs including peer-reviewed journal articles, postgraduate theses, and books (Smith, 2011).

Guidelines to assess the quality of IPA studies have been developed (Smith, 2011). The guidelines aim to assist readers to judge the quality of a paper reporting in an IPA study and include three quality levels - good, acceptable, and unacceptable, alongside criteria for determining each level. These guidelines were written by the creator of IPA, who designed the quality assessment system by reviewing IPA literature on illness experiences (Smith, 2011). The guidelines further outline what makes a good IPA paper, and prior to and throughout the IPA analysis conducted in this thesis, the guidelines (Smith, 2011) for assessing IPA quality were consulted and influenced how the research was gathered and analysed.

According to the guidelines, high-quality IPA studies utilise researcher skills including interviewing, rigour, and critical interpretation of the data (Willing & Rogers, 2017; Smith, 2011). Each interview transcript in this thesis was coded by identifying and highlighting key words or short phrases that captured salient information relevant to the research questions (Saldaña, 2013). The codes were then grouped under key themes, through a process of collaborative discussions amongst the researchers and numerous consultations of the interview data, including re-reading interview transcripts, codes, and relistening to the interview audio. In the write up of the results (see Chapters 4, 5 and 6), the key themes were organised to represent the narrative of the data set, including extracts from participant interviews. The extracts selected represent the essence of each theme.

The analysis and coding process of the interview data were undertaken by at least two and often three researchers, for each study. Throughout the process, bracketing occurred, which involved setting aside the researchers' own experiences and preconceptions in order to fully engage with and understand participants' perspectives (Zahavi, 2019). Bracketing is crucial for maintaining the integrity and authenticity of the participant's lived experiences as interpreted by the researchers. It involved the researchers firstly acknowledging their own biases, beliefs, and assumptions about the research topic. It further involved engaging in reflexivity where the researchers continuously reflect on their own impact on the research process (Zahavi, 2019). The primary researcher, the PhD candidate, demonstrated bracketing

through keeping an interview journal to document experiences and views of conducting each interview, to later consult during the analysis stage to prevent possible biases effecting the analysis. An excerpt from the research journal can be found in Appendix A.

Further, the primary researcher engaged in collaborative discussions within regular supervision sessions regarding the quality and interpretation of interview data throughout writing the thesis. All researchers remained mindful of possible biases and influences throughout the IPA process and accepted and acknowledged the limitations of their knowledge. Further, collaborative discussion regarding the coding and grouping of codes into themes occurred between the researchers for each study in the thesis. Despite these bracketing efforts, it is also worth acknowledging that complete objectivity is unattainable, and that the researchers' subjectivity inevitably influences the research design and all decision making throughout the research process (Tuffour, 2017). Whilst the researchers put in measures to minimise biases, a level of subjectivity was also embraced as an integral part of the research process, which could enrich the interpretation and understanding of the data (Tuffour, 2017).

IPA guidelines outline that strongly rated papers have a clear focus, high-quality data, and have sufficient detail when presenting and elaborating on each theme, rather than discussing the themes superficially (Smith et al., 2009). IPA studies should be rigorous and rather than simply describing the data obtained, researchers should be critical and analytical when working with the data (Smith et al., 2009). The analysis should be both convergent and divergent, meaning the analysis will not only point to shared themes expressed by individuals, but also present the particular way in which these themes play out for individuals, and how these may differ between individuals (Larkin et al., 2008). Therefore, researchers need to demonstrate patterns of similarity among participants as well as identify the unique experiences of participants, in studies with a sample greater than one. Throughout the studies presented in this thesis, the analysis of data were both convergent and divergent and differences among participants in relation to their experiences of using the different therapeutic modalities is discussed in the papers as relevant.

4.4 Procedure

The section below provides an overview and justification of procedures. Further information about the specific procedures employed in each study are provided in the following chapters (Chapter 4, 5, and 6). Procedures were approved by the Monash

University Human Research Ethics Committee prior to beginning the research (See Appendix B for ethics approval).

4.4.1 Recruitment and Sampling

Convenience and purposeful sampling approaches were used for all studies. Participants were recruited on the basis of specific criteria relevant to the research question (whether they were schema therapists, narrative therapists or acceptance and commitment therapists) (Patton, 2015). Snowball sampling methods were used, which involves participants promoting the study through their own networks (Biernacki & Waldorf, 1981). IPA research is well suited to purposive and snowball sampling as these methods target participants who can offer specific, relevant insight into a particular phenomenon (Smith et al., 2009). Recruitment involved posting a notice in professional social media forums and professional therapist groups (Schema Therapist, ACT and Narrative Therapist groups respectively for each study) which included a link to an online survey hosted on Qualtrics. The suitability for participation in each study was determined based on responses to the online survey by screening out people who did not have years of experience practicing either Schema therapy (ST), Acceptance and Commitment therapy (ACT) or Narrative therapy (NT), with parents with mental health challenges. Eligible participants where then emailed to organise a time for the interview.

4.4.2 Data Collection

The data collection procedure for studies 1, 2 and 3 were the same. All potential participants were invited to complete a short online survey, hosted on Qualtrics, which collected consent, demographic information including age and gender, and the contact details of potential participants. Participants were sent via email the explanatory statement (Appendix C) and the interview schedule (Appendix D) prior to the interview.

Data were collected for all studies through semi-structured interviews. The semi-structured interviews involved asking a limited number of core questions from an interview schedule; however, it is not followed prescriptively (See Appendix D for the interview schedules developed for this thesis) (Olsen, 2016). The interview schedules used were shown to at least two experts in the field who provided feedback on the core questions, which were then adjusted in the final interview schedule used in interviews. During each interview, the interviewer probed for further details where relevant, by asking additional questions beyond those on the interview schedule. All additional probes and questions asked were relevant to

the discussion and concerned key topics, providing participants with opportunities to elaborate on areas that they deemed important (Englander, 2012). Not only are semi-structured interviews helpful for flexibly obtaining information about key issues, but they are also an ideal method for collecting data in IPA studies (Smith, Jarman & Osborn, 1999; Smith, 2004) because they allow for in-depth exploration of participants' personal experiences and meanings, providing rich, detailed insights that align with the interpretative and phenomenological focus of IPA.

During the interviews with schema therapists, ACT therapists and narrative therapists, participants provided information about their personal experiences and views about working therapeutically with clients who are parents. For the most part, participants readily described their experiences in sessions and voiced their opinions about the therapeutic modality they practiced. In some instances, participants did not know how to respond to a question, which they then voiced by saying, for example, “I haven't considered this before,” or “I wouldn’t be able to answer that question right now.”

All interviews across study 1, 2 and 3 were conducted via the Zoom video conferencing platform. This enabled participants from all around Australia to take part in the research. Many of the participants joined the Zoom meeting for their interview from their work office over a lunch break, or during an hour break between seeing clients. The use of Zoom interviews was considered well-suited to the participants in this study who were located across a large geographical area and were busy working professionals (Hiselberg & Stępińska, 2023). Zoom has been posited as a feasible communication method for the collection of qualitative health research due to its ease of use and cost-effectiveness (Archibald et al., 2019). However, research has also highlighted challenges associated with using Zoom to conduct qualitative research including participants experiencing technical difficulties (Archibald et al., 2019), and difficulty building rapport and taking turns speaking (Hiselberg & Stępińska, 2023). Nonetheless, no participants across the studies noted any difficulty accessing Zoom for the interview. This may be attributed to the professional nature of participants recruited many of whom would have had experience using Zoom or similar software for tele-health appointments and supervision during the COVID-19 pandemic. Further, measures were put in place to overcome challenges with using Zoom for qualitative research including building rapport and taking turns speaking (Hiselberg & Stępińska, 2023). For example, prior to each interview starting, the interviewer and participants engaged in small talk over Zoom for approximately five minutes to build rapport (Hiselberg & Stępińska, 2023). Additionally, the interviewer played an active role in taking turns speaking with the

participants by waiting for silences and asking clarifying questions to ensure the participant did not have anything else they wished to add, before moving onto the next question.

Notes were taken throughout each interview to record notable facial expressions, long pauses and other non-verbal cues that were important for interpreting the data. The research journal was written in at the conclusion of each interview to capture the interviewer's feelings and perceptions of conducting the interview with the particular participant. Prior to analysis of the data, the research journal entry for the participant was read and reflected upon to remind myself the feelings and reflections I had during the interview, to ensure I had a critical awareness of my own emotional responses and perceptions of the interview data. A sample journal entry completed after interviewing a participant can be found in Appendix A.

Interviews were audio-recorded using Zoom software with participant consent. The audio recordings were then transcribed using an automatic intelligence service (Otter.ai). The transcripts were then cross checked with the audio-recording by the researcher, to check they were verbatim and to ensure personal and identifiable information was removed from the transcripts. Member checking occurred, which involved returning the interview data in the form of a transcript to the participant who gave the interview, to seek their feedback on and/or confirmation of the data they provided (Lincoln & Guba, 1985). Further, participants were given the opportunity to add or remove information, although across the three studies, no participants made any amendments to their transcripts. The approved transcripts were used as the data for the research which were analysed according to IPA guidelines.

4.5 Participants

Participants self-identified as either a schema therapist, ACT therapist or narrative therapist when they completed the short online survey. In this survey, demographic information was collected from participants including their age, gender, state and whether they lived in an urban/suburban, regional, or rural location. Participants were also asked to specify their profession, with options including psychologists, social workers and occupational therapists. Data were collected on participants' experience level practicing either schema therapy, ACT, or narrative therapy, as measured by number of years practicing the modality. Additionally, parenting status of the schema therapist participants was also gathered to explore the potential influence of being both a therapist and a parent on their therapeutic work with clients who are parents. The following sections further presents participants demographic information from each study.

Study 1: Schema Therapist Study

Mental health professionals with experience of practicing schema therapy (referred to as schema therapists in this thesis) in Australia were targeted for Study 1. Thirteen Schema therapists from across Australia were recruited for Study 1 (two males, eleven females). In order to practice schema therapy, therapists much undertake schema therapy training certification and data were collected on schema therapists' certification status from the online survey. Various levels of certification can be achieved by therapists through the International Society of Schema Therapy (ISST), starting with the Standard Schema Therapy Practitioner Certification (Standard) and advancing to the Advanced Schema Therapy Practitioner Certification (Advanced), with each level requiring progressively more training, supervision, and demonstrated competence in applying schema therapy techniques (ISST; 2024). Participant self-reported demographic information is provided in Table 4.1 and in Chapter 4 in the paper on schema therapists.

Table 4.1

Schema Therapy Participants' Self-Reported Demographic Information

Pseudonym	Gender	State and area	Profession	Certification Status	Years practicing schema therapy	Parenting status
P1	Female	ACT – Urban/suburban	Psychologist	Advanced, Couples	10	Yes
P2	Female	ACT - Urban/suburban	Psychologist	Undertaking Standard	2	Yes
P3	Female	QLD - Urban/suburban	Psychologist	Undertaking Standard	7	Yes
P4	Male	ACT - Urban/suburban	Psychologist	Undertaking Standard	5	No
P5	Female	ACT - Urban/suburban	Psychologist	Undertaking Standard	3	No
P6	Female	VIC - Urban/suburban	Psychologist	Undertaking Standard	1	No
P7	Female	VIC - Urban/suburban	Psychologist	Undertaking Standard	3	Yes
P8	Female	ACT - Urban/suburban	Psychologist	Undertaking Standard	2	Yes

P9 -	Female	VIC - Urban/suburban	Occupational therapist	Not undertaking certification	6	Yes
P10	Male	ACT - Urban/suburban	Psychologist	Not undertaking certification	3	Yes
P11	Female	VIC - Urban/suburban	Psychologist	Advanced	6	No
P12	Female	VIC - Urban/suburban	Psychologist	Advanced	4	Yes
P13	Female	QLD - Urban/suburban	Psychologist	Advanced	10	Yes

Study 2: Acceptance and Commitment Therapist Study

Mental health therapists who use an ACT framework (referred to as ACT therapists in this thesis) in Australia were targeted for Study 2. Nine ACT therapists from across Australia were recruited for Study 2 (three males, six females). Unlike schema therapists, ACT therapists do not require formal ACT certification to practice, and most are trained through undertaking workshops, courses, or supervision from experienced ACT practitioners in addition to their professional training (such as in psychology). More detail about participants is provided in Chapter 5 and participant demographics can be found in table below and in the paper on ACT therapists.

Table 4.2

Acceptance and Commitment Therapy Participants' Self-Reported Demographic Information

Pseudonym	Gender	State and area	Profession	Years practicing ACT	Parenting status
P1	Female	SA - Rural	Mental Health Social Worker	13	Yes
P2	Male	VIC - Urban/suburban	Psychologist	8	Yes
P3	Female	VIC - Urban/suburban	Psychologist	5	Yes
P4	Male	ACT - Urban/suburban	Psychologist	15	Yes

P5	Male	VIC - Urban/suburban	Psychologist	3	No
P6	Female	VIC - Urban/suburban	Psychologist	16	Yes
P7	Female	VIC - Regional	Psychologist	6	Yes
P8	Female	NSW- Urban/suburban	Psychologist	2	Yes
P9 -	Female	VIC - Urban/suburban	Psychologist	6	Yes

Study 3: Narrative Therapist Study

Mental health therapists who primarily practice within a Narrative Therapy framework (referred to as narrative therapists in this thesis) in Australia were targeted for Study 3. Six narrative therapists across Australia were recruited for Study 3, all of whom were female. Narrative therapists do not need a specific narrative therapy certification to practice, but have gained expertise through workshops, supervision and through professional training programs. More detail about participants is provided in the table below and in Chapter 6 in the paper on narrative therapists.

Table 4.3

Narrative Therapy Participants' Self-Reported Demographic Information

Pseudonym	Gender	State and area	Profession	Years practicing NT	Parenting status
P1	Female	NT - Regional	Psychologist	9	Yes
P2	Female	VIC - Urban/suburban	Psychologist	28	Yes
P3	Female	VIC - Urban/suburban	Psychologist	1	Yes
P4	Female	QLD - Rural	Counsellor	6	Yes
P5	Female	QLD - Urban/suburban	Psychologist	16	No

P6	Female	VIC - Urban/suburban	Social Worker	3	No

4.6 Ethical Considerations

All participants were provided with an explanatory statement, which outlined the nature of the research, and any risks involved (See Appendix C for the explanatory statements for each study). The explanatory statement also informed participants of the limits of confidentiality including how group findings will be reported as part of the student researchers' thesis and that findings may also be submitted for publication, but individual participants will not be identifiable in any such publications. The statement also noted how and where the collected data will be stored. Written consent was obtained from participants of all studies via online surveys, which included the explanatory statements. Prior to starting interviews, verbal consent to being audio recorded was obtained. All identifying information from participants' transcripts were removed, and participants were de-identified by being assigned a number to be referred to (i.e., Participant 1). Member checking also occurred with participants given the opportunity to read through their transcripts and make amendments, which ensured participants had control over their research contributions. All three studies were categorised as "low risk" as the subject matter of therapists' professional experiences was considered a non-sensitive topic and very unlikely to cause of harm to participants.

Chapter 5 - What are Schema Therapists' experiences and perceptions of working with parents with a mental illness

5.1 Background

This chapter presents the first of the three studies included in this thesis. The study was submitted to *Australian Counselling Journal* on September 7, 2023, and has been accepted for publication. The study addresses important gaps in the literature about the experiences and perspectives of schema therapists working with parents with mental health challenges. Previous literature supports the effectiveness of schema therapy with diagnostic groups such as personality disorders, obsessive-compulsive disorder, chronic depression and anxiety and post-traumatic stress disorder (Legra & Verhey, 2017; Khasho et al., 2019; Videler et al., 2018). However, there is a paucity of research related to the use of schema therapy across other demographic groups such as cross-cultural groups and parents with a mental illness. Given the focus that schema therapy has on developing self-parenting skills and addressing unmet childhood core emotional needs, it is valuable to examine its use with parents who have mental health challenges.

5.2 Aim of the Study

The aim of this study was to examine the views and experiences of therapists who practice schema therapy with parents. Specifically, the following research questions were investigated:

- What are the experiences of schema therapists when working with parents?
- How do schema therapists perceive the effectiveness of schema therapy in meeting the needs of parents?
- What are the enablers and barriers that therapists have found using schema therapy when working with parents?

5.3 Relevance of the Study

Workforce development planning should take into consideration the challenges and strengths of therapeutic modalities for working with different population groups. An understanding of therapists' experiences using schema therapy to work with parents who have mental health issues, including aspects that they find challenging and how they manage

these challenges, can be used to enhance future initiatives (such as training and supervision efforts) and practice with parents.

5.4 Declaration of Contribution

The following tables outline the contributions of the candidate (Table 5.1) and the other authors (Table 5.2) to the published study presented in Chapter 5.

Table 5.1

The Candidate's Contribution to the Study in Chapter 5

Nature of Contribution	Extent of Contribution (%)
Study conceptualisation and design	70%
Participant recruitment	50%
Data collection, recording and transcription	80%
Analysis and interpretation of results	70%
Preparation of manuscript	90%

Table 5.2

The Contribution of the Other Authors to the Study in Chapter 5

Name	Nature of contribution	Extend of contribution (%) for student co-authors only
Dr Phillip Tchernegovski	Led the study conceptualisation and design, assisted with participant recruitment, data collection, recording and transcription. Further, was involved in the analysis and interpretation of results and provided feedback on the manuscript.	20%
Prof Andrea Reupert	Provided feedback on the manuscript.	5%
Dr Rochelle Hine	Provided feedback on the manuscript.	5%

5.5 Declaration of Ethical Compliance

Ethics approval. Ethics approval was first obtained from Monash University Human Ethics Committee (Project Number: 26573).

Informed consent. Informed consent of all participants was obtained prior to participating in this study, including consent for publication.

Conflict of interest. The authors declare we have no conflicts of interest to disclose.

Paper as accepted by the Australian Counselling journal:

Peer review

Head: Schema therapy and parenting with mental illness

Conflict of interest statement: We have no conflicts of interest to disclose. We confirm that this work is original and has not been published elsewhere, nor is it currently under consideration for publication elsewhere.

Byline: By Ciara Hart

Tags: schema therapy

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Abstract

A core aim of schema therapy is to teach people how to identify their underlying emotional needs and care for themselves like a parent would. Semi-structured interviews were conducted with 13 schema therapists from Australia. Interviews focused on therapists' views and experiences when working with clients who are parents. Transcripts were analysed within an interpretative phenomenological analysis framework to examine participants' perspectives and personal reactions to their professional work with parents. The following 3 findings were identified:

- Schema therapy can be used to increase understanding of one's behaviour related to parenting and builds self-compassion.
- There are parallels between meeting parents' needs and meeting their children's needs.
- There is a need for a systemic focus that encompasses family dynamics.

The findings suggest that schema therapy can be used as a tool to facilitate discussions around parenting while simultaneously addressing the mental health needs of parents.

Schema therapy and parenting with mental illness

1. Introduction

1.1 Background

In Australia, approximately one in five families have at least one parent who has (or has had) a mental illness (Maybery et al., 2009). Although many of these parents adaptively cope in their parenting role (Falkov et al., 2012), for others, mental illness may adversely impact parenting, leading to negative outcomes for children, especially if there is limited appropriate support for the family (Reupert et al., 2015). Parents may find it difficult to balance the demands of parenting while simultaneously looking after their own mental health and recovery needs (Carpenter-Song et al., 2014; Tabak et al., 2016). Fluctuations of severe mental illness can periodically reduce parenting capability (Venkataraman & Ackerson, 2008), making it difficult to consistently attend to the physical and emotional needs of children (Marston et al., 2016; Tabak et al., 2016). Parents report experiencing self-blame and shame, and some may be fearful of the involvement of child protective services (Halsa, 2018). Accordingly, many parents are reluctant to seek help for parenting issues (Halsa, 2018) and may conceal challenges.

Without adequate support, children of parents with a mental illness have an increased risk of developing their own psychological difficulties (Leijdesdorff et al., 2017). To illustrate, children of parents with a severe mental illness (SMI, mostly defined as schizophrenia, major depressive disorder, bipolar disorder or severe borderline personality disorder) have a 50% chance of developing any mental illness (Rasic et al., 2014). Additionally, children of parents with an SMI have a 32% chance of developing an SMI themselves (Rasic et al., 2014). Both environmental and genetic factors play a role in this heightened risk (Reupert & Maybery, 2016; Yung, 2007).

There are limited therapeutic treatments that target both parenting and mental illness simultaneously (Phelan et al., 2012; Zimmer-Gembeck et al., 2021). Nonetheless, parents with a mental illness want their parenting role recognised and supported (Jones et al., 2016). Providing psychological treatment for parents that incorporates support for their parenting roles and responsibilities plays a preventative role for children (Reiss, 2008; Solantaus et al., 2010). Research into the Let's Talk about Children program, a family-focused intervention that promotes parent, family and child wellbeing (Solantaus & Toikka, 2006), highlights how working with parents can decrease negative outcomes and increase protective factors in

children (Allchin & Solantaus, 2022). Therefore, as transgenerational mental illness may be prevented through supporting clients' parenting roles (Allchin & Solantaus, 2022; Reiss, 2008; Solantaus et al., 2010), there is arguably a need for additional therapeutic interventions that address clients' parenting skills as well as provide them with mental health support.

Schema therapy is one therapeutic approach that may be beneficial for attending to parental mental illness. It is a developmentally oriented therapy that emphasises the importance of meeting core emotional needs during childhood (Young et al., 2003). Within this therapy, psychological problems are conceptualised as maladaptive responses to not having emotional needs met in childhood that continue into adulthood (Farrell et al., 2014). The aim is to teach people how to identify their underlying emotional needs and care for themselves when these needs are not being met, as an attuned or 'good' parent would. Thus, schema therapy develops skills that are necessary for being an engaged and responsive parent figure for oneself. These self-parenting skills are promoted in the context of self-growth and not the context of direct parenting of children (Young et al., 2003). Research is needed to examine whether this therapeutic approach may also assist parents with a mental illness to meet the emotional needs of their children.

Early maladaptive schemas (EMS) can be defined as the beliefs we hold about ourselves, others and the world that result from interactions of unmet core childhood needs, early environment and innate temperament (Farrell et al., 2014; Young et al., 2003). EMS help children make sense of their early life experiences; however, when EMS are carried into adulthood, they can become problematic, inaccurate and limiting. When EMS are activated, intense emotional, cognitive and behavioural states, which are referred to as modes, can be triggered (Farrell et al., 2014; Young et al., 2003). Schema therapists may use drawings to depict a client's modes associated with a current problem or situation in session, in a technique called mode mapping (Simeone-DiFrancesco, 2015).

The 4 basic categories of schema modes are:

- innate child modes
- dysfunctional critic modes
- maladaptive coping modes
- healthy modes (Farrell et al., 2014).

Innate child modes are characterised by intense negative emotions and urges that were felt in childhood or early adolescence and are activated by schemas (Young et al., 2003). Dysfunctional critic modes encompass a negative internalised parental 'voice' and reflect aspects of inattentive or critical attachment figures (e.g. parents, teachers, etc.) during childhood and adolescence (Young et al., 2003). Maladaptive coping modes refer to parts of the self that overuse unhealthy coping styles to dampen the felt distress of innate child modes (Young et al., 2003). Healthy modes can help regulate and counter the effects of other modes (Young et al., 2003) and are broken down into the healthy adult mode and happy child mode. The healthy adult mode is characterised by functional thoughts and behaviours and is the part of the self that is capable, strong and well-functioning in adult life (Young et al., 2003). The researchers of this study were curious about whether strengthening the healthy adult mode would have a positive influence on parenting.

Schema therapy is driven by an overarching principle of limited reparenting (Young et al., 2010). Limited reparenting involves the therapist taking on a 'parental role' with the client, to help meet unmet core needs (Farrell et al., 2014). In providing limiting reparenting, the therapist starts by providing co-regulation support to the client, while demonstrating the healthy adult mode, until the client has developed their own healthy adult enough to take on this role for themselves (Young et al., 2003).

Studies have investigated the benefits of schema therapy with diagnostic groups such as personality disorders, obsessive-compulsive disorder, chronic depression and anxiety and post-traumatic stress disorder (Khasho et al., 2019; Legra & Verhey, 2017; Videler et al., 2018). However, there is a paucity of research related to the use of schema therapy across other demographic groups such as cross-cultural groups, populations with diverse genders and sexualities and parents with a mental illness. Given the focus that schema therapy has on developing self-parenting skills and addressing unmet childhood core emotional needs, it is valuable to examine its use with parents who have a mental illness.

1.2 Research objectives

Given the current lack of evidence in this area, this study was exploratory and sought to examine the views and experiences of practitioners who practice schema therapy with parents. Specifically, the study aimed to explore schema therapists' views regarding how schema therapy did and did not meet the needs of parents, as well as any adaptations they had made to the therapy when working with parents (if at all).

2. Methods

Ethics approval was first obtained from [redacted for peer review] Human Ethics Committee (Project Number: 34615).

2.1 Participants

Participants (n = 13) were all schema therapists practicing in Australia (advanced certification = 4, currently undergoing standard certification = 7, not certified = 2). Participants were recruited via emails sent to Australian members of the International Society of Schema Therapy and a post made on the Schema Therapy Institute Australia Facebook page. To be included in the study, therapists had to be practicing schema therapy with clients who were parents. One participant did not specify their age. The mean age of the other 12 participants was 43.75 (SD = 9.69, range = 32). The mean years of experience practicing schema therapy was 4.69 years (SD = 3.01, range = 9 years). With the exception of one occupational therapist, the participants were all psychologists. They were located in urban/suburban areas of ACT, Victoria and Queensland.

Table 1

Participants' Self-Reported Demographic Information

Pseudonym	Gender	State and area	Profession	Certification status	Years practicing schema therapy	Parent or guardian
P1	Female	ACT – Urban/suburban	Psychologist	Advanced, Couples	10	Yes
P2	Female	ACT – Urban/suburban	Psychologist	Undertaking standard	2	Yes
P3	Female	Qld – Urban/suburban	Psychologist	Undertaking standard	7	Yes
P4	Male	ACT – Urban/suburban	Psychologist	Undertaking standard	5	No

P5	Female	ACT – Urban/sub urban	Psychologist	Undertaking standard	3	No
P6	Female	Vic – Urban/sub urban	Psychologist	Undertaking standard	1	No
P7	Female	Vic – Urban/sub urban	Psychologist	Undertaking standard	3	Yes
P8	Female	ACT – Urban/sub urban	Psychologist	Undertaking standard	2	Yes
P9 -	Female	Vic – Urban/sub urban	Occupational therapist	Not undertaking certification	6	Yes
P10	Male	ACT – Urban/sub urban	Psychologist	Not undertaking certification	3	Yes
P11	Female	Vic – Urban/sub urban	Psychologist	Advanced	6	No
P12	Female	Vic – Urban/sub urban	Psychologist	Advanced	4	Yes
P13	Female	Qld – Urban/sub urban	Psychologist	Advanced	10	Yes

2.2 Procedure

The recruitment email and Facebook post directed potential participants to an online survey where they were provided with information about the study, indicated their consent and provided their demographic and contact details. Sixteen responses were received. Respondents were then contacted by email to arrange an interview time; however, 3 respondents did not reply.

Semi-structured interviews were conducted via the Zoom video conferencing platform. Interview lengths ranged from 19 minutes to 53 minutes, averaging 32 minutes. With permission from participants, all interviews were recorded and subsequently transcribed using Otter.ai transcribing software. The accuracy of the transcriptions was checked, and personal information was removed from participants' transcripts. These were then emailed to the participants, who were given the opportunity to add or remove incorrect or potentially identifiable information. No participants requested changes to their transcripts.

2.3 Interview

The semi-structured interview schedule was created by the researchers specifically for this study. It consisted of 5 open-ended questions designed to examine schema therapists' experiences when working with parents. Open-ended questions were followed up with additional probing questions, as needed, to obtain more detail. For example, participants were asked: 'What have your experiences been like of using schema therapy with parents with a mental illness?' and 'Do you think that the schema therapy model is relevant to the experiences of clients who are parents? Why/Why not?' The interview schedule, which can be found in Appendix A, was reviewed by 2 practicing schema therapists, who approved it without suggesting any changes.

2.4 Analysis

Interview data were analysed using interpretative phenomenological analysis (IPA). This methodology, which examines participants' experiences and perspectives of phenomena (Smith et al., 2009), was aligned with the aim of the study, which was to explore schema therapists' experiences when working with parents with a mental illness. Following IPA guidelines, each transcript was coded by identifying and highlighting key words or short phrases that captured salient information relevant to the research questions (Saldaña, 2015). The codes were revised multiple times and then used to identify key themes relating to the research aim. Double coding of each transcript also occurred, with all transcripts analysed by the first author, in addition to a separate analysis of 4 transcripts undertaken by the second author. The remaining 9 transcripts were double coded by the third author. Differences in coding were discussed and managed by further reviewing the transcripts. Throughout the study, the first 3 authors also engaged in reflective conversations about possible interpretations of the interview data and themes.

2.5 Reflexivity statement

The first author has lived experience of growing up with a parent who suffered from mental illness. She has also practiced as a provisional psychologist in a Master of Educational and Developmental Psychology degree in Australia. The author drew on these experiences to understand and interpret the interview data. However, in accordance with IPA practices of intersubjective reflexivity (Eatough & Smith, 2008), this author regularly clarified her understanding of participants' meanings throughout the interviews and engaged in interrogative self-reflection after each interview, taking notes of thoughts and emotions that might have influenced the research process.

The second author is a qualified psychologist, an experienced schema therapist and experienced researcher into mental health professionals' experiences and families where parents have mental illness. The third author, also a qualified psychologist, is an academic professor with specialist research experience in families where parents experience mental illness. The fourth author is a social worker and an experienced mental health professional and academic with clinical and research experience in families with parental mental illness.

3. Results

The analysis resulted in 3 findings being identified: schema therapy can be used to increase understanding of one's parenting behaviour; there are parallels between meeting parents' needs and meeting their children's needs; and there is a need for a systemic focus that encompasses family dynamics. These findings are described below with exemplars from interviews. Participants are tagged using codes from Table 1 (e.g. P1, P2).

3.1 Schema therapy can be used to increase understanding of one's parenting behaviour

Participants indicated that schema therapy helped their clients develop understanding in a range of areas relating to their parenting. These included 'what mode their child [was] in … why they're clashing with their children' (P1), how 'coping styles shaped [their] parenting practices' (P5) and 'the core needs' of their children. P5 observed, 'Building that historical contextual perspective has really helped people understand how they relate to their own kids.'

Seven participants commented that schema therapy helped clients recognise transgenerational parenting patterns and 'to relate [these to] their own parenting style'. In particular, schema therapy '[brought] to mind [clients'] own experiences of being parented' and helped them realise that their 'critical voices' were often 'echoes of their parents', which were then negatively impacting their own parenting (P10). According to P8, schema therapy also 'help[ed] them see the pattern' of negative parenting styles and mental illness that

extended across previous generations, rather than originating with them. Six participants suggested that a recognition of this history offered 'the opportunity for [parents] to actually be able to correct intergenerational trauma' (P13). It provided an opportunity to do 'the opposite' (P8), 'parent differently' (P3) 'so that they don't "monkey see, monkey do" and continue the cycle' (P12).

While many of the participants did not give clear details about how schema therapy in its standardised form achieved this increased understanding of intergenerational and parenting issues, 3 participants described adaptations they used to emphasise family systems and build intergenerational understanding within their schema therapy practice. P7 worked with clients to identify schemas held by their parents and what it 'would look like for their children' if the same schemas were passed on to them. P4 created mode maps with clients that also included modes of their children. P9 regularly referred to the 'healthy adult mode' of a client's partner to emphasise that this mode was 'her ally' and that she was not parenting alone, and even included the partner's healthy adult mode on the client's mode map.

Participants noted that an increased understanding of the transgenerational nature of schemas and modes was painful for many parents. Three participants commented that many parents felt 'guilt … or the shame' (P2) when they 'realise[d] that [they] [hadn't] been meeting [their] child's needs' (P13) and that their maladaptive modes and schemas were being passed on to them. P2 reflected on sessions where parents had 'that "aha" moment of "I'm doing this aspect of parenting that didn't work, that hurt me. And now I'm putting it on my kids".' Similarly, P7 described parents 'feeling a sense of guilt for the way that their modes or schemas ... impact their kids'. Alternatively, P13 suggested that an understanding of intergenerational patterns also 'gives you clear targets for what to hope to address as a parent' and can be used to prompt hope for change.

When awareness of these intergenerational and parenting issues was framed as an opportunity for change, parents developed greater 'empathy for themselves' (P1) and 'self-compassion' (P3). P2 reflected that self-compassionate understanding reduces parents' stress and high expectations of themselves, so that they are more able to attend to what their child needs and are also more compassionate towards their child (P2). Additionally, schema therapy was seen as an opportunity to 'change ... what happens for [the clients'] own children' (P3) as parents recognised transgenerational schemas and modes.

3.2 There are parallels between meeting parents' needs and meeting their children's needs

Five participants highlighted how schema therapy can provide a dual focus for parents, on meeting both the needs of their child and their own needs, by accessing their own vulnerable child mode. P2 highlighted this when she said, 'There is this beautiful parallel process of meeting those unmet needs … growing up your own healthy adult, which then enables that parent to have an embodied experience about how to meet their own child's needs.'

Participants described techniques to achieve this. P3 prompted clients to reconsider their relationship with their vulnerable child mode by making comparisons to how they respond to their child if they are upset. She described using 'an example of if this was a biological child at age 7 … how would we respond to them?' This helped address issues when a client '[could] see the vulnerability in the biological child, but they [couldn't] necessarily see it in themselves'. Similarly, P5 asked parents to identify criticisms that they regularly made of themselves and then direct those criticisms to photographs of their children. This helped clients recognise that these criticisms were inappropriate and harmful to their vulnerable child mode.

> We're ... going to use those messages and say, what does it feel like to actually say to your child when they make a mistake: 'hey you're pathetic', 'you're stupid' … I suspect he will be horrified by that. (P5)

An adaptation of limited reparenting was discussed by 2 participants, which was referred to as 'limited re-grandparenting' (P1). This was when participants assisted parents to develop their healthy adult mode in order to attend to the needs of their vulnerable child mode so that they could be available to meet the emotional needs of their children. Importantly, this method of working with parents had been informed by participants' previous training and experience in systemic practices, rather than purely from the schema therapy framework.

Six participants echoed the importance of strengthening clients' healthy adult mode to promote good parenting of themselves and their children. P4 noted that when working with parents, schema therapists want to 'build up … the healthy adult', who 'can take a step back and deal with' challenging situations with children. Likewise, P10 described how growing one's healthy adult mode through schema therapy helps parents to 'learn how to handle

[confrontation] better' with their children. P8 summarised the importance of the healthy adult mode by stating 'good parenting comes from healthy adult space', while P9 stated 'to be an effective parent needs strong, healthy adult modes'.

3.3 There is a need for a systemic focus that encompasses family dynamics

Despite their varying descriptions of how schema therapy was used to meet the specific needs of parents and their children, participants commonly explained how they applied standard schema therapy techniques, without acknowledging parenting-specific considerations. Four participants described that they were 'not sure' how to adapt aspects of schema therapy to meet the needs of parents, in addition to P13, who said that they '[didn't] think schema therapy would need to be adapted'. These 4 participants did not distinguish between their clients who were and were not parents. Conversely, the 9 other participants noted that they adapted their practice when working with parents, such as emphasising the role of family members in techniques and drawing on 'other therapy modalities' (P2) to add to schema therapy, including cognitive behavioural therapy, emotion-focused coaching and parenting programs.

Participants expressed a need for additional training and resources for using schema therapy with parents. Five participants said that they wanted formalised schema therapy models and protocols for working with parents and additional training, including 'specific information as to what schemas and modes make parenting difficult' (P9). Three participants expressed a desire for resources on schema therapy for parents with a mental illness, including 'books or literature around how schema therapy might interact with parenting' (P3). P1 described how the lack of parent-specific schema therapy resources meant that they drew on resources for couples, and children and adolescents, when working with parents. Meanwhile, P2 noted that they had drawn on resources from non-schema therapy 'parenting programs' to extend their schema therapy with parents.

4. Discussion

The purpose of this study was to explore schema therapists' experiences in using schema therapy with parents, their views on its impact on parenting, and how they adapted schema therapy when working with parents, if at all. Three key findings were identified:

- Schema therapy can be used to increase an understanding of one's behaviour relating to parenting and builds self-compassion.

- There are parallels between meeting parents 'needs and meeting their children's needs.
- There is a need for a systemic focus that encompasses family dynamics.

All 3 findings speak to the utility for therapists of using schema therapy to raise and explore the topic of parenting when proving mental health treatment to clients who are parents. Recognising clients' identity as a parent is important for mental health practice and promotes client recovery (Hine et al., 2019).

Parenting demands can be difficult for all parents, let alone those who are balancing these demands and their own mental health needs (Carpenter-Song et al., 2014; Marston et al., 2016; Tabak et al., 2016). Some participants described how schema therapy can provide a dual focus on educating clients about the needs of their internal vulnerable child mode as well as the needs of their real-life child. This dual focus in schema therapy could potentially help parents address their own mental health, while concurrently learning about the needs of their children. Further, some viewed the schema therapy model as a framework to develop self-parenting abilities by strengthening clients' healthy adult mode which they described as having a flow-on effect to the parenting of their children.

Participants also noted that they were able to use schema therapy to promote client insight into their parenting. Some described using different aspects of the schema therapy model, including modes and experiential techniques, to help clients recognise and discuss behaviours related to parenting. Further, others commented on their use of the schema therapy model to discuss transgenerational parenting patterns. Hence, schema therapy could be used as a therapeutic tool to introduce and facilitate discussions about clients' roles as parents, parenting behaviours and any potential difficulties therein.

However, some participants did not distinguish between clients who were parents and clients who were not parents. This finding is consistent with research in other adult mental health services (psychiatric services) where the parenting status of clients is not routinely identified (Dean & Macmillan, 2001; Maybery & Reupert, 2009). By failing to identify and conceptualise the parenting role of clients, therapists may subsequently not respond to clients' parenting and family needs, missing an opportunity to support their clients' recovery.

Further, there appeared to be a dichotomy between schema therapists who saw a need to adapt the model when working with parents and those who did not do this or were unsure how to. The differing ways schema therapists delivered the model to parents (through

delivering it as standard or adapting it in consideration of the parenting role) suggests different levels of comfort with the model, experience working with families or parents, and understanding of parents' needs. There is a need for further professional development among some schema therapists on how they might apply the schema therapy model as a tool to discuss parenting. Additional training and resources designed for practicing schema therapy in relation to parenting, and to being a parent with mental health challenges, might be beneficial.

4.1 Limitations and future directions

The voluntary sampling method used is a limitation of this study as it may have attracted participants with a strong interest in working with clients who are parents. Survey-based methods or additional qualitative studies achieving data meaning saturation could enhance the generalisability of the research and further develop these findings within the schema therapy workforce (Hennink et al., 2017). In this study, data collection ceased upon reaching data code saturation, as no new codes emerged. However, the research could be further strengthened by pursuing data meaning saturation. This occurs when additional interviews provide no additional understandings of the codes, and only repeats existing insights (Hennink et al., 2017). At this stage, the researcher has thoroughly explored the nuances and variations within the themes or concepts being studied, and additional data is unlikely to yiild new or deeper meanings (Hennink et al., 2017). Additionally, further research might investigate parents' perspectives and experiences of undergoing schema therapy within the context of their parenting needs and role. The insights gained from parents who undergo schema therapy could be used to inform and develop iterations of the schema therapy model that incorporate family dynamics. Formalised adaptations of the model to encompass a systemic focus and family dynamics could enhance therapists' practice framework when working with parents.

5. Conclusion

The findings of this study indicate that some schema therapists found the schema therapy model to be a useful tool to introduce and speak to clients' roles as parents. However, not all schema therapists recognised or addressed clients' unique parenting roles. Looking forward, professional development that recognises the role of parenting might be developed and provided to schema therapists. This study also highlighted scope for further iterations of the schema therapy model that explicitly encompass parenting and family dynamics.

References

Allchin, B., & Solantaus, T. (2022). An evidence-based practice developed in-situ: Let's Talk About Children and a consolidation of its evidence base. *Frontiers of Psychiatry, 13*, 824241.

Carpenter-Song, E. A., Holcombe, B. D., Torrey, J., Hipolito, M. M. S., & Peterson, L. D. (2014). Recovery in a family context: Experiences of mothers with serious illnesses. *Psychiatric Rehabilitation Journal, 37*(3), 162–169.

Dean, C., & Macmillan C. (2001). Serving the children of parents with a mental illness: Barriers, breakthroughs and benefits. *Building Bridges: Promoting mental health for families and communities*.

Eatough, V., & Smith, J. A. (2008). Interpretative phenomenological analysis. In C. Willig & W. Stainton-Rogers (Eds.), *The SAGE handbook of qualitative research in psychology.* London: Sage Publications Ltd.

Falkov, A., & Lindsey, C. (2002). *Patients as parents: Addressing the needs, including the safety, of children whose parents have mental illness*. Council Report CR105. London: Royal College of Psychiatrists, http://www.londonscb.gov.uk/diary/2008conference

Farrell, J. M., Reiss, N., & Shaw, I. A. (2014). *The schema therapy clinician's guide: A complete resource for building and delivering individual, group and integrated schema mode treatment programs*. John Wiley and Sons.

Halsa, A. (2018). Trapped between madness and motherhood: Mothering alone. *Social Work in Mental Health, 16*(1), 46–61.

Hine, R., Maybery, D., & Goodyear, M. (2019). Identity in personal recovery for mothers with a mental illness. *Frontiers in Psychiatry, 10*(89).

Jones, M., Pietilä, I., Joronen, K., Simpson, W., Gray, S., & Kaunonen, M. (2016). Parents with mental illness: A qualitative study of identities and experiences with support services. *Journal of Psychiatric Mental Health Nursing, 23*(8), 471–478.

Khasho, D. A., van Alphen, S., Heijnen-Kohl, S., Ouwens, M. A., Arntz, A., & Videler, A. C. (2019). The effectiveness of individual schema therapy in older adults with borderline personality disorder: Protocol of a multiple-baseline study. *Contemporary Clinical Trials Communications*, *14*, 100330.

Legra, M., Verhey, F., & Van Alphen, S. (2017). A first step toward integrating schema therapy in geriatric psychiatry: A Delphi study. *International Psychogeriatrics, 29*(7), 1069–1076.

Leijdesdorff, S., van Doesum, K., Popma, A., Klaassen, R., & van Amelsvoort, T. (2017). Prevalence of psychopathology in children of parents with mental illness and/or addiction: An up-to-date narrative review. *Current Opinion in Psychiatry, 30*(4), 312–317.

Marston, N., Maybery, D., & Reupert, A. (2016). Parent perceptions comparing times of parental mental wellness and illness using a family functioning model. *Journal of Family Studies*, *24*, 235–256.

Maybery, D., Reupert, A., Patrick, K., Goodyear, M., & Crase, L. (2009). Prevalence of children whose parents have a mental illness. *Psychiatric Bulletin*, *33*, 22–26.

Mrazek, P. J., & Haggerty, R. J. (Eds.). (1994). *Reducing risks for mental disorders: Frontiers for preventive intervention research*. National Academies Press (US).

Phelan, R., Howe, D., & Batchelor, S. (2012). Enhancing parenting skills for parents with a mental illness: The Mental Health Positive Parenting Program. *The Medical Journal of Australia, 3*(199), 30–33.

Rasic, D., Hajek, T., Alda, M., & Uher, R. (2014). Risk of mental illness in offspring of parents with schizophrenia, bipolar disorder, and major depressive disorder: A meta-analysis of family high-risk studies. *Schizophrenia Bulletin*, *40*(1), 28–38.

Reupert, A., Cuff, R., & Maybery, D. (2015). Helping children understand their parent's mental illness. In A. Reupert, D. Maybery, J. Nicholson, M. Gopfert, & M. Seeman (Eds.), *Parental psychiatric disorder: Distressed parents and their families* (pp. 201–209). Cambridge, UK: Cambridge University Press

Reupert, A., & Maybery, D. (2016). What do we know about families where parents have a mental illness? A systematic review. *Child and Youth Service, 37*(2), 98–111.

Reiss, D. (2008). Transmission and treatment of depression. *The American Journal of Psychiatry, 165*(9), 1083–1085.

Saldaña, J. M. (2015). *The coding manual for qualitative researchers.* 3rd ed. Sage Publications.

Schaap, G. M., Chakhssi, F., & Westerhof, G. J. (2016). Inpatient schema therapy for nonresponsive patients with personality pathology: Changes in symptomatic distress, schemas, schema modes, coping styles, experienced parenting styles, and mental well-being. *Psychotherapy, 53*(4), 402–412.

Simeone-DiFrancesco, C., Roediger, Eckhard, & Stevens, B. A. (2015). *Schema therapy with couples: A practitioner's guide to healing relationships*. Wiley Blackwell.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research.* London: Sage Publications.

Solantaus, T., Paavonen, E. J., Toikka, S., & Punamäki, R. L. (2010). Preventive interventions in families with parental depression: Children's psychosocial symptoms and prosocial behaviour. *European Child and Adolescent Psychiatry, 19*(12), 883–892.

Tabak, I., Zabtocka-Zytka, L., Ryan, P., Poma, S. Z., Joronen, K., Vigano, G., Simpson, W., Paavilainen, E., Scherbaum, N., Smith, M., & Dawson, I. (2016). Needs, expectations and consequences for children growing up in a family where the parent has a mental illness. *International Journal of Mental Health Nursing, 25*(4), 319–329.

Tchernegovski, P., Hine, R., Reupert, A. E., & Maybery, D. J. (2018). Adult mental health clinicians' perspectives of parents with a mental illness and their children: Single and dual focus approaches. *BMC Health Services Research, 18*(611).

Venkataraman, M., & Ackerson, B. (2008). Parenting among mothers with bipolar disorder: Strengths, challenges, and service needs. *Journal of Family Social Work, 11,* 389–408.

Videler, A. C., van Alphen, S., van Royen, R., van der Feltz-Cornelis, C. M., Rossi, G., & Arntz, A. (2018). Schema therapy for personality disorders in older adults: A multiple-baseline study. *Aging and Mental Health*, *22*(6), 738–747.

Young, J. E., Klosko, J. S., & Weishaar, M. E. (2003). *Schema therapy: A practitioner's guide*. Guilford.

Yung, A. R., & McGorry, P. D. (2007). Prediction of psychosis: Setting the stage. *The British Journal of Psychiatry. Supplement*, *51*, 1–8.

Zimmer-Gembeck, M., Rudolph, J., Edwards, E., Swan, K., Campbell, S., Hawes, T., & Webb, H. (2021). The Circle of Security Parenting Program (COS-P): A randomized controlled trial of a low intensity, individualized attachment-based program with at-risk caregivers. *Behavior Therapy, 52(2)*, 208–223.

Chapter 6 - Acceptance and Commitment Therapy for Parents who have Mental Health Challenges: Therapists' Perceptions

6.1 Background

This chapter presents the second of the three studies included in this thesis and was submitted to *Clinical Psychologist* journal on 27th of February, 2024. In June 2024, the paper was returned for revisions and re-submitted. This research adds to the literature concerning the experiences and perspectives of acceptance and commitment (ACT) therapists when working with parents with mental health challenges.

ACT is a transdiagnostic therapeutic approach which addresses a range of presenting difficulties (Dindo et al., 2017). The central goals of ACT are to increase psychological flexibility, develop acceptance of uncomfortable thoughts and emotions, and encourage behaviour which is aligned with clients' values (Hayes., 2004; Hayes et al., 2011). Research investigating ACT and parenting is still in its infancy. However, the studies published to date have shown promising effectiveness of ACT for parents, such as finding increased psychological flexibility associated with higher-quality and more frequent parent–child interactions, as well as more adaptive and effective parenting practices (Leeming & Hayes, 2016; Brassell et al., 2016). Given such findings, it is useful to examine its use with parents who have mental health challenges.

6.2 Aim of the study

The aim of this study was to examine the views and experiences of therapists who practice ACT with parents with mental health challenges. Specifically, the following research questions were investigated:

- What are the experiences of ACT therapists when working with parents?
- How do ACT therapists perceive the effectiveness of ACT in meeting the needs of parents?
- What are the enablers and barriers that therapists have found using ACT when working with parents?

6.3 Relevance of the study

Workforce developments in the field of mental health should account for the challenges and strengths of therapeutic modalities experienced and perceived by therapists practicing the modality, with different population groups. Understanding how ACT therapists

experience using ACT when working with parents who have mental health challenges, including the barriers they encounter and how they address them, can help inform future initiatives. For instance, future training and supervision could be enhanced through the findings of this study, to improve therapeutic practice with parents.

6.4 Declaration of contribution

The following tables outline the contributions of the candidate (Table 6.1) and the other authors (Table 6.2) to the published study presented in Chapter 6.

Table 6.1

The Candidate's Contribution to the Study in Chapter 6

Nature of Contribution	Extent of Contribution (%)
Study conceptualisation and design	70%
Participant recruitment	100%
Data collection, recording and transcription	100%
Analysis and interpretation of results	70%
Preparation of manuscript	90%

Table 6.2

The Contribution of the Other Authors to the Study in Chapter 6

Name	Nature of contribution	Extend of contribution (%) for student co-authors only
Prof Andrea Reupert	Assisted with the study conception and design, provided feedback on the manuscript	10%
Dr Rochelle Hine	Assisted with the study conception and design, involved in analysis and interpretation of results, provided feedback on the manuscript	10%
Irene Martin	Input into data analysis and manuscript preparation	10%

6.5 Declaration of ethical compliance

Ethics approval. Ethics approval was first obtained from Monash University Human Ethics Committee (Project Number: 26573).

Informed consent. Informed consent of all participants was obtained prior to participating in this study, including consent for publication.

Conflict of interest. The authors declare we have no conflicts of interest to disclose.

Paper as submitted to Clinical Psychologist
Peer review

Head: Acceptance and Commitment Therapy for parents who have mental health challenges: Therapists' Perceptions

Conflict of interest statement: We have no conflicts of interest to disclose. We confirm that this work is original and has not been published elsewhere, nor is it currently under consideration for publication elsewhere.

Byline: By Ciara Hart

Abstract

The aim of Acceptance and Commitment Therapy (ACT) is to increase clients' psychological flexibility, help clients stay focused on the present moment and accept their thoughts and feelings without judgment. Even though many clients who experience mental health issues are parents with dependent children, there is limited research that has qualitatively examined therapists' experiences using ACT when working with this population group. This exploratory study investigated therapists' experiences using ACT when working with parents. Semi-structured interviews were conducted with nine ACT therapists working in Australia. Interview questions focused on therapists' views and experiences when working parents who experience mental health issues. Transcripts were analysed within an Interpretative Phenomenological Analysis (IPA) framework. Three themes were identified, (i) ACT helps tune into what is important for parents and their parenting values (ii) ACT can promote self-compassion, and (iii) adaptations of ACT when working with parents. Findings suggest that ACT may provide a useful framework for discussing parenting whilst simultaneously addressing parents' mental health needs.

Acceptance and Commitment Therapy for parents who have mental health challenges: Therapists' Perceptions

1.Introduction

The definition of *parent* has varied across the literature relating to parents with mental health challenges. (Diaz-Caneja & Johnson, 2004; van der Ende et al., 2016; Awram et al., 2017, Afzelius, Plantin & Östman, 2018). Some researchers have focused exclusively on only parents who have full-time custody of dependent children (Afzelius, Plantin & Östman, 2018; Stallard, Norman, Huline-Dickens, Salter & Cribb, 2004) whilst others recognize that some parents with mental health challenges do not live with their children (Diaz-Caneja & Johnson, 2004; van der Ende et al., 2016). The exact prevalence of mental health challenges among parents is not a clearly defined in the literature, however, data from the Australian Bureau of Statistics (1998; 2003), suggests that about 23.3% of Australian families have at least one parent with a mental illness. Although the experience of parents with mental health challenges is unique to each individual and family, across the last 30 years of research into the area, both positive (Abrams & Curran, 2011; van der Ende et al., 2016; Maybery & Reupert, 2018a, 2018b) and challenging experienced have been identified (Awram et al., 2017; Dolman et al., 2013; Montgomery et al., 2011). Some of the challenges experienced by parents with mental health challenges raised in literature include difficulty balancing parenting with addressing their mental health needs (Awram et al., 2017; Montgomery et al., 2011), leading to difficulties in maintaining routines and providing adequate care for children (Diaz-Caneja & Johnson, 2004; Dolman et al., 2013; van der Ende et al., 2016).

Compared to their same aged peers, children of parents with mental health challenges are at greater risk of developing mental health problems themselves (Leijdesdorff et al., 2017; Rasic et al., 2014; Reupert & Maybery 2016). They may assume onerous caring responsibilities and be socially excluded by peers (Dam et al., 2018; Gatsou et al. 2017; Koschade & Lynd-Stevenson 2011; Oskouie et al. 2011). As a result, children may miss out on educational and other social opportunities (Dam et al., 2018; Gray et al., 2008). Some parents who experience mental health challenges may struggle with internalised and public stigma around having a mental health issue and caring for children (Reupert et al., 2021), face intersecting socioeconomic disadvantages (Macintyre et al., 2018) and find balancing parenting responsibilities and managing their mental health overwhelming (Carpenter-Song et al., 2014; Tabak et al., 2016; Marston et al., 2016). Nonetheless, the risk for these families

might be alleviated with appropriate support, including timely and appropriate mental health treatment for the parent (Allchin & Solantaus, 2022).

Mental health practitioners who offer therapy in private practice, such as psychologists, counsellors, and social workers, represent one of the largest groups within the Australian mental health workforce who support parents experiencing mental health challenges (State of Victoria, 2019; Stokes et al., 2010). To date, the majority of research into parents receiving mental health support has focused on the practice of multidisciplinary teams, such as within rehabilitation or psychiatric settings (Dolman et al., 2013) and research is only beginning to investigate the experiences of parents receiving mental health support in private practice (Cooper et al., 2023). Research by Cooper et al., (2023) investigated the experiences of Australian parents who had seen a psychologist in private practice for support with their mental health, although the type of therapeutic modality practiced by the psychologists was not reported on. They found that it is important for parents to have their psychologist understand the significance of their parenting identity (Cooper et al., 2023). Therefore, although counselling therapy is typically focused on alleviating mental health distress there is a desire from parents to have their therapist consider and address their parenting needs alongside providing mental health support (Cooper et al., 2023).

To date, only a few studies have investigated the impacts of specific psychotherapies for meeting the needs of parents with mental health challenges (Bright et al., 2020; Coiro et al., 2012). For example, research has shown that Interpersonal Therapy (IPT) reduces symptoms of depression and anxiety as well as improves social support, relationship satisfaction, and adjustment, in women during their pregnancy and postpartum period (Bright et al., 2020). However, it remains unclear how other therapeutic modalities such as acceptance and commitment therapy (ACT), narrative therapy, meet the needs of parents with mental health challenges and their children. Shedding light on how counsellors experience specific therapeutic modalities with working with parents with mental health challenges can inform the adaptation and implementation of treatment modalities, to better support parents and their families.

Acceptance and Commitment therapy (ACT) is a therapeutic approach that is transdiagnostic in nature and aims to address a multitude of client presenting difficulties (Dindo et al., 2017). The central goals of ACT are to increase psychological flexibility, develop acceptance of uncomfortable thoughts and emotions, and encourage behaviour which is aligned with clients' values (Hayes., 2004; Hayes et al., 2011). ACT does not attempt to change unwanted thoughts and emotions, but rather focuses on building acceptance and

orienting clients to important personal values, to bring purpose and direction (Hayes et al., 2012).

Although research around ACT and parenting is still in its infancy, there have been studies that show that increasing psychological flexibility through ACT is associated with higher-quality and more-frequent parent–child interactions, as well as more adaptive and effective parenting practices (Leeming & Hayes, 2016; Brassell et al., 2016). Further, increased psychological flexibility in parents can facilitate a "positive spiral" that in turn leads to greater parenting satisfaction and improved welfare for the entire family (Leeming & Hayes, 2016) including enhanced parenting and child psychosocial wellbeing (Brassell et al., 2016).

Psychological flexibility is promoted through the development of six core ACT processes (Hayes et al., 2006). The six core processes are acceptance, cognitive defusion, self-as-context, contact with the present moment, values, and committed action (Hayes et al., 2006). Additionally, ACT therapists may also use mindfulness practice and behaviour change strategies to promote psychological flexibility in clients (Hayes et al., 2006). ACT encourages clients to live in the present moment rather than dwelling on the past or anticipating the future (Hayes et al., 2004). Previous research has highlighted that mindful attention to parent-child interactions in the present improves the quality of parenting (Gouveia et al., 2016; Potharst et al., 2018).

Acceptance

ACT seeks to move clients away from engaging in experiential avoidance; basing actions on avoiding feeling bad, and emotional control, and instead towards acceptance and willingness to experience whatever shows up, including unpleasant thoughts and feelings.

Cognitive defusion

As clients progress through ACT, therapists work to undermine the language-based processes that promote fusion (unclear distinction between thoughts and reality – such as seeing the world through difficult thoughts). ACT instead promotes defusion of thoughts, whereby one can notice their thoughts as thoughts, and choose their response.

Self-as-context

Self-as-context (SAC) is usually taught as an extension of mindfulness, which encourages clients to focus on a grounded and enduring sense of self that has a flexible perspective. Clients come to distinguish between their conceptualised self and self-as-context, which provides a position from which acceptance of events is less threatening (Hayes et al., 2004).

Contact with the present moment

ACT encourages clients to live in the present moment rather than dwelling on the past or anticipating the future (Hayes et al., 2004). Previous research has highlighted that mindful attention to parent-child interactions in the present improves the quality of parenting (Gouveia et al., 2016; Potharst et al., 2018).

Connecting with values

Throughout ACT clients identify their valued outcomes and gain awareness of what matters to them. In doing so, they go from not having a sense of purpose or direction, towards striving for what sort of person they want to be and how they want to behave (Hayes et al., 2004).

Committed action

Committed action is another core process and involves going from being on 'autopilot,' or taking line of least resistance, towards building patterns of purposeful actions that are consistent with one's values. This involves following through to convert their stated goals and plans into action to live the life that is congruent with their values, even when that is difficult.

Self-compassion

In addition to the six core processes, self-compassion, which involves having recognition and sensitivity to suffering and motivation to alleviate suffering with kindness and care (Moreira, 2023) plays a role in ACT. Previous literature describes how self-compassionate parents may feel less stressed by daily parenting challenges and more compassionate toward their children (Gilbert, 2009; Moreira, 2023). A meta-analysis has found that parenting interventions that include self-compassion significantly decreased parental depression, parental anxiety, and parental stress, and increased parental mindfulness (Jefferson et al., 2020). Parents with depression who have greater self-compassion have been found to have fewer distressed reactions to children's emotions and express less criticism of the child (Psychogiou et al., 2016).

A growing body of systematic reviews and meta-analyses attest to the efficacy of ACT for a range of psychiatric disorders and chronic health conditions including mood and anxiety disorders (Atjak et al., 2015; Powers et al., 2009; Ruiz, 2010), psychosis, chronic pain, substance use (Gloster et al., 2020), cancer, diabetes, epilepsy, obesity (Öst, 2014), and attention deficit hyperactivity disorder (Munawar et al., 2021). Research into the effectiveness of ACT for treating a variety of psychological conditions continues to grow and substantiate its effectiveness for treating a variety of mental health conditions.

Research has also begun to investigate the effectiveness of ACT for different population groups, including for parents of children with a disability or mental health condition. Flujas-Contreras et al., (2022) found that brief-ACT treatment, across four sessions, for mothers with a child with a diagnosis of Oppositional Defiant Disorder significantly improved their psychological flexibility, emotional regulation, and parenting stress after the intervention and at the three-month follow-up period.

A systematic review found that ACT appears promising for assisting parents of children with different disabilities to manage stress and distress (Byrne et al., 2020). High levels of parental psychological flexibility, prompted by the ACT intervention, have been linked with well-being and better family functioning in families with children who have chronic conditions and autism (Lappalainen et al., 2021; Prevedini et al., 2020). Gould and colleagues (2018) found that ACT-based therapy prompted parents of children with autism to adopt more value-based behaviours. Another systematic review found that ACT was effective in managing distress when working with parents of children with autism (Juvin et al., 2022). Although results are positive, Juvin et al., (2022) noted that the field of research is still relatively new. Nonetheless, the studies to date, which have investigated the impact of ACT on parents who have a child with a disability, suggest that ACT can be useful for decreasing stress in parents and improving family functioning.

Others have also started to investigate the effectiveness of the core processes of ACT for parents with mental health challenges. Maternal dysphoria, parenting stress, child behaviour problems, and maladaptive parenting have been found to be positively correlated with experiential avoidance (as opposed to acceptance and action) (Shea & Coyne, 2011). Emotional avoidance was found to mediate the relationship between dysphoria and parenting stress (Shea & Coyne, 2011). Parental present-moment awareness, or mindfulness in mental health care, has also been found to reduce parental stress, parental psychopathology, child psychopathology (Bögels et al., 2014). Kirby (2016) highlighted the importance of mindfulness, acceptance, and compassion in enhancing nurturing family environments. Thus, findings to date suggest there is benefit to not only parents' mental health, but also outcomes for the broader family (Shea & Coyne, 2011; Bögels et al., 2014; Leeming & Hayes, 2016).

Despite the growing literature into the effectiveness of ACT, there remains a dearth of qualitative research into the experiences of ACT for parents who experience mental health challenges. Further, no study to date has qualitatively examined mental health practitioners'

experiences of using ACT with parents. Hence, this exploratory study seeks to gain insight into the views of practitioners who practice ACT with parents who experience mental health challenges. The study aimed to explore ACT therapists' experiences about how ACT meets the needs of parents with mental health challenges, as well as any adaptations they had made to the therapy when working with parents (if at all). Such data may be used to enhance or adapt ACT for use with parents and applied in professional development programs.

2. Methods

Ethics approval was first obtained from Monash University Human Ethics Committee (Project Number: 26573).

2.1 Participants

Participants (N= 9) were all ACT therapists practicing in Australia (see Table 1 for participant demographics). Participants were recruited via social media posts placed on ACT Facebook pages, LinkedIn group pages and the Australian Psychological Society professional online forum. To be included in the study, therapists had to be practicing ACT with parents. With the exception of one mental health social worker, the participants were all psychologists. Three participants identified as male, and six as female. Seven participants were parents themselves. Three participants did not specify their age. The mean age of the other six participants was 48 years (SD = 10.49, range = 32-60). One participant did not list the number of years they had been practicing ACT, however, the mean years of experience practicing ACT amongst the other eight participants was 9.43 years (SD=5.19, range =13 years). Seven participants were located in urban/ suburban areas of Australia and two in rural and regional Australia.

Table 1

Participants Self-Reported Demographic Information

Pseudonym	Gender	State and area	Profession	Years practicing ACT	Parent or Guardian
P1	Female	SA - Rural	Mental Health Social Worker	13	Yes
P2	Male	VIC - Urban/suburban	Psychologist	8	Yes
P3	Female	VIC - Urban/suburban	Psychologist	5	Yes

P4	Male	ACT - Urban/suburban	Psychologist	15	Yes
P5	Male	VIC - Urban/suburban	Psychologist	3	No
P6	Female	VIC - Urban/suburban	Psychologist	16	Yes
P7	Female	VIC - Regional	Psychologist	6	Yes
P8	Female	NSW- Urban/suburban	Psychologist	2	Yes
P9 -	Female	VIC - Urban/suburban	Psychologist	6	Yes

2.2 Procedure

The recruitment Facebook and LinkedIn posts directed potential participants to further information about the study and an online survey to provide their consent and their demographic and contact details. Ten responses were received, and they were then contacted by email to arrange an interview time; however, one person did not reply.

Semi-structured interviews were conducted via the Zoom video conferencing platform. Interview lengths ranged from 17 minutes to 42 minutes, (averaging 34 minutes). All participants gave permission for their interview to be recorded and transcribed using Otter.ai transcribing software. Any personal or identifiable information was removed from participants' transcripts and a copy was emailed to the participants for member checking, the opportunity to add to or edit the transcripts, if they considered any of the transcript to be identifiable or incorrect. No participants requested changes to their transcripts.

2.3 Interview

A semi-structured interview schedule consisting of five open-ended questions was created specifically for this study by the researchers. The questions were designed to examine ACT practitioners' experiences when working with parents with mental health challenges, including parents presenting with a range of challenges, such as a mental illness or parenting issues. The open-ended questions were followed up with additional probing questions, to obtain more detail. The interview schedule can be found in Table 2.

Table 2

Interview schedule

Questions
1. **What have your experiences been like of using ACT with parents with a mental health challenges?** Example probes: If anything, what have you found positive about using ACT with parents?
2. **Do you think that the ACT model is relevant to the experiences of clients who are parents? Why/Why not?** Example probes: Which aspects of the model, if any, do you think are relevant to parenting experiences?
3. **Do you think ACT techniques meet the needs of clients who are parents with mental health challenges? Why/ why not?** Example probes: Which techniques of ACT, if any, do you think are suited to the needs of your clients who are parents? Why are they suited?
4. **If at all, how do you think the therapy could be adapted to better suit practice with parents?**
5. **What resources, if any, do you think would be helpful for practicing ACT with parents?**

2.4 Analysis

Phenomenology is a philosophical movement concerned with lived experience (Husserl, 1983). Interpretative Phenomenological Analysis (IPA) is an approach to analysis that examines participants' experiences and perspectives of phenomena (Smith et al., 2009) and was used to analyse interview data. IPA analysis was aligned with the aims of the study, which were to explore ACT therapists' accounts and experiences working with parents with mental health challenges. Following IPA guidelines, participants' transcripts were initially coded by identifying and highlighting key phrases that captured salient information relevant to the research questions (Saldaña, 2015). Each transcript was independently coded by at least two authors, with some coded by three. All transcripts analysed and coded by the first author, in addition to separate analysis of the transcripts undertaken by the second and fourth author. Any coding differences were resolved through discussion and managed by further reviewing the transcripts. After the transcript codes were revised multiple times, guided by

collaborative discussion between authors, they were then used to identify key themes relating to the research aim. These themes were then used to re-annotate the transcripts to ensure they accurately represented the data. Reflective conversations about possible interpretations of the interview data and themes were had by the researchers coding the transcripts throughout the process.

2.5 Reflexivity Statement

The first author who undertook the data collection is a cisgender woman who is an early career provisional psychologist and not a parent. This is an important position to acknowledge given seven participants were parents themselves, and all nine participants had a least three years practicing ACT as a therapist, with a group average of 9.42 years practicing ACT. The first author does have lived experience growing up with a parent who experienced mental illnesses and has practiced as a Provisional Psychologist for approximately three years in Australia. The first author has undertaken training in ACT and typically practices an integrated therapeutic modal, including ACT, when working with children and parents with mental health challenges. Recognising the likelihood that the researcher's professional experiences, preconceptions and personal views and may have influenced interpretation (Larkin et al., 2021), numerous strategies were employed, including blind, double, or triple annotation, to moderate bias and member checks to promote reflexivity. Aligned with IPA practices of intersubjective reflexivity (Eatough & Smith, 2008), the first author regularly clarified her understanding of participants' meanings throughout the interviews and engaged in interrogative self-reflection after each interview, taking notes of thoughts and emotions which might have influenced the research process. The second author is a mother, a qualified psychologist, including experience training and practicing ACT, and academic professor with extensive experience in mental health practice and research with families where a parent has mental health challenges. The third author is a mother, social worker, and an experienced mental health clinician and academic with clinical and specialist research experience in families with parental mental health challenges. The fourth author is a Provisional Psychologist who has experience working from an integrated practice with families with mental health challenges and is not a parent.

3. Results

The analysis resulted in the identification of three themes; (i) the six core processes in the ACT model is useful for parents in supporting both their parenting role and mental health

(ii) ACT can promote much-needed self-compassion in parents, and (iii) adaptations of ACT when working with parents. These themes are described below with excerpts from the interviews. Participants are tagged using codes from Table I (i.e.,. P1, P2…).

3.1 ACT model is useful for parents in supporting their parenting role and mental health

All participants agreed that the ACT model was useful for working with clients who are parents because it supports their mental health and can assist with parenting issues. P5 commented that ACT "really resonates with parents" and they "respond really well to ACT." Further, three participants (P2, P3 and P6) highlighted the transdiagnostic nature of the ACT model made it useful for working with parents presenting with a range of issues, with P3 describing "anyone could walk through the door, including a high functioning parent who's really struggling with the basics of parenting and the ACT processes are still relevant." Three participants (P3, P6, P9) explicitly described how all "six ACT processes are relevant to parenting," (P3) and when asked if they thought the ACT model was relevant to the experiences of parents with mental health challenges. Without being directly asked about the six core processes in ACT, all participants brought up and proceeded to described how at least one of the ACT core processes meet the needs of parents.

Awareness of Personal Values

Creating an awareness of values was the ACT processes most commonly discussed by participants in relation to the how the ACT model is relevant to parents' needs. Seven participants described the utility of ACT in that it facilitates "exploration and connection with what really matters" to parents (P2). P3 highlighted that the values work in ACT offers "parents a sense of choosing how they want to parent rather than necessarily being guided or told what they should be doing," a sentiment also echoed by P2 who indicated, "giving you [the therapist] an invitation to ask them about what's important to them". P9. highlighted parenting difficulty amongst clients who were "not clear about values, who they want to be as a parent, and so they've kind of just given up on the whole thing." Similarly, P2 noted how parents often express "feeling not great" or "doesn't fit with how they want to be," when they have not "given a great deal of thought into how they really want to live." Similarly, P2 described consumers "not being happy with [their] parenting," when their interactions with children were unaligned with their values.

Four participants (P2, P4, P6, P8) gave examples of conversations with parents about parenting values, including P2 asking "what do you want to model as a parent [to your children]? … what values do they want to instil?" (P2). P6 further outlined that parents are

usually “shocked” because “they’ve never had that question (“what kind of a parent do you want to be?”) asked them. P4. spoke to the importance of recognising differences in values between parents and children; “have them notice that what is important to them may not be what is important to their child, describing how ACT is helpful in recognising that “the way that your child acts isn't always a reflection of you as a parent and being a bad parent.” Similarly, P6 raised how incongruencies between values in parents and children can “be challenging” when parents are “rigid around their own values.” P6 also described how working on values as per the ACT model can be useful for parents in “exploring the children’s needs as well,” and values that are important to their child.

Committed Action

Two participants described how the Committed Action process is relevant to meeting the needs of clients who are parents. P2 described how they use Committed Action about parenting, by encouraging clients to “identify actions with … their children that they’re wanting to take in line with their values” and then focusing on gathering data around what helped implement those actions, or what “got caught in the way,” to make them difficult to implement. P2 noted a barrier to implementing committed action was when parents reported feeling like they’re “an imposter” and they “don’t know what [they’re] doing,” in their parenting role, and subsequently highlighted the importance of working on “self-doubt” with clients who were parents. P4 gave an example of parents valuing “connection with their child,” and undertaking the Committed Action process with them, asking “What are the actions that you take in order to foster that connection with your child?” and creating a plan for undertaking those actions.

Flexible perspective taking

Four participants noted how Flexible Perspective Taking, another ACT processes, was used to help parents (P3, P4, P8, P9). P9 described how parenting “requires you to be extremely flexible, because your child's just not going to do what you expect or hope that it will do all the time.” Similarly, P4 noted that perspective taking of children was “essential” and “really helpful” when working with parents. P3 described flexible perspective taking process work in the following way,

> Perspective taking skills helps parents to really be able to put themselves in their kids’ shoes and understand why it is that they behave the way they do. What are their needs in that moment. Perspective taking helps parents to understand their kids better (P3).

Additionally, P8 described "becoming a parent, you do need to develop your psychological flexibility," and gave an example of needing to "be attuned to the needs of [an] infant, kids, and checking in with what's going on for you." P9 continued,

> There's just one challenge after another for parents so the more emotionally resilient and psychologically flexible you are, the better you are, and I think that's what ACT teaches (P9).

Defusion

The ACT process of Defusion which involved helping parents "unhook from unhelpful thoughts," (P4) and not be consumed by them, was noted by five participants (P2, P3, P4, P6, P9). P2 described the usefulness of the Defusion process for parents who are "often caught up in stories about themselves as people and as parents." Through the Defusion process, P6 described how some "parents find [it] hard to accept,…[the] uncomfortable thoughts and feelings that show up." P3 noted that Defusion teaches parents to "tolerate their own discomfort and remain in control of their behaviours… in the service of doing what's best for [their] child" (P3). P9 described how the parents who uphold strong believes and rules about "what a good parent should be," can let go of these rules and come to see that they "can be a good parent in a different way," through the Defusion process.

Acceptance/ Willingness to experience

The utility of the Acceptance process for working with parents was described by four participants (P2, P3, P6, P4). P2 highlighted that the importance of "willingness to accept and willingness to be with difficult experiences in order to behave how we want to be as a parent" often comes up in therapy. For example, parents "often have to sit with frustration, patience, anger with their kids and maybe sadness." Similarly, P3 described how they focus on "emotional acceptance… being able to tolerate and experience particularly, you know, frustration, anger, resentment, sadness and fear," with parents. P4 worked to support the mental health of parents whose child has a disability and described the role of acceptance work with such parents, who experience "a sense of loss" when they "see other parents and families with children who appear on the surface not to have with disability" and compare this with their own child. P4 noted the utility of "acceptance and making space for those difficult emotions when they come up," for parents with a child with a disability.

Present Moment Awareness

Present moment awareness, described as "being present with whatever is showing up," (P2), was another ACT process considered to be useful when working with parents. P8 described mindfulness parenting was "best practice parenting," and described how "being

present and mindful" were "essential for parenting." P8 described how present-moment awareness helps parents better meet the needs of their children, as it "creates space for a moment of checking-in and a moment of relaxation or being present" which assists in "being attuned to infants, children and checking-in with what's going on for [themselves]." Similarly, P1, P2 and P6 also explicitly noted the importance of mindfulness for parenting, describing "regular mindfulness practice is really helpful for parents" (P2). P2 noted that at the beginning of the first session in their practice with any client, not just parents, they are introducing present-moment awareness by "asking [them] to notice whatever it is showing up in [their] body right now". Five participants (P2, P3, P5, P8 and P9) described how they recommended mindfulness resources, including apps, books, and podcasts, for parents to use at home.

3.2 ACT can promote much-needed self-compassion in parents with mental health challenges

Five participants highlighted how ACT can facilitate a level of self-compassion for parents with mental health challenges. Participants described parents struggling with "the idea of not being good enough" (P4) because of their mental health issue. For example, P2 noted working with parents who were "disappointed" with themselves and "beat themselves up about" having a "difficult interaction with their kid and didn't respond in the way they wanted to." While self-compassion is important for everyone with mental health challenges, according to P3, it's "particularly important for parents. It's a tough gig." Subsequently, P3 usually gave "more emphasis on self-compassion" when working with parent clients, as feelings of not being "good enough" comes up in therapy for "most" of them as explained here, "People tend to be pretty hard on themselves, because it's incredibly important for people to be the best parents they can be" (P3).

Several participants (P2, P3, P4) spoke to "reframing around being kind to yourself," (P4) was an important technique they drew on when working with parents who have mental health challenges. P1 described reframing as "helping parents understand that they are on a journey, they don't have to have all the answers," and that everyone is "trying to figure out what is the right thing to do." P2 noted how it was "incredibly rewarding" to see parent clients "reframe [their] critical self-talk," and become "more compassionate about themselves and the job they are doing." A technique P2 described to be particularly helpful in eliciting self-compassion in parents was by asking them to put themselves into a family or friend's shoes, and asking them to "notice the difference between how [they] talk to family and friends, compared to [themselves]."

3.3 Adaptations of ACT when working parents

Although many participants identified the benefits of using ACT with parents, some therapists spoke to how they adapted ACT when working with parents. The need to simplify some of ACTs terminology and metaphors when working with some parents was indicted. P5 noted that the "language used in ACT can be really complex," and subsequently adapted the traditional ACT model for some parents by simplifying the six core processes terms to plain language concepts. P5 additionally highlighted how the complexity of terminology in ACT "can take practitioners years to really understand." Further, P8 described that the use of metaphors in ACT "can feel a bit abstract," and can be "not suitable" for some parents who are "in survival mode," and thus adapted them when working with parents.

Additionally, some participants found "it more challenging" conducting ACT with parents who had previously undergone other forms of therapy, for example CBT, because it is "counterintuitive to what a lot of people are used to," (P5). P1 noted that "it can be difficult when" teachings from other therapies which clients may have previously undertaken, somewhat "contradict or go against" ideas taught in ACT. By contrast, P2 and P3 detailed how they "draw on other therapeutic modalities in combination with ACT," to "assist [their] work with parents" (P2). The Circle of Security model was an example of "another theoretical perspective used in addition to ACT," that P3 drew on in addition to ACT to facilitate conversations around parenting needs. P3 described how it is "really helpful to pull out another theoretical perspective to aid talking about" parenting and providing psychoeducation around the needs of children. Additionally, P2 drew on other therapeutic models alongside ACT, including "gratitude work, attachment theory, inner child work and ego state therapy" describing how they "felt parents who come to therapy with many different concerns, benefited from" the combination of multiple modalities of therapy. However, unlike P2 and P3, the majority of therapists interviewed in this study, did not practise from an integrative approach rather preferred to solely use ACT when working with parents.

4. Discussion

The purpose of this study was to explore ACT therapists' experiences when applying ACT with parents who have mental health challenges, their views on its impact on parenting, and how they adapted ACT when working with parents, if at all. Three key themes were identified; (i) the six core processes in the ACT model is useful for parents in supporting both their parenting role and mental health (ii) ACT can promote much-needed self-compassion in parents, and (iii) adaptations of ACT when working with parents. The first two themes speak to how the ACT therapists interviewed felt they were readily able to apply the ACT

framework to meet the needs of parent clients, including addressing parenting issues and improving mental health outcomes. The third theme, highlights the limitation ACT therapists perceived when using the approach with parent clients, including how some therapists felt that language in the ACT model should be adapted when working with parents and how other modalities or parenting programs could be brought in to enhance psychoeducation around the needs of children and conversations about parenting issues.

In line with previous research, participants viewed the ACT model as relevant to meeting the needs of parents (Flujas-Contreras et al., 2022; Shea & Coyne, 2011; Leeming & Hayes, 2016). The therapists interviewed reinforced the findings of Leeming and Hayes (2016) and Brassell et al., (2016) that increasing psychological flexibility has positive impacts on both mental health and their role as a parent, such as by reducing parenting stress.

Further, the experiences and perceptions of participants in the current study, around the usefulness and importance of self-compassion for parents with mental health challenges, aligned with previous literature (Blegen et al., 2012; Gilbert, 2009; Hine et al., 2019; Moreira, 2023; Wilson & Crowe, 2009). Participants echoed the experiences that parents often struggle with self-compassion and self-criticisms, particularly mothers who experience mental health challenges (Hine et al., 2019; Wilson & Crowe, 2009; Blegen et al., 2012). Further, this study supports previous research that greater levels of self-compassion in parents leads to less self-criticism and stress concerning parenting challenges, and more caring and compassion parenting behaviour towards children (Gilbert, 2009; Gilbert, 2015; Psychogiou et al., 2016; Moreira, 2023). The current study contributes to the literature in this field, as participants described numerous techniques, including reframing and helping parents understand they do not need to have all the answers to parenting, which they perceived as effective for eliciting self-compassion in parents with mental health challenges. As such, the ACT model, which has a particular focus on building self-compassion, can be considered to be well suited to meeting the needs of parents with mental health challenges as it appears to not only improve the wellbeing of parents undertaking the therapy, but also positively impact parent-child relationships.

Some ACT therapists interviewed spoke to limitations of the ACT model when working with parents with mental health challenges. For example, some therapists spoke to how ACT terminology and metaphors being complex and inappropriate for parents with mental health challenges and drawing on other modalities or parenting programs to assist with psychoeducation around children's needs and parenting conversations. This finding relates to literature by Whittingham and Coyne (2019) who recently coined an ACT model

with adapted and simplified language for working with parents and families with a diverse range of clinical presentations, including anxiety, neurodevelopmental disorders, conduct problems, and postnatal depression and perinatal loss. Although this previous literature has provided updated terminology for working with parents and families, no participants of the current study directly referenced their work, indicating that they adapted the ACT terminology in a different way to Whittingham and Coyne (2019). The results of the current study, including inconsistences on whether and how ACT terminology was adapted, indicate that there is scope for additional research, training and professional development for ACT therapists on how ACT terminology can be adapted to suit clients who are parents with mental health challenges.

The findings from this study highlight a dichotomy between therapists who adapted the ACT model when working with parents and those that did not experience the need to do so. Most of the participants interviewed felt comfortable Appling ACT as a stand-alone therapy to work with parents, however two therapists drew on additional modalities or parenting programs to work with parents with mental health challenges. There did not appear to be a pattern based on years of experience of practicing ACT and whether additional modalities were drawn upon when working with parents or not. The two therapists who did draw on other modalities to facilitate conversations around parenting and provide psychoeducation around the needs of children aligns with previous literature by Brown et al., (2015). Brown et al., (2015) described how ACT practised alongside established parenting approaches, including the Stepping Stones Triple P program, can improve parents' psychological distress, psychological flexibility and confidence in managing behaviours and family adjustments. However, no participants interviewed spoke to adapting the ACT model in a formalised way when working with parents, such as in line with Whittingham and Coyne's work (2019) who adapted the ACT model specifically for parents. Rather, the participants in the current study appeared to adapt the ACT model in an ad-hoc basis by introducing additional techniques and psychoeducation from other modalities besides ACT, as they deemed relevant for the specific parent client they were working with. Indeed, there is scope for further research into how ACT can be most effectively adapted or integrated with other programs, when working with parents with mental health challenges.

4.1 Limitations and future directions

A limitation of this study is the voluntary sampling method used which may have attracted participants with an interest in working with clients who are parents. Another limitation is considering parents as a homogenous group, and further research might be

conducted into therapists' experiences about working with distinct populations of parents, such as mothers, fathers, parents from different cultural backgrounds, single compared with partnered parents and LGBTQI+ parents. Additionally, it is critical to investigate the experiences and views of parents who undertake ACT within the context of their parenting needs, to build on the findings of this study. Collectively, the insights from parents and therapists could inform adaptations of the ACT model to encompass a systemic and family dynamics focus which would enhance therapists' practice when working with parents.

5. Conclusion

Overall, results of the current study suggest that when working with parents with mental health challenges, the ACT model is suited for parenting needs and has an important role in promoting self-compassion. Findings suggest the six core processes in ACT; acceptance, cognitive defusion, self-as-context, contact with the present moment, values, and committed action (Hayes et al., 2006), which can all lend themselves to working with parenting issues.

Conflict of Interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

Author Contributions

The study was primarily designed by CH. CH developed the main research question, recruited the acceptance and commitment therapists who participated in the study, and collected the data through conducting interviews. CH, RH and IM analyzed the data and CH drafted the manuscript for publication. AR was the primary supervisor of the Doctor of Philosophy project and RH was the co-supervisor of the Doctor of Philosophy project. AR and RH contributed to the conception and design of the study and reviewed and revised the manuscript. They provided feedback regarding the choice of analysis, ethical considerations, and critically reviewed the manuscript prior to being submitted to the journal "Parents with Mental and/or Substance Use Disorders and their Children." All the authors have approved the final version of the manuscript to be published and have agreed to be accountable for all aspects of the work.

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References

Abrams, L., & Curran, L. (2011). Maternal identity negotiations among low-income women with symptoms of postpartum depression. *Qualitative Health Research, 21*(3), 373-385. http://doi.org/10.1177/1049732310385123

Afzelius, M., Planton, L., & Östman, M. (2018). Families living with parental mental illness and their experiences of family interventions. *Journal of Psychiatric and Mental Health Nursing, 25(2)*, 69-77. http://doi.org/10.1111/jpm.12433

Allchin, B., Weimand, B. M., O'Hanlon, B., & Goodyear, M. (2022). A sustainability model for family-focused practice in adult mental health services. *Frontiers in Psychiatry, 12*, 761-889. https://doi.org/10.3389/fpsyt.2021.761889

Atjak, J. G., Davis, M. L., Morina, N., Powers, M. B., Smits, J. A., & Emmelkamp, P. M. (2015). A meta-analysis of the efficacy of acceptance and commitment therapy for clinically relevant mental and physical health problems. *Psychotherapy and Psychosomatics, 84*(1), 30–36. https://doi.org/10.1159/000365764

Australian Bureau of statistics (ABS). (1998). *Mental health and wellbeing: Profile of adults, Australia, 1997 (Cat. No. 4326.0)*. Canberra, Australia: Australian Bureau of Statistics. Australian Bureau of statistics (ABS). (2003). *Family Characteristics Australia (Cat. No. 4442.0).* Canberra, Australia: Australian Bureau of Statistics.

Awram, R., Hancock, N., & Honey, A. (2017). Balancing mothering and mental health recovery: the voices of mothers living with mental illness. *Advances in Mental Health, 15*(2), 147- 160. http://doi.org/10.1080/18387357.2016.1255149

Blegen, N. E., Hummelvoll, J. K., & Severinsson, E. (2012). Experiences of motherhood when suffering from mental illness: a hermeneutic study. *International Journal of Mental Health Nursing, 21*(5), 419–427. https://doi.org/10.1111/j.1447-0349.2012.00813.x

Bögels, Susan M., Hellemans, Joke, van Deursen, Saskia, Römer, Marieke, & van der Meulen, Rachel. (2014). Mindful parenting in mental health care: Effects on parental and child psychopathology, parental stress, parenting, coparenting, and marital functioning. *Mindfulness, 5*(5), 536–551.https://doi.org/10.1007/s12671-013-0209-7

Brassell, Anne A., Rosenberg, Elyse, Parent, Justin, Rough, Jennifer N., Fondacaro, Karen, & Seehuus, Martin. (2016). Parent's psychological flexibility: Associations with

parenting and child psychosocial well-being. *Journal of Contextual Behavioral Science, 5*(2), 111–120. https://doi.org/10.1016/j.jcbs.2016.03.001

Brown, F. L., Whittingham, K., Boyd, R. N., McKinlay, L., & Sofronoff, K. (2014). Improving child and parenting outcomes following paediatric acquired brain injury: A randomised controlled trial of Stepping Stones Triple P plus acceptance and commitment therapy. *Journal of Child Psychology and Psychiatry, 55*, 1172–1183. https://doi.org/10.1111/jcpp.12227

Byrne, G., Ghráda, Á. N., O'Mahony, T., & Brennan, E. (2020). A systematic review of the use of acceptance and commitment therapy in supporting parents. *Psychology and Psychotherapy: Theory, Research and Practice*, 378–407. https://doi.org/10.1111/papt.12282

Carpenter-Song, E. A., Holcombe, B. D., Torrey, J., Hipolito, M. M. S., & Peterson, L. D. (2014). Recovery in a family context: Experiences of mothers with serious mental illnesses. *Psychiatric Rehabilitation Journal, 37*(3), 162-169. https://doi.org/10.1037/prj0000041

Coiro, M. J., Riley, A., Broitman, M., & Miranda, J. (2012). Effects on children of treating their mothers' depression: Results of a 12-month follow-up. *Psychiatric Services, 63,* 357–363. https://doi.org/10.1176/appi.ps.201100126

Cooper, C., Tchernegovski, P., & Hine, R. (2023). "The validation is not enough": Australian mothers' views and perceptions of mental health support from psychologists in private practice. *Clinical Psychologist, 27*(3), 392-403. https://doi.org/10.1080/13284207.2023.2259053

Dam, K., Joensen, D. G. & Hall, E. O. C. (2018). Experiences of adults who as children lived with a parent experiencing mental illness in a small-scale society: A qualitative study. *Journal of Psychiatric and Mental Health Nursing, 25*(2),78–87. https://doi.org/10.1111/jpm.12446

Diaz-Caneja, A., & Johnson, S. (2004). The views and experiences of severely mentally ill mothers: A qualitative study. *Social Psychiatry and Psychiatric Epidemiology, 39*(6), 472-482. http://doi.org/10.1007/s00127-004-0772-2

Dindo, L., Van Liew, J. R., & Arch, J. J. (2017). Acceptance and Commitment Therapy: A transdiagnostic behavioral intervention for mental health and medical conditions. *Neurotherapeutics: The Journal of the American Society for Experimental NeuroTherapeutics, 14*(3), 546–553. https://doi.org/10.1007/s13311-017-0521-3

Dolman, C., Jones, I., & Howard, L. M. (2013). Pre-conception to parenting: A systematic review and meta-synthesis of the qualitative literature on motherhood for women with severe mental illness. *Archives of Women's Mental Health, 16*, 173–196. https://doi.org/10.1007/s00737-013-0336-0

Duncan, L. G., Coatsworth, J. D., & Greenberg, M. T. (2009). A model of mindful parenting: Implications for parent-child relationships and prevention research. *Clinical Child Family Psychology Review, 12,* 255–270. https://doi.org/10.1007/s10567-009-0046-3

Eatough, V., & Smith, J. A. (2008). 'Interpretative Phenomenological Analysis' in The SAGE Handbook of Qualitative Research in Psychology. London: SAGE Publications Ltd.

Flujas-Contreras, J. M., García-Palacios, A., & Gómez, I. (2022). Parenting intervention for psychological flexibility and emotion regulation: Clinical protocol and an evidence-based case study. *International Journal of Environmental Research and Public Health, 19*(9), 5014. https://doi.org/10.3390/ijerph19095014

Forman, D. R., O'Hara, M. W., Stuart, S., Gorman, L. L., Larsen, K. E., & Coy, K. C. (2007). Effective treatment for postpartum depression is not sufficient to improve the developing mother–child relationship. *Development and Psychopathology, 19*, 585–602. https://doi.org/10.1017/S0954579407070289

Gatsou, L., Yates, S., Goodrich, N. & Pearson, D. (2017). The challenges presented by parental mental illness and the potential for whole-family intervention to improve outcomes for families. *Child & Family Social Work, 22*, 388–397. https://doi.org/10.1111/cfs.12254

Gilbert, P. (2009b). Introducing compassion-focused therapy. *Advances in Psychiatric Treatment, 15*, 199–208.

Gloster, A. T., Walder, N., Levin, M. E., Twohig, M. P., & Karekla, M. (2020). The empirical status of acceptance and commitment therapy: A review of meta-analyses. *Journal of Contextual Behavioral Science, 18*, 181-192. https://doi.org/10.1016/j.jcbs.2020.09.009

Gould, E. R., Tarbox, J., & Coyne, L. (2018). Evaluating the effects of Acceptance and Commitment Training on the overt behavior of parents of children with autism. *Journal of Contextual Behavioral Science, 7*, 81–88. https://doi.org/10.1016/j.jcbs.2017.06.003

Gouveia, M. J., Carona, C., Canavarro, M. C., and Moreira, H. (2016). Self- compassion and dispositional mindfulness are associated with parenting styles and parenting stress: the

mediating role of mindful parenting. *Mindfulness, 7*, 700–712. https://doi.org/10.1007/s12671-016-0507-y

Gray, B., Robinson, C. & Seddon, D. (2008). Invisible children: Young carers of parents with mental health problems – perspectives of professionals. Child and Adolescent Mental Health, 13, 169–172. https://doi.org/10.1111/j.1475-3588.2007.00477.x

Hayes, S. C. (2004). Acceptance and commitment therapy, relational frame theory, and the third wave of behavioral and cognitive therapies. Behavior therapy, 35(4), 639-665.

Hayes, S. C., Luoma, J. B., Bond, F. W., Masuda, A., & Lillis, J. (2006). Acceptance and commitment therapy: Model, processes and outcomes. Behaviour research and therapy, 44(1), 1-25. https://doi.org/10.1016/j.brat.2005.06.006

Hayes, S. C., Pistorello, J., & Levin, M. E. (2012). Acceptance and commitment therapy as a unified model of behavior change. The Counseling Psychologist, 40(7), 976-1002. https://doi.org/10.1177/0011000012460836

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (2011). Acceptance and commitment therapy: The process and practice of mindful change. Guilford press.

Hine, R. H., Maybery, D. J., & Goodyear, M. J. (2019). Identity in personal recovery for mothers with a mental illness. *Frontiers in Psychiatry, 10*, 89. https://doi.org/10.3389/fpsyt.2019.00089

Jefferson, F. A., Shires, A., & McAloon, J. (2020). Parenting self-compassion: A systematic review and meta-analysis. *Mindfulness, 11*(9), 2067–2088. https://doi.org/10.1007/s12671-020-01401-x

Juvin, J., Sadeg, S., Julien-Sweerts, S., & Zebdi, R. (2022). A systematic review: acceptance and commitment therapy for the parents of children and adolescents with autism spectrum disorder. *Journal of Autism and Developmental Disorders, 52*(1), 124–141. https://doi.org/10.1007/s10803-021-04923-y

Kirby, J. (2016). The role of mindfulness and compassion in enhancing nurturing family environments. *Clinical Psychology: Science and Practice, 23*(2), 142–157. http://doi.org/10.1111/cpsp.12149

Koschade, J. E.,& Lynd-Stevenson, R. (2011). The stigma of having a parent with a mental illness: Genetic attributions and associative stigma. *Australian Journal of Psychology, 63*, 93–99. https://doi.org/10.1111/j.1742-9536.2011.00009.x

Lappalainen, P., Pakkala, I., Strömmer, J., Sairanen, E., Kaipainen, K., & Lappalainen, R. (2021). Supporting parents of children with chronic conditions: A randomized

controlled trial of web-based and self-help ACT interventions. *Internet Interventions, 24*, 100382. https://doi.org/10.1016/j.invent.2021.100382

Larkin, M., Flowers, P., & Smith, J. A. (2021). Interpretative phenomenological analysis: Theory, method and research. In Interpretative Phenomenological Analysis (pp. 1–100).

Leeming, E., & Hayes, S. C. (2016). Parents are people too: The importance of parental psychological flexibility. *Clinical Psychology: Science and Practice, 23*(2), 158–160. https://doi.org/10.1111/cpsp.12147

Leijdesdorff, S., van Doesum, K., Popma, A., Klaassen, R., & van Amelsvoort, T. (2017). Prevalence of psychopathology in children of parents with mental illness and/or addiction: an up to date narrative review. *Current Opinion in Psychiatry, 30*(4), 312–317. https://doi.org/10.1097/YCO.0000000000000341

Macintyre, A., Ferris, D., Gonçalves, B., & Quinn, N. (2018). What has economics got to do with it? The impact of socioeconomic factors on mental health and the case for collective action. *Palgrave Communications, 4*(1), 1-5. http://dx.doi.org/10.1057/s41599-018-0063-2

Marston, N., Maybery, D., & Reupert, A. (2016). Parent perceptions comparing times of parental mental wellness and illness using a family functioning model. *Journal of Family Studies, 24*, 235–256.

Maybery, D., & Reupert, A. (2018a). A family-focused, recovery approach when working with families when a parent has a history of mental health problems: From theory to practice. In J.C. Santos & J.R. Cutcliffe (Eds), *European Psychiatric/Mental Health nursing in the 2st century: A person-centred evidence-based approach* (pp. 283-291). Switzerland: Springer.

Maybery, D. & Reupert, A. E. (2018b). The number of parents who are patients attending adult psychiatric services *Current Opinion in Psychiatry, 31*(4), 358-362. https://doi.org/10.1097/YCO.0000000000000427

Montgomery, P., Mossey, S., Bailey, P., & Forchuk, C. (2011). Mothers with serious mental illness: their experience of "hitting bottom". *ISRN nursing*, *2011*, 708318. https://doi.org/10.5402/2011/708318

Moreira, H., Gouveia, M. J., Carona, C., Silva, N., and Canavarro, M. C. (2015). Maternal attachment and children's quality of life: the mediating role of self-compassion and parenting stress. *Journal of Child and Family Studies, 24*(8), 2332-2344. https://doi.org/10.1007/s10826-014-0036-z

Moreira, H. (2023). Self-Compassion in Parenting. In: Self-compassion in psychotherapy: Clinical integration, evidence base, and mechanisms of change. In A. Finlay-Jones, K. Bluth, & K. Neff (Eds.), Handbook of self-compassion (pp. 379–415). Springer Nature Switzerland AG. https://doi.org/10.1007/978-3-031-22348-8_22

Munawar, K., Choudhry, F. R., Lee, S. H., Siau, C. S., Kadri, N. B. M., & Sulong, R. M. B. (2021). Acceptance and commitment therapy for individuals having attention deficit hyperactivity disorder (ADHD): A scoping review. *Heliyon, 7*(8). https://doi.org/10.1016/j.heliyon.2021.e07842

Oskouie, F., Zeighami, R., & Joolaee, S. (2011). Outcomes of parental mental illness on children: A qualitative study. *Journal of Psychosocial Nursing and Mental Health Services, 49*, 32–40. https://doi.org/10.3928/02793695-20110802-06

Öst, L. G. (2014). The efficacy of acceptance and commitment therapy: an updated systematic review and meta-analysis. *Behaviour Research and Therapy, 61*, 105-121. https://doi.org/10.1016/j.brat.2014.07.018

Potharst, E. S., Zeegers, M., & Bögels, S. M. (2018). Mindful with your toddler group training: feasibility, acceptability, and effects on subjective and objective measures. *Mindfulness, 12*, 489–503. https://doi.org/10.1007/s12671-018-1073-2

Powers, M. B., Zum Vörde Sive Vörding, M. B., & Emmelkamp, P. M. (2009). Acceptance and commitment therapy: A meta-analytic review. *Psychotherapy and Psychosomatics, 78*(2), 73-80. https://doi.org/10.1159/000190790

Prevedini, A., Hirvikoski, T., Holmberg Bergman, T., Berg, B., Miselli, G., Pergolizzi, F., & Moderato, P. (2020). ACT-based interventions for reducing psychological distress in parents and caregivers of children with autism spectrum disorders: Recommendations for higher education programs. *European Journal of Behavior Analysis*, 1–25.

Psychogiou, L., Legge, K., Parry, E., Mann, J., Nath, S., Ford, T., & Kuyken, W. (2016). Self-compassion and parenting in mothers and fathers with depression. *Mindfulness, 7*, 896-908. https://doi.org/10.1007/s12671-016-0528-6

Rasic, D., Hajek, T., Alda, M., & Uher, R. (2014). Risk of mental illness in offspring of parents with schizophrenia, bipolar disorder, and major depressive disorder: a meta-analysis of family high-risk studies. *Schizophrenia Bulletin, 40*(1), 28–38. https://doi.org/10.1093/schbul/sbt114

Reupert, A., & Maybery, D. (2016). What do we know about families where parents have a mental illness? A systematic review. *Child and Youth Service, 37*(2), 98-111. https://doi.org/10.1080/0145935X.2016.1104037

Reupert, A., Gladstone, B., Helena Hine, R., Yates, S., McGaw, V., Charles, G.,Drost, L.,& Foster, K. (2021). Stigma in relation to families living with parental mental illness: An integrative review. *International Journal of Mental Health Nursing, 30*(1), 6–26. https://doi.org/10.1111/inm.12820

Ruiz, F. J. (2010). A review of Acceptance and Commitment Therapy (ACT) empirical evidence: Correlational, experimental psychopathology, component and outcome studies. *International Journal of Psychology and Psychological Therapy, 10*(1), 125–162.

Shea, S. E., & Coyne, L. W. (2011). Maternal dysphoric mood, stress, and parenting practices in mothers of head start preschoolers: The role of experiential avoidance. *Child & Family Behavior Therapy, 33*(3), 231–247. https://doi.org/10.1080/07317107.2011.596004

Stallard, P., Norman, P., Salter, E., Cribb, J., & Huline-Dickens, S. (2004). The effects of parental mental illness upon children: A descriptive study of the views of parents and children. *Clinical Child Psychology and Psychiatry, 9*(1), 39-52. http://doi.org/10.1177/1359104504039767

State of Victoria. (2019). Royal commission into Victoria's mental health system: Interim report: Parliament paper No.87. Victorian Government.

Stokes, D., Mathews, R., Grenyer, B. F., & Crea, K. (2010). The Australian psychology workforce 3: A national profile of psychologists in salaried employment or in independent private practice. *Australian Psychologist, 45*(3), 178–188.

Tabak, I., Zabtocka-Zytka, L., Ryan, P., Poma, S.Z., Joronen, K., Vigano, G., Simpson, W., Paavilainen, E., Scherbaum, N., Smith, M., & Dawson, I. (2016). Needs, expectations and consequences for children growing up in a family where the parent has a mental illness. *International Journal of Mental Health Nursing, 25*(4), 319–29. https://doi.org/10.1111/inm.12194

Tirch, D., Schoendorff, B., & Silberstein, L. R. (2014). The ACT practitioner's guide to the science of compassion: Tools for fostering psychological flexibility. New Harbinger Publications.

van der Ende, P. C., van Busschbach, J. T., Nicholson, J., Korevaar E. L., & van Weeghel, J. (2016). Strategies for parenting by mothers and fathers with a mental illness. *Journal of Psychiatric and Mental Health Nursing, 23*(2)*,* 86-97. http://doi.org/10.1111/jpm.12283

Whittingham, K., and Coyne, L. W. (2019). Acceptance and Commitment Therapy: The Clinician's Guide for Supporting Parents. London: Academic Press.

Williams, K. E., Ciarrochi, J., & Heaven, P. C. L. (2012). Inflexible parents, inflexible kids: A 6-year longitudinal study of parenting style and the development of psychological flexibility in adolescents. *Journal of Youth and Adolescence, 41*, 1053–1066. https://doi.org/10.1007/s10964-012-9744-0

Wilson, L., & Crowe, M. (2009). Parenting with a diagnosis bipolar. *Journal of Advanced Nursing, 65*(4), 877–884. https://doi.org/10.1111/j.1365-2648.2008.04954.x

Chapter 7 - Narrative Therapy for parents who have mental health issues: Therapists' Perceptions

7.1 Background

Included in this chapter is the third and final study of this thesis. This study was submitted for publication with the *International Journal of Narrative Therapy and Community Work* on the 28th of June 2024. The study outlines the experiences and perspectives of narrative therapists working with parents with mental health challenges. In seminal narrative therapy literature by White and Epston (1990), narrative therapy principles and techniques were applied in family therapy settings to enhance communication and address conflict within families by focusing on several key principles: externalising problems, re-authoring narratives, deconstructing dominant narratives, exploring multiple perspectives, restoring relationships and through cultural and contextual sensitivity (White & Epston, 1990). Early research found that narrative therapy was effective in reducing parent-child conflicts Besa (1994). Since then, research has demonstrated how narrative therapy can be to support a range of issues within families (Banker & Goldenson, 2023; Gold, 2016; Fraenkel et al., 2009; Shalay & Brownlee, 2007; Stokes & Poulsen, 2014; Suddeath et al., 2017). However, to the best of our knowledge, no research to date has focused on investigating therapists' overall perspectives of using narrative with parents who experience mental health challenges.

7.2 Aim of the Study

The aim of this study was to examine the views and experiences of practitioners who practice narrative therapy with parents. Specifically, the study sought to explore the following research questions:

- What are the experiences of narrative therapists when working with parents?
- How do narrative therapists perceive the effectiveness of narrative therapy in meeting the needs of parents?
- What are the enablers and barriers that therapists have found using narrative therapy when working with parents?

7.3 Relevance of the Study

There is a growing body of research demonstrating the utility of practicing narrative therapy with parents with mental health challenges (McQueen & Hobbs, 2014; Suddeath et al., 2017). However, it remains under-researched how therapists practicing narrative therapy

experience narrative therapy when working with parents with mental health issues. Data gained from therapists using narrative therapy with parents could be used to inform adaptations of the model specifically for working with parents with mental health challenges and inform future professional development opportunities.

7.4 Declaration of Contribution

The following tables outline the contributions of the candidate (Table 7.1) and the other authors (Table 7.2) to the published study presented in Chapter 7.

Table 7.1

The Candidate's Contribution to the Study in Chapter 7

Nature of Contribution	Extent of Contribution (%)
Study conceptualisation and design	90%
Participant recruitment	95%
Data collection, recording and transcription	100%
Analysis and interpretation of results	70%
Preparation of manuscript	70%

Table 7.2

The Contribution of the Other Authors to the Study in Chapter 7

Name	Nature of contribution	Extend of contribution (%) for student co-authors only
Prof Andrea Reupert	Assisted with the analysis and interpretation of results, provided feedback on the manuscript	10%
Dr Rochelle Hine	Assisted with the analysis and interpretation of results, provided feedback on the manuscript	10%

7.5 Declaration of Ethical Compliance

Ethics approval. Ethics approval was first obtained from Monash University Human Ethics Committee (Project Number: 27250).

Informed consent. Informed consent of all participants was obtained prior to participating in this study, including consent for publication.

Conflict of interest. The authors declare we have no conflicts of interest to disclose.

Paper as submitted to the International Journal of Narrative Therapy and Community Work

Peer review

Head: Narrative Therapy for parents who have mental health challenges: Therapists' Perceptions

Conflict of interest statement: We have no conflicts of interest to disclose. We confirm that this work is original and has not been published elsewhere, nor is it currently under consideration for publication elsewhere.

Byline: By Ciara Hart

Abstract

Many people who undertake therapy are parents with mental health challenges who have unique needs relating to their parenting role. Narrative therapy is a collaborative and non-pathologizing approach to therapy which is growing in popularity and focuses on understanding and reshaping individuals' stories and narratives about their lives (White & Epston, 1990). A narrative approach emphasises the importance of externalizing problems, exploring alternative narratives, and promoting agency and empowerment in clients (White & Epston, 1990). Semi-structured interviews were conducted with six narrative therapists from Australia. Interviews focused on therapists' views and experiences when working with clients who are parents. Transcripts were analysed within an interpretative phenomenological analysis framework to examine participants' perspectives and personal reactions to their professional work with parents.

The following three findings were identified:

1) Deconstructing dominant narratives of family problems
2) Externalising the Problem to reduce parenting guilt and improve parent-child relationships
3) Adapting narrative therapy for use with parents

The findings suggest that narrative therapy can be used to improve family problems, parenting guilt and parent-child relationships, while simultaneously addressing mental health challenges experienced by parents.

Narrative Therapy for parents who have mental health challenges: Therapists' Perceptions

Many mental health service users are parents (Maybery et al., 2015). Parents with mental health challenges have unique needs relating to their parenting role (Reupert & Maybery, 2011). Previous mental health literature has established that family-focused practice, which aims to support both the person with mental health challenges, alongside their family, improves wellbeing and resilience for the client alongside other family members including children (Allchin et al., 2022; Dixon et al., 2001; Mottaghipour & Bickerton, 2005). Therapy is a common treatment option for mental health challenges, yet despite its popularity it remains unclear whether and how parenting needs and responsibilities are addressed in one-on-one therapy with a parent client. This paper will explore one therapeutic option parents with mental health challenges may seek for treatment: narrative therapy (NT).

Parents who experience mental health challenges face the same parenting difficulties that all parents face, but simultaneously need to manage their mental illness. Nonetheless, some studies have found that the experience of being a parent can be uplifting and support recovery. To illustrate, having caring responsibilities for children may provide a structure to one's daily routine (van der Ende et al., 2016), opportunities for social engagement (e.g. with other parents) and a sense of purpose and hope, all of which may promote recovery (Maybery & Reupert, 2018a, 2018b). Moreover, some parents are strongly motivated to engage in mental health services in order to be the best parent they can be for their children (Diaz-Caneja & Johnson, 2004). Nonetheless, some parents find balancing parenting responsibilities while managing their mental health challenges to be overwhelming and detrimental to their mental health (Carpenter-Song et al., 2014; Tabak et al., 2016; Marston et al., 2016, van der Ende et al., 2016).

Some parents who experience mental health challenges report difficulties in being psychologically present, communicating with children and maintaining emotional connections (Marston et al., 2016). Other parents find enforcing boundaries with their children challenging (Marston et al., 2016). Parents may also perceive themselves to be deficient in their parenting role and struggle with feelings of shame and guilt, even when they are providing adequate care (Dolman et al., 2013; Halsa, 2018). It is common for parents to worry about the impact of their mental health challenges on their children (Marston et al., 2016). They may also worry that they will be separated from their children due to family breakdowns, hospitalisation, or child protection interventions (Dolman et al., 2013; Jones et al., 2016). Another common concern of parents is the inheritability of their mental health

condition (Dolman et al., 2013; Halsa, 2018). Parental mental illness, resulting in feelings of worry, insecurity, or withdrawal, as well as negative family interactions, has been identified as a mediating factor between parental and child mental health issues (Leinonen et al., 2003; Weissman et al., 2016; Solantaus-Simula et al., 2002).

Moreover, the social disadvantages commonly associated with mental illness, such as insecure housing, unemployment, poverty, substance use and addiction, have all been found to exacerbate the likelihood of transgenerational mental illness (Beardslee et al., 2011; Hosman et al., 2009; Powell et al., 2020; Power et al., 2016). When social disadvantage is faced by families, problems are often cumulative, for example parental mental illness leading to unemployment, which in turns might lead to insecure housing (Reupert et al., 2022). Thus, due to both generic and environmental reasons, children of parents who have a mental illness are two to three times more likely to develop a mental health problem compared to other children (Maybery et al., 2009a).

Like others in the community, parents may receive support for their mental illness from public mental health services (Dolman et al., 2013; Hine et al., 2018). Most parents have reported receiving little support for their parenting needs and responsibilities from mental health services and instead parents describe feeling misunderstood (Dolman et al., 2013; Jeffery et al., 2013; Jones et al., 2016) and their relationship with their children disregarded (Jeffery et al., 2013; van der Ende et al., 2016). Others fear that if they discuss the concerns they have about their children, child protection services will become involved (Hollingsworth, 2004; Seeman, 2012). Consequently, some parents may conceal or downplay the extent of their parenting difficulties, despite desiring support in these areas (Dolman et al., 2013; Jones et al., 2016).

Most research in this field has investigated mothers' experiences within public adult mental health settings, including the practices of multi-disciplinary teams within psychiatric settings (Dolman et al., 2013). Recent research by Cooper et al., (2023) found that mothers who accessed private mental health services, wanted to feel understood and recognised in their parenting role by their treating psychologist. They also highlighted the importance of having a non-judgemental therapeutic space and practical support to help reduce the impact of their mental health on their children, with particular advice on parenting strategies and techniques while managing their illness (Cooper et al., 2023). These findings contribute to an otherwise limited research base of how private practice therapists support parents with mental health challenges (Cooper et al., 2023).

Therapists who work in private practice represent a large group of the professionals within the mental health workforce (Schofield, 2008). Therapists in private practice, who may have a background in psychology, counselling, or social work, typically work in isolation from other mental health professionals, with individualised and self-directed professional development and supervision (Hammond et al., 2017). Therapists typically work one-on-one with clients who present with a range of different psychological concerns and degrees of complexity (Hammond et al., 2017). Within private practice, there are numerous therapeutical modalities or treatments that therapists may employ when working with clients. At present, there has been very little research into the experiences of therapists practicing across different modalities when working with parents with mental health challenges. Narrative Therapy is one such therapeutic modality practiced by therapists, which is the focus of this study.

Narrative Therapy Model

Narrative therapy (NT), developed by White and Epston (1990) is a systemic form of therapy that is well suited for working with families. It is a collaborative and non-pathologizing approach to therapy that focuses on understating individuals' narratives and stories about their lives and explores alternative narratives, that are more empowering for clients (White & Epston, 1990). In NT the therapist works with the person to develop an empowering and liberating narrative, that heightens the client's sense of agency and personal growth. The approach is collaborative between therapist and client and narrative therapists view clients as having the skills and abilities that will assist them to reduce the problems in their lives and move towards their preferred future. One of the fundamental principles of NT is recognising that each person is an expert in their own lives and is capable of change (Morgan, 2000). In NT, the therapist maintains a position of curiosity, and stays 'decentred' in sessions, holding space for the experiences of the client, and aims to be 'influential' through asking questions which influence what becomes visible in the session (White, 2000).

In the seminal literature by White and Epston (1990) narrative therapy principles and techniques were applied in family therapy settings to enhance communication and address conflict within families by focusing on several key principles: externalising problems, re-authoring narratives, deconstructing dominant narratives, exploring multiple perspectives, restoring relationships and through cultural and contextual sensitivity (White and Epston, 1990).

Key Techniques

Externalising problems

NT places significant emphasises on externalizing problems, regarding problems as distinct from the person (Payne, 2006). For instance, problems are viewed as products of interpersonal relationships or broader social and cultural contexts. Through externalising the problem, clients are encouraged to adopt a critical stance towards problems, questioning how these issues have come to exert influence in their lives without attributing personal fault or inherent deficiencies (Payne, 2006). Externalising the problem helps the person see the problem as something they can change rather than something that defines them. The first steps of externalising the problem involves naming, objectifying, and personifying the problem (Payne, 2006). Externalising problems can also involve externalising conflicts and viewing them as separate from personal identities which allows individuals to explore how these problems have influenced their relationships without attributing blame or fault to each other (Nicholas, 2013; White and Epston, 1990).

Re-authoring Narratives

Individuals or families undertaking NT work collaboratively with the therapist to construct alternative and preferred stories about their lives (White, 2007). This could involve co-constructing alternative narratives about relationships and conflicts by exploring and amplifying instances of positive interactions, and shared values, thereby promoting a more balanced understanding of the relationship.

Deconstructing dominant narratives

NT involves critically challenging problem-saturated or dominant narratives that individuals or families hold about themselves and their experiences (White & Epston, 1990). These narratives may contribute to misunderstandings or conflicts within relationships. Examining moments in a person's life that deviate from dominant problem-saturated narratives, that the client might neglect in their life story, but are ultimately meaningful (Payne, 2006) is an example of deconstruction. Through deconstruction, clients are able to understand the whole picture and develop a rich, more balanced story (Payne, 2006; Brown & Augusta-Scott, 2006).

Cultural and contextual sensitivity

NT interventions are sensitive to cultural backgrounds and contexts, recognizing the impact of cultural beliefs, traditions, and social norms on relationship dynamics (Wendt & Gone, 2017; Vromans et al., 2016). This sensitivity helps therapists tailor interventions that respect and integrate cultural diversity within the therapeutic process.

Effectiveness of NT for families and parents

In addition to the seminal literature by White and Epston (1990) which highlighted how narrative therapy principles and techniques could be applied in family therapy settings, more recent literature has demonstrated that NT can be used to support a range of issues within families. For example, NT has been used to assist blended families (Shalay & Brownlee, 2007; Gold, 2016), to address adoption issues within families (Stokes & Poulsen, 2014), to support homeless families (Fraenkel et al., 2009), and to improve the family functioning of couples (Suddeath et al., 2017). NT has also been shown to assist women in deconstructing unhelpful narratives they may have developed during pregnancy and the postpartum period (Banker and Goldenson, 2023). Besa (1994) found that narrative therapy was effective in reducing parent-child conflicts. Literature by Suddeath et al., (2017) describes how NT techniques can be applied in family therapy including externalising the problem from the family, re-authoring narratives and recognising cultural discourse and its impact on family narratives.

McQueen and Hobbs (2014) described how using a narrative approach with parents can address the power differentials between professionals and parents, and lead to a sense of collaboration. They found that this technique can provide parents with an opportunity to examine, reflect and recognise their resources and skills (McQueen & Hobbs, 2014).

No study to date has focused on investigating therapists' overall perspectives of using NT with parents who experience mental health challenges. Thus, this study aimed to explore NT therapists' experiences about whether and how NT might meet the needs of parents with mental health challenges. Such data may be used to inform adaptations of NT for parents and inform professional development opportunities.

Method

This study was reviewed and approved by Monash University Ethics Committee (Project Number: 27250), and the procedures followed were in accordance with the Helsinki Declaration as revised in 2013. The participants provided their written informed consent to participate in this study.

Participants

To be included in the study, therapists had to be practicing NT with clients who were parents living with mental health challenges. Participants were recruited via social media

posts placed on closed NT Facebook pages, LinkedIn group pages and the Australian Psychological Society research forum. Six narrative therapists practicing in Australia participated, including two counsellors, one social worker, and three psychologists, all working in private practice. One therapist worked in rural areas, and the other five worked in urban areas of Australia. All six participants identified as female. Four participants were parents themselves. One participant did not provide their exact age, but noted they were aged in their 60s. The mean age of the others was 42.93 (SD = 9.32, range = 25). The mean years of experience practicing NT amongst the six participants was 10.67 years (SD = 9.05, range = 27 years).

Procedure

Recruitment posts on Facebook and LinkedIn directed potential participants to the explanatory statement which detailed additional information about the study. Following this, participants were invited to complete an online consent form and provide their demographic and contact information. Seven responses were received, and participants were contacted via email to schedule interviews; one individual did not respond. A total of six semi-structured interviews were conducted through the Zoom video conferencing platform, with interview durations ranging from 24 minutes to 61 minutes, averaging at 40 minutes. Prior to the interviews, all participants gave both written and verbal permission for their interview to be recorded and transcribed using Otter.ai transcription software. To ensure confidentiality, personal or identifiable information was removed from the transcripts. Each transcript was shared with participants for member checking (Lincoln & Guba, 1985), a process whereby participants were given the opportunity to make additions or revisions to their transcripts if they considered any content to be identifiable or inaccurate. No participants requested changes to their transcripts.

Interview

The researchers created a semi-structured interview schedule, consisting of five open-ended questions specifically designed for this study. The open-ended questions were aimed at examining NT practitioners' experiences when working with parents and were followed up with additional probing questions, to obtain more detail as needed. Sample questions included, "Do you think that the NT model is relevant to the experiences of clients who are parents? Why/Why not?" and "What have your experiences been of using NT with parents who have a mental illness?"

Analysis

The interview data (transcripts) were analysed with Interpretive Phenomenological Analysis (IPA). IPA is a qualitative research method which seeks to understand and examine participants' lived experiences and personal perspectives of phenomena (Smith et al., 2009). In this study, IPA facilitated the examination of the lived experiences of therapists who had worked with NT with clients who were parents with mental health challenges, and how they perceived this experience to be. Each transcript underwent initial coding by identifying and highlighting key phrases capturing core conceptual content and language of the transcripts relevant to the research questions (Saldaña, 2015). Each transcript underwent independent coding by two authors; all transcripts were analysed and coded by the primary author, and also analysed and coded by either the second or third authors. Any discrepancies in coding between the authors was resolved through discussion and additional review of the transcripts. Potential differences based on participant demographics were considered and noted when found.

After revisions of the transcript codes, these codes were then used to identify key overarching themes relevant to the research aims. These overarching themes were then employed to re-annotate the transcripts to ensure accurate representation of the data. Reflective discussions and considerations relating to potential interpretations of the interview data and themes occurred among the researchers throughout the analysis process.

Reflexivity Statement

The first author is a cisgender woman with lived experience growing up with a parent who experienced mental illnesses. She has practiced as a Provisional Psychologist for approximately three years in Australia, working with children and parents with mental health challenges. The first author is not trained in NT and is not a parent herself. Following IPA practices of maintaining intersubjective reflexivity (Eatough & Smith, 2008), the first author regularly sought clarification on participants' intended meanings throughout the interviews by making notes of her thoughts and emotions in a research diary (Eatough & Smith, 2008). Other strategies employed included blind, double, or triple annotation, whereby the first, second and third authors analysed and coded the transcripts without being aware of the coding decisions made by one another (Eatough & Smith, 2008). The second author is a qualified psychologist, mother and academic professor with extensive experience in mental health practice and research involving families with parental mental health challenges. Similarly, the third author, is also a mother, social worker and academic, specialising in family mental health research.

Results

The analysis resulted in the identification of three themes; (i) deconstructing dominant narratives of family problems (ii) Externalising the Problem to reduce parenting guilt and improve parent-child relationships and (iii) Adapting NT for use with parents. These themes are described below with excerpts from the interviews. Participants are tagged using codes (e.g., P1 is Participant one, P2 is Participant two and so on.)

Deconstructing dominant narratives of family problems

Several participants highlighted how the NT process of 'deconstructing dominant narratives,' by critically examining problem-saturated narratives that parents hold about their family, was a useful tool for parents to discuss and think about parenting issues. After clients described their family problems, the NT deconstructing process allowed parents to see beyond the problem story i.e., it helps them see that "family problems… are not all that's happening" (P1) and helps them see a bigger picture of family dynamics. P1 noted that through 'deconstructing dominant narrative' parents are encouraged by their therapist to "not just talk about what's going wrong but also what's going right" within their family. P1 described how 'deconstructing dominant narratives' could be "liberating" for parents with mental health challenges, who "so often concern themselves with the issues going on in their families," and neglect "family strengths." Similarly, P2 described how 'deconstructing dominant narratives' helps parents with mental health challenges see that there are "so many layers to" themselves as a parent (P2), helping them to see beyond the problem story.

Therapists described how 'deconstructing dominant narratives' about family "problem stories" helped parents with mental health challenges to see the positive relationship dynamics present in their families, such as "positive parent-child interactions" (P5). P2 described how through the deconstruction process, and inquiring about the whole picture, "the complexities" of parenting, were often brought up, "both good and bad". P5 reported how through 'deconstructing dominant narratives' "you are helping [parents] to realise times when they have felt proud of their parenting and things have worked well. … Parents really appreciate and feel empowered by that."

Three participants (P1, P2, P3) described how deconstructing parents' problems facilitated discussions around transgenerational parenting, which P3 described as discussing "how clients were parented". P2 noted how conversations about transgenerational parenting were naturally brought up in NT as clients discussed their "life history" and where participants asked questions related to the deconstruction process, including "How has their past shaped them?" and "How has their family shaped them?" (P2). Likewise, P3 described

how NT encouraged parents to reflect on their "family stories," and prompted them to consider how similar behaviour "shows up in [their] parenting," practices (P3).

Externalising the Problem to reduce parenting guilt and improve parent-child relationships

Five participants noted the utility of the NT technique of externalising the problem for reducing parenting guilt (P1, P4, P3, P5, P6) and promoting parents' positive relationships with children (P1, P4, P5). Participants described how externalising the problem was a useful tool to help them to challenge the "critical voices" parents experienced (P4) which tells them they are "a failure as a parent and a terrible parent," (P6). P4 explained how when parents with mental health challenges "internalised cultural values," about parenting, this often led to them "critiquing their own parenting." P4 noted how "externalising language really helps shift parents" from feeling "blame and failure… to richer conversations where they're able to see different options for action." Similarly, P3 described how through NT, clients externalise parenting guilt, through an exercise involving "sitting guilt on the chair," and "trying to get to an understanding of the impact of guilt on parenting."

P1 described how in their practice with parents with a mental illness, they introduced external perspectives, such of those from other family members, especially the clients' parents. P1 noted that critical voices in parents were often passed down from their parents. By introducing external perspectives participants were able to ask parents, "is this [critical voice] something you've learned from your parents," and "is there anything you can say that's more encouraging?"

According to P4, P5 and P6, the NT focus of externalising problems promoted parents' positive relationships with their child. P4 described how the "externalising practice is super helpful to help parents and kids get on the same team," so that they view problems as not "inherently in their child [or themselves] but as something that has an influence or an effect on everybody in the household… and that they can team up together to make problems smaller." Further P5 noted the utility of using this technique for parents, who were then able to "see the child outside of the problem," for the first time.

Adapting NT for use with parents

Despite some descriptions of how Narrative Therapy techniques readily lent themselves to discussions around parenting problems and needs, some participants described adapting NT for work with parents. P1, P2 and P6 who all had less than four years of practicing NT, indicated how maintaining "a NT focus throughout the entire session" (P1) was a challenge when working with parents with mental health challenges, who desired more

direction and specific parenting strategies. Similarly, P2 described how some parents "really struggled" with the "non-directive" nature of NT.

> *Some people having a little bit of a hard time with narrative as such a non-directive, feeling approach, and sometimes feelings like "why can't you just tell me what to do? such as parents who ask "how do I effectively parent, my child?" Or" how do I navigate a different parenting style that I have versus my partner has?" Or "how do I connect with my child?" (P2).*

According to P1, some parents struggle with NT as they want therapists to be less explorative, and more skills based: "They're looking more for that expert where they're trying to learn… to get more skills. Not as much to explore what's happening."

To overcome this difficulty, P1 adapted NT, by "moving quite a bit between giving some input, and then I'll go back to [asking] questions." P1 noted that they "give some input on parenting strategies" and introduce psychoeducation into therapy sessions with parents. P2 described:

> *Some parents … need direction and have a harder time with some of the nonlinear approaches. I think narrative therapy could still be modified in a way to support those parents. I see this as a weakness [of NT] - how do we support those parents who just want techniques and strategies? (P2).*

P6 employed psychoeducation and attachment theory in order to meet the needs of parents. Further P6 noted that the non-pathologizing nature of NT is not well suited for some parents who desire "labels or diagnoses," to help them "communicate with agencies, and their children," about their mental health challenges. When parents wanted a diagnostic based therapy, P6 "refers them onto another therapist" working from a different modality than NT.

Conversely, participants with more than five years' experience practicing NT, did not indicate that they had any difficulty maintaining a narrative approach when working with parents with mental health challenges. P5 described how they found it natural to be "in a position of curiosity" when working with parentings, and further noted that "as the therapists, I'm not coming with all the answers to their parenting issues". Similarly, P4 described how the flexible nature of NT, and that fact that it "is not prescriptive," or "manualised" lends itself to working with parents presenting with diverse challenges.

> *A parent whose struggling with parenting, versus a parent whose dealing with maybe their own childhood history that they want to sort through - I think narrative allows for the ability to support both of those parents in both situations, uniquely (P4).*

P3 and P6 also echoed the sentiment that the "adaptive and flexible nature of NT" (P3) was useful for working with parents "and meeting their needs," (P6). P3 further described how they "adapted the questions," they asked parents in therapy, taking into consideration the parents "culture.., disability, age," and education level, to "make things more straightforward," for them.

Discussion

The aim of this study was to investigate the experiences of narrative therapists who work with parents with mental health challenges. The participating therapists highlighted the utility of the 'deconstructing dominant narrative' of family problems with parents and how externalising problems can alleviate parenting guilt and foster positive parent-child relationships. Further, narrative therapists with more years' experience of practicing NT with parents with mental health challenges felt more comfortable maintaining the curious and non-directive typical NT approach, compared to therapists with less experience who reported adjusting NT to enable the provision of parenting strategies and skills when working with parents.

While there have been no qualitative or quantitative studies into NT and parental mental illness to date, the findings of the current study build on existing literature relating to NT (Suddeath et al., 2017). For example, previous research has shown how helping families to 'deconstruct dominant narrative' and remember elements of their family story not characterised by conflict or challenges, contributes to fostering hope amongst family members (Suddeath et al., 2017). This sentiment was echoed by participants of the current study who noted how the 'deconstructing dominant narrative' allowed parents to see beyond their problem and recognise positive aspects of themselves as parents, which was accordingly described as an empowering process for parents.

In line with previous literature (Nichols, 2013; Suddeath et al., 2017; White, 2007), participating therapists in this study highlighted how NT technique of 'externalising the problem' enables parents to see that family problems do not reside within the family or a single individual, including their children. As outlined by participants, 'externalising the problems' can promote positive parent-child relationships, which has been found in previous research (Besa, 1994). Moreover, participants suggested that 'externalising the problem' reduces feelings of blame and guilt in parents, who were described to often present to NT with these feelings. The fact that 'externalising the problems' can reduce parenting guilt is particularly notable, given the high prevalence of guilt and shame in parents with mental health challenges, even when providing adequate care of their children (Halsa, 2018;

Tchernegovski et al., 2017; Hine et al., 2019; Leenman & Arblaster, 2020; Maddocks et al., 2010; Radley et al., 2021; Skundberg-Kletthagen et al., 2020; Strand & Rudolfsson, 2018).

In addition to 'externalising the problem' reducing guilt in parents over parenting-issues, the narrative therapists interviewed in this study also spoke to how this technique could also help to create a non-judgemental therapeutic space which allowed parents to open up. This finding contrasts against many studies that highlight how parents with mental health challenges often feel judged and stigmatised in their interactions with healthcare professionals, despite desiring non-judgemental support (Dolman et al., 2013; Hine et al., 2018; Jeffery et al., 2013; Savvidou et al., 2003). Therefore, it can be considered that the NT approach is well suited for working with parents to meet their needs of having a non-judgemental therapeutic space.

Another key finding of this study was a disparity between therapists with fewer years practicing NT sometimes experiencing difficulty maintaining a narrative approach with parents, compared to NT with more years' experience. The sentiment shared by therapists with fewer than 5 years' experience practicing NT, included that some parents wanted them to be more directive and strategies focused, which aligns with previous research that found parents undertaking therapy want their therapists to provide them with strategies for their parenting role (Cooper et al., 2023). By contrast, therapists with greater than five years' experience practicing NT did not identify finding the narrative approach difficult to maintain when working with parents, and instead emphasised the inherent flexibility and adaptability of the NT approach compared to other therapeutic modalities. This finding suggests that over time, as narrative therapists gain more experience practicing from a narrative approach, they feel increasingly comfortable using it without adapting it by bringing in other therapeutic modalities. Further, this finding highlights the importance of supervision and training for early-career narrative therapists around feeling comfortable maintaining a narrative approach when working with parents with mental health challenges. It also suggests that therapists and clients who are parents with mental health challenges, may have differing expectations about the support they can expect when undertaking NT.

Limitations and future directions

A limitation of this study is the use of a voluntary sampling method, which may have attracted participants with a particular interest in working with clients who are parents. There is scope to repeat this research with a larger sample of narrative therapists, who practice with clients across the lifespan and gain insight into their experiencing working with parents. Additionally, future research could also be conducted which compares the usefulness of NT

for parents with mental health challenges, to other therapeutic modalities. This research may indicate which psychotherapeutic modalities are best suited to practicing with parents with mental health challenges or highlight what techniques from different modalities address the needs for parents. For instance, the findings of this study highlighted that the NT processes of 'externalising the problem' and 'deconstructing dominant narratives of family problems' were particularly useful techniques for working with parents with mental health challenges. Therefore, there is utility for therapists who work from an integrated practice and draw on techniques from numerous modalities, to draw on NT techniques as appropriate.

Additionally, it would be useful to triangulate the data by investigating parents' perspectives and experiences of undertaking NT, to support their mental health challenges and parenting needs. Collectively, the insights from this study alongside parents experiences of NT could be used to inform future NT training for working with parents and supervision practices.

Conclusion

The findings of this study indicate that a narrative therapy approach, especially the processes of externalisation and deconstruction of unique outcomes, are well suited to meeting the needs of parents who have mental health challenges. Future research might deliver further perspectives of narrative therapists, especially around their level of comfortability with the NT model in their first few years post training, as well as research into the experiences of parents themselves as end recipients of narrative therapy.

References

Allchin, B., & Solantaus, T. (2022). An evidence-based practice developed in-situ: Let's Talk About Children and a consolidation of its evidence base. *Frontiers of Psychiatry,* https://doi.org/10.3389/fpsyt.2022.824241

Besa, D. (1994). Evaluating narrative family therapy using single-system research designs. *Research on Social Work Practice, 4,* 309–325. https://doi.org/10.1177/104973159400400303

Beardslee, W. R., Solantaus, T., Morgan, B. S., Gladstone, T. R., & Kowalenko, N. M. (2012). Preventive interventions for children of parents with depression: international perspectives. *The Medical journal of Australia, 199*(3 Suppl), S23-S25. https://doi.org/10.5694/mja12.11129

Brown, C., & Augusta-Scott, T. (2006). *Narrative Therapy: Making Meaning, Making Lives* (1st ed.). SAGE Publications, Incorporated. https://doi.org/10.4135/9781452225869

Carpenter-Song, E. A,. Holcombe, B. D., Torrey, J., Hipolito, M. M. S., & Peterson, .L D. (2014). Recovery in a family context: Experiences of mothers with serious mental illnesses. *Psychiatric Rehabilitation Journal, 37*, 162 169. http://doi.org/10.1037/prj0000075

Cooper, C., Tchernegovski, P., & Hine, R. (2023). "The validation is not enough": Australian mothers' views and perceptions of mental health support from psychologists in private practice. *Clinical Psychologist*, *27*(3), 392–403. https://doi.org/10.1080/13284207.2023.2259053

Diaz-Caneja, A., & Johnson, S. (2004). The views and experiences of severely mentally ill mothers: A qualitative study. *Social Psychiatry and Psychiatric Epidemiology, 39*(6), 472-482. https://doi.org/10.1007/s00127-004-0772-2

Dolman, C., Jones, I., & Howard, L. M. (2013). Pre-conception to parenting: A systematic review and meta-synthesis of the qualitative literature on motherhood for women with severe mental illness. *Archives of Women's Mental Health, 16*(3), 173-196. https://doi.org/10.1007/s00737-013-0336-0

Dixon, L., McFarlane, W. R., Lefley, H., Lucksted, A., Cohen, M., Falloon, I., Miklowitz, D., Solomon P., Sondheimer, D. (2001). Evidence-based practices for services to families of people with psychiatric disabilities. *Psychiatric Services, 52*(7), 903–910. https://doi.org/10.1176/appi.ps.52.7.903

Eatough, V., & Smith, J. A. (2008). 'Interpretative Phenomenological Analysis' in *The SAGE Handbook of Qualitative Research in Psychology.* London: SAGE Publications Ltd.

Freedman, J., & Combs, G. (1996). *Narrative therapy: The social construction of preferred realities*. Norton.

Fraenkel, P., Hameline, T., & Shannon, M. (2009). Narrative and collaborative practices in work with families that are homeless. *Journal of Marital and Family Therapy, 35,* 325–342. http://doi.org/10.1111/j.17520606.2009.00119.x

Gallant, P., & Strauss, I. (2011). Narrative therapy with couples. In D. K. Carson & M. Casado- Kehoe (Eds.), *Case studies in couples therapy: Theory-based approaches* (pp. 289–301). Routledge.

Gold, J. M. (2016). *Stepping in, stepping out: Creating stepfamily rhythm*. Alexandria, VA: American Counseling Association.

Halsa, A. (2018). Trapped between madness and motherhood: Mothering alone. *Social Work in Mental Health, 16*(1), 46–61.

Hammond, I., Eastman, A. L., Leventhal, J. M., & Putnam-Hornstein, E. (2017). Maternal mental health disorders and reports to child protective services: A birth cohort study. *International Journal of Environmental Research and Public Health, 14*(11), Article E1320. https://doi.org/10.3390/ijerph14111320

Hine, R. H., Maybery, D., & Goodyear, M. J. (2018). Challenges of connectedness in personal recovery for rural mothers with mental illness. *International Journal of Mental Health Nursing, 27*(2), 672–682. https://doi.org/10.1111/inm.12353

Hine, R., Maybery, D., & Goodyear, M. (2019). Identity in personal recovery for mothers with a mental illness. *Frontiers in Psychiatry, 10*(89). https://doi.org/10.3389/fpsyt.2019.00089

Hollingsworth, L. D. (2004). Child custody loss among women with persistent severe mental illness. *Social Work Research, 28*(4), 199–209. https://doi.org/10.1093/swr/28.4.199

Hosman, C. M. H., van Doesum, K. T. M., & van Santvoort, F. (2009). Prevention of emotional problems and psychiatric risks in children of parents with a mental illness in the Netherlands: I. The scientific basis to a comprehensive approach. *Australian e-Journal for the Advancement of Mental Health, 8*(3), 250–263. https://doi.org/10.5172/jamh.8.3.250

Jeffery, D., Clement, S., Corker, E., Howard, L. M., Murray, J., & Thornicroft, G. (2013). Discrimination in relation to parenthood reported by community psychiatric service users in the UK: A framework analysis. *BMC Psychiatry, 13*(1), 120.

https://doi.org/10.1186/1471-244X-13-120

Jones, M., Pietila, I., Joronen, K., Simpson, W., Gray, S., & Kaunonen, M. (2016, October). Parents with mental illness - a qualitative study of identities and experiences with support services. *Journal of Psychiatric & Mental Health Nursing, 23*(8), 471–478. https://doi.org/10.1111/jpm.12321

Jørgensen, C. B., Behrmann, J. T., Blaabjerg, J., Pettersen, K. A., & Jensen de López, K. M. (2024). Narrative therapy with children: A qualitative interview study with Danish therapists about the application of narrative practices. *Counselling and Psychotherapy Research, 24*(1), 295–307. https://doi.org/10.1002/capr.12656

Leenman, G., & Arblaster, K. (2020). Navigating rocky terrain: A thematic analysis of mental health clinician experiences of family-focused practice. *The Journal of Mental Health Training, Education and Practice, 15*(2), 71–83. https://doi.org/10.1108/jmhtep-04-2019-0022

Leinonen, J. A., Solantaus, T. & Punamäki, R.-L. (2003). Parental mental health and children's adjustment: The quality of marital interaction and parenting as mediating factors. *Journal of Child Psychology and Psychiatry*, *44* (2), 227–241. https://doi.org/10.1111/1469-7610.t01-1-00116

Lincoln, Y., & Guba, E. G. (1985). *Naturalistic inquiry*. Sage.

Maddocks, S., Johnson, S., Wright, N., & Stickley, T. (2010). A phenomenological exploration of the lived experience of mental health nurses who care for clients with enduring mental health problems who are parents. *Journal of Psychiatric and Mental Health Nursing, 17*(8), 674–682. https://doi.org/10.1111/j.1365-2850.2010.01582.x

Marston, N., Stavnes, K., Van Loon, L. M. A., Drost, L. M., Maybery, D. J., Mosek, A., Reupert, A. E. (2016). A content analysis of Intervention Key Elements and Assessments (IKEA): What's in the black box in the interventions directed to families where a parent has a mental illness? *Child & Youth Services, 37*(2), 112–128. https://doi.org/10.1080/0145935X.2016.1104041

Maybery, D. & Reupert, A. (2009, November). Parental mental illness: A review of barriers and issues for working with families and children. *Journal of Psychiatric & Mental Health Nursing, 16*(9), 784–791. https://doi.org/10.1111/j.1365-2850.2009.01456.x

Maybery, D., Reupert, A., Goodyear, M., Ritchie, R., Brann, P., & Maybery, D. (2015). Investigating the strengths and difficulties of children in families with a parental mental illness. *Journal of Psychiatric and Mental Health Nursing, 22*(1), 3-12. https://doi.org/10.1111/jpm.12174

Maybery, D., & Reupert, A. (2018a). A family-focused, recovery approach when working with families when a parent has a history of mental health problems: From theory to practice. In J.C. Santos & J.R. Cutcliffe (Eds), *European Psychiatric/Mental Health nursing in the 2st century: A person-centred evidence-based approach* (pp. 283-291). Switzerland: Springer.

Maybery, D. & Reupert, A. E. (2018b). The number of parents who are patients attending adult psychiatric services *Current Opinion in Psychiatry, 31*(4), 358-362. http://doi.org/10.1097/YCO.0000000000000427

McQueen, C., & Hobbs, C. (2014). Working with parents: Using narrative therapy to work towards genuine partnership. *Educational and Child Psychology, 31*, 9-17. https://doi.org/10.53841/bpsecp.2014.31.4.9

Morgan, A. (2000). *What is narrative therapy?* Dulwich Centre Publications.

Mottaghipour, Y., & Bickerton, A. (2005). The Pyramid of Family Care: A framework for family involvement with adult mental health services. *Australian e-Journal for the Advancement of Mental Health, 4*(3), 210–217. https://doi.org/10.5172/jamh.4.3.210

Nichols, M. P. (2013). *Family therapy: Concepts and methods* (10th ed.). Pearson.

Payne, M. (2006). *Narrative therapy*. Sage.

Powell, R. M., Mitra, M., Nicholson, J., & Parish, S. L. (2020). Perceived community-base needs of low-income parents with psychiatric disabilities who experienced legal challenges to their parenting rights. *Children and Youth Services Review, 112*, 104902. https://doi.org/10.1016/j.childyouth.2020.104902

Power, J., Goodyear, M., Maybery, D., Reupert, A., O'Hanlon, B., Cuff, R., & Perlesz, A. (2016). Family resilience in families where a parent has a mental illness. *Journal of Social Work, 16*(1), 66-82. https://doi.org/10.1177/1468017314568081

Radley, J., Barlow, J., & Johns, L. (2021). Mental health professionals' experiences of working with parents with psychosis and their families: A qualitative study. *BMC Health Services Research, 21*(1), 1–11. https://doi.org/10.1186/s12913-021-06416-1

Reupert, A., & Maybery, D. (2011). Families affected by parental mental illness: A multiperspective account of issues and interventions. *American Journal of Orthopsychiatry, 81*(1), 38-47. https://doi.org/10.1111/j.1939-0025.2010.01073.x

Reupert, A., Straussner, S., Weimand, B., & Maybery, D. (2022). It Takes a Village to Raise a Child: Understanding and Expanding the Concept of the "Village". *Frontiers in Public Health*. Advance online publication. https://doi.org/10.3389/fpubh.2022.756066

Rivett, M., & Buchmüller, J. (2017). *Family therapy skills and techniques in action*. Taylor & Francis Group.

Savvidou, I., Bozikas, V., Hatzigeleki, S., & Karavatos, A. (2003). Narratives about their children by mothers hospitalized on a psychiatric unit. *Family Process, 42*(3), 391. https://doi.org/10.1111/j.1545-5300.2003.00391.x

Seeman, M. V. (2012). Intervention to prevent child custody loss in mothers with schizophrenia. *Schizophrenia Research and Treatment,* 1–6. https://doi.org/10.1155/2012/796763

Slack, K. & Webber, M. (2008). Do we care? Adult mentalSchofield, M. J. (2008). Australian counsellors and psychotherapists: A profile of the profession. *Counselling and Psychotherapy Research, 8*(1), 4-11. https://doi.org/10.1080/14733140801936369

Shalay, N., & Brownlee, K. (2007). Narrative family therapy with blended families. *Journal of Family Psychotherapy, 18,* 17–30. http://doi:10.1300/J085v18n02_02

Skundberg-Kletthagen, H., Gonzalez, M. T., Schröder, A., & Moen, Ø. L. (2020). Mental health professionals' experiences with applying a family-centred care focus in their clinical work. *Issues in Mental Health Nursing, 41*(9), 815–823. https://doi.org/10.1080/01612 840.2020.1731028

Solantaus-Simula, T., Punamäki, R.-L., & Beardslee, M. D. (2002). Children's responses to low parental mood. II: Associations with family perceptions of parenting styles and child distress. *Journal of the American Academy of Child & Adolescent Psychiatry, 41*(3), 287-295. https://doi.org/10.1097/00004583-200203000-00007

Strand, J., & Rudolfsson, L. (2018). Professionals' experiences of integrating a child perspective in adult psychosis service. *American Journal of Psychiatric Rehabilitation, 21*(1), 57–78.

Stokes, L. D., & Poulsen, S. S. (2014). Narrative therapy for adoption issues in families**,** couples, and individuals**:** Rationale and approach. *Journal of Family Psychotherapy, 25,* 330–347. http://dx.doi.org/10.1080/08975353.2014.977681

Suddeath, E. G., Kerwin, A. K., & Dugger, S. M. (2017). Narrative Family Therapy: Practical Techniques for More Effective Work with Couples and Families. *Journal of Mental Health Counseling, 39*, 116-131. http://doi.10.17744/mehc.39.2.03

Tabak, I., Zabłocka-Żytka, L., Ryan, P., Poma, S. Z., Joronen, K., Viganò, G., Simpson, W., Paavilainen, E., Scherbaum, N., Smith, M., Dawson, I. (2016). Needs, expectations and consequences for children growing up in a family where the parent has a mental

illness. *International Journal Mental Health Nursing 25*(4), 319–329. https://doi.org/10.1111/inm.12194

Tchernegovski, P., Maybery, D., & Reupert, A. (2017). Legislative policy to support children of parents with a mental illness: Revolution or evolution? *International Journal of Mental Health Promotion*, 19, 1–13. https://doi.org/10.1080/14623730.2017.1281125

van der Ende, P. C., van Busschbach, J. T., Nicholson, J., Korevaar E. L., & van Weeghel, J. (2016). Strategies for parenting by mothers and fathers with a mental illness. *Journal of Psychiatric and Mental Health Nursing, 23*(2)*,* 86-97. https://doi.org/10.1111/jpm.12283

Vromans, L. P., Schweitzer, R. D., & Brough, M. (2016). Narrative therapy for refugees: Developing practice guidelines based on qualitative research in Australia. *Journal of Ethnic & Cultural Diversity in Social Work, 25*(3), 158-173. https://doi.org/10.1080/15313204.2015.1132968

Weissman, M. M., Wickramaratne, P., Gameroff, M. J., Warner, V., Pilowsky, D., Kohad, R. G., Talati, A. (2016). Offspring of Depressed Parents: 30 Years Later. *American Journal of Psychiatry, 173*(10), 1024–1032. https://doi.org/10.1176/appi.ajp.2016.15101327

Wendt, S., & Gone, J. P. (2017). Rethinking cultural competence: Insights from indigenous community treatment settings. *Culture, Medicine, and Psychiatry, 41*(4), 581-605. https://doi.org/10.1007/s11013-017-9517-2

White, M. (2000**).** Reflections on narrative practice: Essays and interviews**.** Dulwich Centre Publications.

White, M. (2007). *Maps of narrative practice*. Norton.

White, M., & Epston, D. (1990). *Narrative Means to Therapeutic Ends*. Norton.

Chapter 8 - General discussion

8.1 Introduction

The previous chapters presented the experiences and perceptions of therapists who practiced one of three different therapeutic interventions when working with parents with mental health challenges. In this chapter, the thesis rationale and aims are reviewed. The main findings of these three studies, including therapists' perceptions of using each modality with parents who have mental health challenges, and the enablers (strengths) and barriers (challenges) of the therapies for working with parents will be revisited. Further, the main findings across the three studies will be compared, and similarities and differences in experiences of working with parents with mental health challenges will be discussed. The strengths and limitations of the thesis are noted, and recommendations are made in relation to future research directions. Clinical and other implications when working with parents with mental health challenges conclude this chapter.

8.2 Rationale and Summary of Aims

One third of mental health service users are parents with dependent children (Maybery et al., 2009) who have support needs that may be different or additional to the support needs of service users who are not parents (Reupert & Maybery, 2016). While there are various approaches for working with parents with mental health challenges, including family approaches, organisational approaches and community approaches, this thesis investigated an individual approach, one-on-one counselling with parents. Counsellors in private practice present a large proportion of the Australian mental health workforce (Australian Government Department of Health, 2019) and are considered to be one of the most common and accessible mental health supports for parents with mental health challenges (AIHW, 2023). Despite this, the majority of research relating to parents' experiences of mental healthcare has focused on the practices of multidisciplinary teams within rehabilitation and psychiatric settings in the public mental health sector (Dolman et al., 2013).

There have been few studies that have investigated the experiences of parents with mental health challenges who undertake therapeutic counselling in private settings (Cooper et al., 2023). Previous research suggests that non-parenting focused mental health interventions, including cognitive behaviour therapy (CBT) may not consistently meet the needs of parents with mental health challenges and their children (Coiro et al., 2012). By contrast, other

research has found that interpersonal therapy (IPT) may reduce psychological distress in perinatal women and improve social support, relationship satisfaction, and parental adjustment (Bright et al., 2020). Further, a meta-analysis conducted by Cuijper et al., (2015) showed how psychotherapies, including CBT, psychodynamic therapy and interpersonal psychotherapies, lead to decreased depression levels and reduced parental distress in mothers with mental health challenges, and may have positive impacts on the mental health of their children. The psychotherapies reviewed in this meta-analysis were conducted in various settings, including outpatient mental health clinics, hospitals, and community-based facilities. However, the authors noted that more research is needed in this field to better understand the specific mechanisms by which these psychotherapies influence parent and child mental health outcomes, to determine the long-term effects of such interventions, and to address gaps such as diverse populations, and more rigorous study designs (Cuijper et al., 2015).

Although the utility of various psychotherapeutic interventions for meeting the unique needs of parents with a mental illness remains unclear, the effectiveness of psychotherapy for treating a range of different mental illnesses across different population groups has been well documented (Wampold & Imel, 2015). Studies have shown how schema therapy can be effective for clients with borderline personality disorder (BPD) (Spinhoven et al., 2007), depression (Hawke & Provencher, 2011; Köruk & Özabaci, 2018), anxiety, obsessive-compulsive disorder and post-traumatic stress disorder (Peeters et al., 2021). Acceptance and commitment therapy (ACT) has been shown to be effective in reducing symptoms in adults experiencing a range of conditions including anxiety, depression, substance use, pain, and transdiagnostic groups (Gloster et al., 2020). Narrative therapy has been found to be effective in improving depressive symptoms (Lopez et al., 2014a; Vromans & Schweitzer, 2011) and those with anorexia and bulimia (Lock et al., 2005; Heywood et al., 2022) and specific phobias (Tadros et al., 2022). Schema therapy, ACT and narrative therapy have all been found to help improve symptoms of a range of mental health challenges. The aim of this thesis was to examine the use of schema therapy, ACT and narrative therapy with parents who have mental health challenges, from the experiences and perspectives of therapists working with parents. Specifically, this thesis sought to examine the following questions:

- What are the experiences of therapists using different modalities when working with parents with mental health challenges? Do therapists using different modalities, have different experiences working with parents?

- From the perspective of therapists, what elements of the various therapeutic strategies and approaches appear to respond to the needs of parents who experience mental health challenges? Are there common strategies or tools across the three modalities that therapists find work best for parents with mental health challenges? If so, what are these?
- What enablers and barriers have therapists found when working with these therapeutic modalities with parents? How do these compare between the different modalities?

The research in this thesis was explorative in nature and aimed to investigate the ways in which therapists experience and perceive how schema therapy, acceptance and commitment therapy and narrative therapy are practiced with parents with mental health challenges, including their views on whether (and if so, how) these modalities meet the needs of parents. In line with my phenomenological ontological views of the world, the thesis sought to explore the experiences of therapists and their subjective realties of what it was like therapeutically practicing with parents with mental health challenges (Smith et al., 2009). Throughout the research, therapists described different therapeutic techniques that they considered to be well suited to parents. Additionally, challenging aspects related to the use of each therapeutic model with parents were raised, as well as techniques that therapists felt they needed to adapt.

8.3 Summary of Research Findings

The three studies in this thesis examined participants' experiences and views about their therapeutic work with parents, by practicing schema therapy, ACT or narrative therapy. The following sections summarise the main findings of each of the three studies.

8.3.1 Schema Therapists' Experiences of Working with Parents with Mental Health Challenges

The study in Chapter 5 presented the experiences of schema therapists working with parents with mental health challenges. Using an IPA methodology, which is underpinned by constructivist epistemological and phenomenological ontological frameworks, the study explored how schema therapists use schema therapy with parent clients (Packer et al., 2000). This included understanding their perspectives regarding how schema therapy did and did not meet the needs of parents as well as any adaptations they may have made to the therapy when working with parents with mental health challenges.

After conducting semi structured interviews with thirteen schema therapists and analysing the data using IPA, three key themes were identified: (1) schema therapy can be used to increase understanding of a client's parenting behaviour; (2) schema therapy allows for a dual focus on the client's child and Vulnerable Child Mode; and additionally (3) the need for a systemic focus within schema therapy that encompass family dynamics.

Findings indicated that there is utility for therapists to use schema therapy to raise and explore the topic of parenting within the context of their mental health treatment. Some participants noted that schema therapy offered a dual focus by addressing the needs of the internal Vulnerable Child Mode (Young et al., 2003) and the real-life children of parents. This dual approach in schema therapy may aid parents in addressing their own mental health concerns while gaining insight into the needs of their children because the approach entails examining the core needs of children and how they are met (or not) by primary caregivers, knowledge which could be applied to the client's experiences of both parenting and being parented.

Participants highlighted that the schema therapy model could be used as a means to develop or enhance self-parenting skills by strengthening clients' Healthy Adult Mode (Young et al., 2003). For example, P2 described how strengthening one's Healthy Adult helps parents experience how they can meet the needs of their own child which in turn can positively influence their parenting practices. Participants noted that they were able to use schema therapy to promote client insight into their parenting. Some reported using various aspects of the schema therapy model, such as modes and experiential techniques, to assist clients in identifying and addressing parenting-related behaviours. Others discussed using the schema therapy model to explore transgenerational parenting patterns. Consequently, schema therapy might serve as a valuable therapeutic tool for initiating discussions about clients' parental roles and related challenges.

While some participants applied schema therapy flexibly to address parental needs, another key finding was that many therapists used standard techniques without acknowledgment of parenting-specific considerations. Some were unsure how to adapt schema therapy for parents, while others stated that it did not require adaptation as it was appropriate to use with parents in its traditional form. Conversely, a number of participants noted that they adapted their practice for parents, integrating family-focused techniques, parenting programs and drawing from other modalities such as CBT. Participants expressed a need for more training and resources for using schema therapy with parents. A desire for a schema therapy model that encompassed family dynamics and had a greater systemic focus

was expressed. Further, participants expressed a need for parenting-specific resources in general, as some reported drawing on resources from couples therapy and parenting programs when working with parents, highlighting the current lack of parent-specific schema therapy resources.

8.3.2 ACT Therapists' Experiences of Working with Parents with Mental Health Challenges

The study presented in Chapter 6 explored the experiences of ACT therapists when working with parents with mental health challenges. This sought to explore therapists' perspectives on how ACT therapy did and did not meet the needs of parents as well as any adaptations they may have made to this therapeutic approach when working with these parents. Using semi-structured interviews with nine ACT therapists, three key themes were identified: (1) The ACT model is useful for parents in supporting their parenting role and mental health; (2) ACT can promote much-needed self-compassion in parents with mental health challenges; and (3) limitations of ACT when working with parents with mental health challenges.

Across the interviews, therapists described how ACT was a useful model for supporting parents with parenting issues and their mental health challenges. Numerous participants described how all six ACT core processes could be applied to parenting issues. Some participants highlighted how the transdiagnostic nature of the acceptance and commitment therapy model was useful for working with parents presenting with a range of mental health challenges. The finding that the ACT model meets the needs of parents through improving their emotional regulation in interactions with their children, builds upon similar findings from previous research (Flujas-Contreras et al., 2022; Leeming & Hayes 2016; Shea & Coyne, 2011).

Further, the ability for ACT to promote much-needed self-compassion in parents was highlighted. For example, P3 described placing more emphasis on building self-compassion when working with clients who were parents, than clients who were not parents. The findings from this thesis builds upon parenting and self-compassion research, which has previously highlighted the importance of promoting self-compassion for parents with mental health challenges, who often struggle with self-criticism and guilt (Hine et al., 2019; Wilson & Crowe, 2009; Blegen et al., 2012).

Limitations of the ACT model for use with parents with mental health challenges were also raised. For instance, some participants indicated that they adapted some of the

terminology and metaphors used in the traditional ACT model when working with parents, to be more appropriate to parents' situations and needs. Some participants used only the ACT model in their therapeutic work with parents, while other therapists felt the need to draw on additional modalities or parenting programs to better meet the needs of parents with mental health challenges. There did not appear to be a pattern based on years of experience of practicing ACT or whether participants used ACT as a stand-alone therapy or not, suggesting that the decision to draw on additional modalities was driven by individual preferences rather than their level of familiarity with the ACT model. The finding that therapists drew on additional modalities or parenting programs to better meet the needs of parents with mental health challenges aligns with previous research which described how practicing ACT alongside an established parenting approach, including the Stepping Stones Triple P program, can improve parents' psychological distress, psychological flexibility and confidence in managing behaviours and family adjustments (Brown et al., 2015).

The ACT model has been adapted for working with parents formally in the literature by Whittingham and Coyne (2019). Whittingham and Coyne's (2019) work tailored the six ACT processes to address the unique challenges of parents of children with a disability. For example, their work highlights how acceptance can be adapted to encourage parents to accept their own thoughts and feelings, rather than fighting them, including accepting the challenges and imperfections of parenting (Whittingham and Coyne, 2019). Additionally, Whittingham and Coyne's (2019) describe how the values process should be adapted with parents to assist parents in identifying what truly matters to them in their parenting lives, as well as their personal lives. Throughout the research conducted for this thesis, no acceptance and commitment therapist participants referenced adapting the model according to Whittingham and Coyne's work (2019). However, many of the therapists in Study 2 described adapting the ACT model in line with Whittingham and Coyne's model (2019), such as having discussions around parenting values. It appears as though the therapists involved in this research adapted aspects of ACT on an ad hoc basis, rather than according to a formalised model such as Whittingham and Coyne's (2019). Many of the participants interviewed indicated that the ACT model is inherently flexible and adapts easily for use with parents, suggesting its suitability and effectiveness for addressing the unique challenges parents face.

8.3.3 Narrative Therapists' Experiences of Working with Parents with Mental Health Challenges

Chapter 7 presented the study on the experiences, of narrative therapists who work with parents who have mental health challenges. This study sought to explore narrative therapists' perspectives on how narrative therapy did and did not meet the needs of parents as well as any adaptations they might make to this style of therapy when working with parents (if at all). Using semi-structured interviews with six narrative therapists, three key themes were identified: (1) using narrative therapy for the deconstruction of family problems (2) externalising the client's problem to reduce parenting guilt and improve parent-child relationships and (3) adapting narrative therapy for use with parents.

The NT process of 'deconstruction of unique outcomes' involves examining moments in a person's life that deviate from dominant problem-saturated narratives to making the whole picture easier to understand. Many participants saw this process as a useful tool for parents to see beyond family problems and think more positively about their parenting. For example, participants noted that deconstruction allowed parents with mental health challenges to recognise moments where they have felt proud of their parenting, such as positive parent-child interactions.

Additionally, it was noted by some narrative therapists that when working with parents with mental health challenges, using the narrative therapy process of 'deconstruction of unique outcomes' can help to facilitate discussions around transgenerational parenting, with clients reflecting on how they were parented and how that has shaped them. Narrative therapists indicated that this technique would prompt parents to consider how they may be displaying similar behaviour in their own parenting, as that they received when they were a child.

Another key finding was that the narrative therapy technique of 'externalising the problem' helped to reduce parenting guilt and improve parent-child relationships. Experiences of parental guilt and shame have been found to be commonplace for parents with mental health challenges (Halsa, 2018; Tchernegovski et al., 2017; Hine et al., 2019; Leenman & Arblaster, 2020; Maddocks et al., 2010; Radley et al., 2021; Skundberg-Kletthagen et al., 2020; Strand & Rudolfsson, 2018). Importantly, the narrative therapy technique of 'externalising the problem' was found to help create a non-judgemental therapeutic space and reduce parents' feelings of shame and guilt. 'Externalising the problem' was found to help parents view problem-stories between themselves and their child

as outside of themselves and their child, which in turn, allowed them to influence and address the problem of concern. This finding builds upon previous research that similarly found how 'externalising the problem' helped people see that problems do not reside within the family or a single individual (Nichols, 2013; Suddeath et al., 2017; White, 2007). Additionally, the finding aligns with previous research that suggests 'externalising the problem' in narrative therapy can be used to promote positive parent-child relationships (Besa, 1994).

This study also highlighted common barriers or difficulties narrative therapists experience when practicing with parents with mental health challenges. Some participants noted that the non-directive nature of narrative therapy was a barrier for parents who expected their therapeutic treatment to be more direct and strategies based. This aligns with previous research by Cooper et al., (2023) who highlighted that parents undertaking therapy preferred therapists who were directive and gave advice about specific parenting strategies. Narrative therapists with less experience described adapting the narrative therapy approach to be more directive with parents, such as by introducing psychoeducation or additional modalities.

8.4 General Findings Across Studies

Across the three studies, several common themes were identified. According to the participants interviewed, schema therapy, ACT and narrative therapy approaches all have utility for working with parents with mental health challenges. Across all three therapeutic approaches, therapists described parents' mental health as well as their parenting practices changing as a result of therapy. The research across all three studies add to the limited body of knowledge on supporting parents with mental health challenges in private practice settings, an area of study still in its early stages (Cooper et al., 2023). Certain techniques from each of the three modalities - schema therapy, ACT and narrative therapy - were considered to be well suited for working with parent clients to meet both their parenting and mental health needs. Therapists described all three modalities as effective in helping parents develop self-compassion. Another common finding was that participants described adapting certain therapeutic techniques or incorporating theories from other modalities or parenting programs to better address the needs of parents.

In reflecting on the data, it was noted that participants did not raise the therapeutic alliance or their own parenting status when describing their experiences of working with parents with mental health challenges. Previous literature has highlighted the importance of the therapists' parenting status (Foster & Isobel, 2018; Grant et al., 2019; Tchernegovski et

al., 2018a, 2018b; Tuck et al., 2023) and the therapeutic relationship (Castonguay et al., 2010; Kraus et al., 2011; Horvath et al., 2011) for working with parents so it was expected that these themes would be raised throughout interviews. Potential reasons for these gaps will be discussed.

8.4.1 Parents' Mental Health and Parenting Practices

Participants across all three studies described how they perceived changes in parent clients' mental health and parenting practices as a result of engaging in therapeutic work. There are many different reasons why clients, including parents, might seek therapy, possibly related to parenting but often not. The focus of this study was to understand therapists' perspectives of using specific modalities with parents who have mental health challenges, regardless of the clients' initial reasons for seeking therapy. According to therapists across all three modalities, the main reason parents attended therapy was related to their mental health challenges and concerns, not specifically related to parenting issues. This is not unusual given parents' reluctance to talk about their parenting and children in therapy, due to concerns about stigma and the fear of child protection notifications (Hollingsworth, 2004; Seeman, 2012).

Nonetheless, interviews with schema therapists, ACT therapists and narrative therapists found that techniques and theortical frameworks within each modality helped therapists initiate conversations about parenting issues. For instance, numerous schema therapists described experiences where they felt that discussions about modes with parents, namely the Healthy Adult Mode and Vulnerable Child Mode, furthered parents' understandings of how their own Healthy Adult Mode and Vulnerable Child Modes were presenting. Parents' new insights regarding their modes and how they presented, facilitated their ability to strengthen their Healthy Adult, or reduce their Vulnerable Child Mode, as modelled by their therapists. Further, as a result of this new understanding, therapists described how parents' mental health and parenting practices improved. Likewise, ACT participants gave examples of how teaching the therapeutic processes of 'flexible perspective taking' and 'defusion' of thoughts, aided parents to reconstruct perceptions and beliefs they held about themselves as parents, which in their view led to changes in their parenting practices. Additionally, participants described how they perceived the process of 'acceptance/willingness to experience' could help parents create new meanings for experiences and emotions which had a positive impact of their mental health. Narrative therapist participants reiterated how therapists and clients could work together to construct

new meanings and insights about parenting practices, such as through reconstructing family narratives.

Participants explained that one-on-one therapy focused on addressing the mental health challenges of parent clients, also facilitated discussions about parenting practices. The schema therapy, ACT, and narrative therapy models were described as supporting these broad conversations beyond mental health concerns. Participants observed that parent clients gained new understandings and insights about their parenting role through therapy, which fostered hope and increased awareness of potential changes they could make. This finding aligns with the constructivist epistemological perspective underpinning this thesis, which emphasises that clients and therapists collaboratively create new meanings and insights by reconstructing perceptions and beliefs, ultimately facilitating change (Braun & Clarke, 2013; Packer et al., 2000). These new insights about parenting practices provided parents with a sense of hope and subsequently positively impacted their mental health, an outcome that others too have found (Maybery et al., 2015).

By exploring the data gathered from therapists who practice across schema therapy, ACT or narrative therapy, a shared experience was perceiving an improvement in parents' mental health and parenting practices as a result of one-on-one counselling. The research from this thesis supports the idea that when parents' mental health issues are effectively treated, improvements in their emotion regulation, stress management, and overall well-being can lead to more positive and consistent parenting behaviours (Bright et al., 2020; Cuijpers et al., 2015).

8.4.2 Contributes to knowledge about private practice settings for supporting parents

Each study within this thesis contributes to the limited knowledge about the experiences of Australian therapists' working one-on-one with parents within a private practice setting. Most existing research has focused on public or community mental health sand adult mental health settings (Cuijpers et al., 2015; Dolman et al., 2013; Hine et al., 2018) with few studies exploring mental health support for parents in private practice settings (Cooper et al., 2023; Tchernegovski et al., 2018). Private practice settings might differ from other contexts as they often provide talking therapy in the therapist's preferred style in a clinical environment, wheras in the public sector, clients usually undertake a goal orientated intervention according to their most urgent needs (Hammond et al., 2018; Stokes et al., 2010). Gaining an understanding of how parents are supported in private practice settings is essential for developing tailored strategies to effectively assist parents with mental health challenges in these environments.

Across all three studies, therapists described tailoring modalities to meet the unique needs of clients who are parents, a task they generally felt able to accomplish through one-on-one practice. This finding builds on recent previous research conducted by Cooper et al., (2023) that described how parents receiving support in private practice want tailored practical parenting assistance and techniques for their unique situations. Further, the research findings from this thesis showed that many therapists in private practice wanted more resources, professional development and supervision opportunities to enhance their capacity to undertake work with clients who are parents.

This thesis also contributes to increasing understanding of how family-focused practices (FFP) can be integrated into individual counselling sessions. Numerous therapists interviewed described how they identified clients who were parents in the initial counselling session, and conducted an assessment regarding family dynamics, even when the main reasons for clients attending counselling related to mental health challenges, not parent-specific issues. The practice standards for FFP in the adult mental health sector, as outlined by Goodyear et al. (2015), include key steps such as identifying parenting status and assessing family dynamics, parenting capacities, and the wellbeing of other family members. The therapists who participated in the research, appeared to align with these standards. Schema therapists, ACT therapists, and narrative therapists described identifying other family members beyond the parent client during one-on-one counselling and asking about their role in supporting the parent client. This aligns with FFP principles by recognising the critical role families play in recovery, care, and overall family functioning and well-being (Foster et al., 2016).

Several schema therapists, ACT therapists, and narrative therapists described how they adapted traditional therapeutic approaches in their preferred modality, by incorporating psychoeducation about parents' mental illness and family dynamics, including its impact on parenting and children. This adaptation, which involves introducing parenting-related psychoeducation, aligns with FFP by addressing the needs of the parent client while also considering the wellbeing of other family members (Goodyear et al., 2015). This research offers new perspectives and foundational knowledge about the application of FFP in private practice, complementing the existing body of research, which has predominately focused on public and community mental health settings (Cuijpers et al., 2015; Dolman et al., 2013; Hine et al., 2018).

8.4.3 Techniques Across the Modalities Suited to Discussing Parenting Issues

A key finding across the three studies was that therapists described various useful techniques for meeting the needs of parents with mental health challenges. Participants practicing either schema therapy, ACT or narrative therapy described how their therapeutic modality could benefit parents with mental health challenges, through facilitating conversations about parenting issues as well as addressing their mental health needs. Previous research has described how it can be difficult for mental health professionals to talk to clients about parenting issues such as the potential impacts of their mental health challenges on children (Radley et al., 2021; Skundberg-Kletthagen et al., 2020; Strand & Rudolfsson, 2018). Moreover, previous literature has highlighted how conversations between mental health professionals and parents about children were not always well received by parents, and at times damaged rapport (Tchernegovski et al., 2017). However, no participants involved in any of the three studies in this thesis spoke to this concern. Thus, a common theme that emerged across the three modalities was that therapists employed various techniques to assist conversations about parenting challenges.

Schema therapists, ACT therapists and narrative therapists all described how talking about parenting issues was important for working with parents with mental health challenges. As parents often consider their parenting role to be "the most important role" (P3 Schema Therapists, Study 1) they have, participants across the three studies described discussing parenting issues as crucial for supporting parents with mental health challenges. Indeed, participants across the three studies spoke to particular techniques unique to each modality that they found well suited to engaging in conversations about parenting.

For example, schema therapists described how discussing the transgenerational nature of schemas and modes could help clients realise the risks that their maladaptive modes and schemas could be passed down to their children. Schema therapists noted that by prompting parents to see the pattern of schemas, modes, and mental illness across generations, they were able to frame the recognition of this history as an opportunity to correct intergenerational trauma. Similarly, acceptance and commitment therapists described how discussing personal values throughout therapy could help parents work towards behaviours that were aligned with how they wanted to parent their children. Narrative therapists explained how the technique 'externalising the problem' facilitated conversations about parenting guilt and helped parents see alternative parenting actions that could promote a positive parent-child relationship. Participants across the three studies described how using these techniques, lent themselves to

conversations around parenting issues, which supported therapists' confidence and competence in having conversations about parenting challenges.

There are other factors that could have contributed to the participants in this thesis feeling confident in having conversations around parenting issues. Previous research found that it is difficult for mental health professions to talk to clients about parenting issues, especially those working in community, outpatient, crisis, rehabilitation, intake and across hospital settings (Tchernegovski et al., 2017). However, many of the participants from previous research were not employed as counsellors engaging in one-on-one therapy with clients, but rather employed across various mental health support roles (Radley et al., 2021; Strand & Rudolfsson, 2018; Tchernegovski et al., 2017). The experiences of mental health professionals, who were not employed in a counselling role nor in a private practice, may be different to the participants of this research. Therefore, the current thesis builds upon previous literature, by adding the viewpoints and experiences of therapists undertaking one-on-one counselling with parents, who find schema therapy, ACT and narrative therapy conducive to having conversations about parenting issues.

8.4.4 Building Self-Compassion in Parents with Mental Health Challenges

Self-compassion refers to recognising and showing sensitivity to one's own suffering alongside motivation to alleviate one's suffering with care (Moreira, 2023). It has been well-documented that parents with mental health problems often struggle with self-compassion (Gilbert, 2009; Jefferson et al., 2020; Psychogiou et al., 2016). Additionally, parents with mental health challenges often have more self-blame and are more self-critical than other parents (Kirby et al., 2019; Werner et al., 2019). Likewise, participants across the three therapeutic modalities noted how parents with mental health challenges often presented with high levels of self-criticism, guilt and shame.

For the population in general, high levels of self-compassion correlate with a high sense of emotional well-being, enhanced quality of life, and low emotional turmoil when resolving relationship conflict (Yarnell & Neff, 2013). By contrast, individuals with low levels of self-compassion have been found to have high levels of self-criticism, guilt, rumination, and worry (Raes, 2010). Additionally, self-compassion research in parents has highlighted that parents with greater self-compassion have fewer criticisms over their children's emotions, and are more compassionate toward their children (Gilbert, 2009; Moreira, 2023; Psychogiou et al., 2016).

Participating therapists across the three modalities used different techniques to promote self-compassion in parents. Schema therapist participants described how through mode work, therapists helped clients cultivate self-compassion by addressing their critical and punitive modes, and replacing them with caring, supportive dialogues. Additionally, through identifying, confronting and healing early maladaptive schemas, some parents realised their "critical voices" (P10) were echoes of things they had heard as a child. This new awareness led parent clients to develop a more compassionate stance towards themselves and become mindful of not wanting to transfer critical schemas to their children. ACT therapists described how self-compassion was an "unofficial seventh process," (P2) when working with parents, and their belief that the ACT model inherently promotes self-compassion. Narrative therapists outlined how the narrative therapy technique of 'externalising the problem' helped alleviate parenting guilt and how externalising language helped to shift parents' focus from blame and failure to more empathetic and self-compassionate conversations. Additionally, in times of conflict with family members, including between parents and children, 'externalising the problem' assisted parents in seeing that the "problem was the problem" and not an issue inherently within their child, which fostered a greater understanding in parents of their child (P5). Whilst therapists across all three modalities perceived their therapeutic approach to be useful in building self-compassion in parents with mental health challenges, they all approached building self-compassion in parents in unique ways, drawing on techniques unique to each modality.

Participants across the three studies identified building self-compassion in parents with mental health challenges as a therapeutic goal and described the importance of self-compassion for meeting parent's needs and improving parenting practices. For example, P2 in Study 1 with schema therapists, reflected that improved self-compassion reduced parents' stress and high expectations of themselves, so that they were better able to attend to what their child needed and in turn were more compassionate towards their children. ACT therapists highlighted how they placed greater emphasis on self-compassion when working with parent clients than with other population groups, due to parents commonly feeling inadequate and being hard on themselves. Narrative therapists (e.g. P3) described the important role self-compassion plays in reminding parents that they are doing their best, especially when parents are reflecting on family narratives which they feel shameful about. This in turn, led parents to recognise their positive parenting practices and bolstered parents' confidence in their abilities, according to narrative therapist P3. Overall, these experiences and insights from participants across the three studies aligns with previous research that self-

compassion plays an influential role in parenting practices (Gilbert, 2009; Moreira, 2023; Psychogiou et al., 2016). Altogether, participants reported that improvements in parents' self-compassion, led to not only improved mental health but also enhanced parent-child interactions.

8.4.5 Tailoring the Modalities to Better Align with the Needs of Parents

Across the three studies, participants described how they tailored structural elements of the therapeutic models to better align with the needs of parents. This finding aligns with previous literature that described how across different therapeutic approaches, therapists can tailor approaches to fit the specific needs, preferences, and stages of change of their clients (Prochaska & Norcross, 2018). The importance of therapists using the respective models flexibility and adapting them in therapy to enhance therapeutic outcomes for each individual client has been established in psychotherapeutic literature (Corey, 2017; Prochaska & Norcross, 2018).

Numerous participants practicing either schema therapy, ACT and narrative therapy described how they either emphasised or introduced family systems theory and introduced discussions about intergenerational mental health when working with parents with mental health challenges. Schema therapists described how they adapted the model by emphasising family systems and building intergenerational understandings within the schema therapy practice. This was done by emphasising the role of other family members, for example identifying schemas or mapping the modes of children, spouses or their own parents, rather than just the clients. The finding that schema therapists were able to consider and address potential transgenerational impacts contrasts with prior research which highlights the difficulties shown in the general mental health workforce in incorporating a transgenerational perspective when working with parents (Gatsu et al., 2016; Pfeiffenberger et al., 2016). Similarly, numerous ACT therapists and narrative therapists described how these modalities facilitated conversations around transgenerational parenting. Participating ACT therapists outlined how values work and undertaking functional analysis aided conversations about transgenerational parenting patterns. Narrative therapists spoke to how discussing family narratives and identity led to discussions of the transgenerational nature of mental health.

In addition to adapting each of the three modalities by introducing the transgenerational nature of mental health, therapists from each study described how their modality could be additionally adapted to suit the needs of parents. For example, ACT therapists highlighted how they adapted language and metaphor-use for parent clients. This

resonates with previous literature conducted by Whittingham and Coyne (2019) who developed an adapted version of ACT specifically when working with parents of children with a disability, which included adapting terminology when working with parents and families. Other participants in Study 2 described how they made slight adaptations to the ACT model "for each client" (P4) rather than adapting it because of a client's status as a parent. Furthermore, numerous narrative therapists described how narrative therapy could be additionally adapted to suit the needs of parents. Two narrative therapists described how they adapted the explorative approach that characterises narrative therapy to be more directive and strategies based, when working with parents, perhaps responding to clients' desire for more practical strategies (Cooper et al., 2024). Participating narrative therapists additionally explained how the narrative therapy model was inherently adaptable and lent itself well to working with a range of presentations from parents with mental health challenges, including parenting issues.

Indeed, schema therapists, ACT therapists and narrative therapists appear to modify their approach to incorporate clients' parenting role and address parenting needs. Therapists described being able to embed parenting issues into schema, ACT and narrative therapy techniques, e.g., identifying schema's and modes relevant to their parenting practices in Study 1, identifying parenting values in Study 2 and exploring family narratives relevant to clients' parenting roles in Study 3. In terms of efficiencies, participants across the three studies described how embedding clients' parenting roles into their therapeutic work enabled them to meet the needs of parents and foster positive therapeutic outcomes. It has been established in the literature that parents with mental health concerns want their parenting role recognised and supported in their experiences with mental health care services (Jones et al., 2016). This was reiterated across the three studies, with schema therapists, acceptance and commitment therapists and narrative therapists describing how by tailoring the modalities to address the unique challenges associated with parenting, they could more effectively support parents in managing their roles and responsibilities. Therefore, a personalised approach tailored for each parent can be considered to not only improve the efficacy of their mental health treatment, but also empower parents to support and promote the wellbeing of their children.

Although the majority of participants interviewed across the studies described feeling comfortable and competent tailoring schema therapy, ACT or narrative therapy to enhance the modalities efficiencies for working with parent clients, there were some participants who did not. These participants fell into one of two categories: they either did not perceive the

model to need adapting to better suit working with parents, or they were unsure how to tailor their modalities when working with parents and desired further training, supervision or support in order to tailor the traditional model for parent clients. Notably, only one participant, a schema therapist, described feeling as though the model did not need to be adapted for working with parent clients. From the interview, this participant did not appear to recognise that parents with mental health challenges have unique difficulties and needs specifically related to their parenting role. Furthermore, there were several participants across all three studies who were uncertain about how best to tailor their therapeutic modality for parent clients and who desired additional training and resources specific to their modality to use with parents. Some participants from each study also expressed a desire for a formalised models and protocols for working with parents.

Tailoring Modalities for Parents Through the Additional of Attachment Theory

Another common finding across the three groups of therapists was that other therapeutic modalities were used to enhance the original modality. Some schema and ACT therapists drew on the parenting program 'Circle of Security,' (Hoffman et al., 2006) which is rooted in attachment theory to build on their therapeutic work with parents. Attachment theory posits that early relationships with caregivers shape a child's emotional and social development (Bowlby 1969). Schema therapists explained how the 'Circle of Security' program aided their understanding about the needs of children which in turn helped inform their work with parents. Likewise, some ACT therapists described how 'Circle of Security' related well to the values-based work done in acceptance and commitment therapy. Additionally, narrative therapist participants described using psychoeducation and emphasising theory from other modalities, including attachment theory, in their practice with parents. Thus, therapists across all three studies described how introducing elements of attachment theory, either directly or indirectly such as through teachings from the 'Circle of Security' model, enhanced their ability meet the needs of parents with mental health challenges.

Integrating attachment theory into ACT and narrative therapy and strengthening its underpinnings in schema therapy by introducing additional psychoeducation from the 'Circle of Security' program, broadens the traditional therapeutic goals of each modality. For instance, a key goal of attachment theory is to foster secure attachment relationships between individuals (Bowlby, 1969). Secure attachment is characterised by a caregiver, in this case a parent, who is consistently responsive and attuned to the child's needs, which helps the child develop a sense of safety, trust, and confidence. The therapist participants interviewed as part

of this thesis, who integrated attachment theory into their practice with parents, would be broadening the traditional therapeutic goals of their modality, to also work towards fostering secure attachments in parents, such as focusing on the bond between the parent and their child. Participants across the three studies described how they achieved this goal by introducing psychoeducation directly from attachment theory, or indirectly through the 'Circle of Security' program, and teaching parent clients the skills and theory related to building secure attachments and being responsive to their child's needs. Integrating attachment theory into the traditional three modalities expands the scope of therapeutic goals to promote a holistic, family orientated treatment. For instance, through drawing on attachment theory, therapists may expand therapeutic goals to also emphasis how early relationships with caregivers shape a child's emotional and social development (Bowlby, 1969). Parents with mental health challenges may be more likely to reflect upon their own experiences of being parented, and/or the relationships they have with their own children, throughout the therapeutic counselling process.

Participants who were interviewed for the thesis, and practiced either schema therapy, ACT and narrative therapy appeared to readily integrate and draw on attachment theory into their work with parents. This is despite the three therapies having different theoretical underpinnings. As attachment therapy readily integrated into the three modalities it can be considered that attachment theory is compatible with the overall therapeutic goals of schema therapy, ACT and narrative therapy. Notably, schema therapy is the only modality of the three which overtly identifies that it has theoretical underpinnings drawn from attachment theory (Young, 1994). The theoretical underpinnings of schema therapy include elements from attachment theory, alongside cognitive-behavioural therapy (CBT), psychoanalysis, and emotion-focused therapy to address psychological issues (Young, 1994). In Study 1, some schema therapist participants described how they found bolstering attachment theory in their practice, through incorporating psychoeducation from the attachment theory-informed Circle of Security program, was beneficial for working with parents. Neither the traditional ACT nor narrative therapy models draw on attachment theory (ACT is drawn from relational frame theory and narrative therapy drawn from systemic family therapy). However, ACT therapists and narrative therapist participants described how they readily drew on attachment theory when working with parents, without issues. This suggests that attachment theory can also integrate well into ACT and narrative therapy models, which may be due to the different therapies sharing some of the same therapeutic goals.

ACT and attachment theory share some goals of therapy, such as emphasising the importance of relationships in facilitating change. Attachment theory posits that secure attachments provide a foundation for emotional regulation and resilience (Bowlby, 1969) whilst ACT promotes the importance of meaningful connections (Hayes et al., 2004). Indeed, both ACT and attachment theory are concerned with the nature of relationships and in particular, two people being attuned with one another's emotional states and needs. Both advocate for emotional processing and acceptance, seeing it as key to psychological flexibility and well-being (Bowlby, 1969; Hayes et al., 2004).

Narrative therapy and attachment theory are also compatible in their focus on how personal stories and relational experiences shape an individual's identity and emotional well-being (Dallos & Denford, 2018). Narrative therapy focuses on how individuals construct and reconstruct their personal stories and identities (White & Epston, 1990) which aligns with attachment theory's view that early relational experiences shape our internal narratives about ourselves and others (Bowlby, 1969). Further, narrative therapy may provide a way for clients to reflect on their own attachment style and build awareness about what they (and their child) might need.

The finding that therapists practicing across either schema therapy, ACT or narrative therapy, experienced enhanced therapeutic outcomes when additionally drawing on attachment theory, builds upon previous literature. Promoting parent-infant or parent-child attachment, has been well established to positively impact child development and parental-attachment (Barlow et al., 2015). Additionally, parent-infant or parent-child attachment has been found to be a protective factor for children's wellbeing (Barlow et al., 2015). It has also been suggested in previous research, that parental mental health challenges can affect the quality of attachment relationships between themselves and their children (Fearon et al., 2010). Attachment security in children can be impacted by experiencing inconsistent caregiving, emotional unavailability, and disruptions in parental responsiveness, which may result from parents' mental health challenges and subsequent treatment (Fearon et al., 2010; Maybery et al., 2015; Nicholson, 2001; Gopfert, 1996; Ballal, 2018; Brockington, 2011; Aldridge, 2006). Therefore, it is a notable finding that some schema therapists, acceptance and commitment therapists and narrative therapists are already drawing on attachment theory to bolster their work with parents, as this would likely have positive flow on effects to their parent-child attachment and subsequently their children's wellbeing.

8.4.6 The Therapeutic Alliance

Previous research has shown that many mental health professionals are concerned that discussing clients' children and parenting issues will negatively impact the therapeutic alliance (Lauritzen & Reedtz, 2013; Maddocks et al., 2010; Strand & Rudolfsson, 2018; Tchernegovski et al., 2018a, 2018b). This was not the case for any of the therapists in this study who all openly discussed parenting and family life with their clients. There are several possibilities for this finding. Therapists with more experience working with parents may feel more comfortable and competent discussing parenting issues, reducing concerns about negatively impacting the therapeutic alliance. The convenience sampling approach used in these studies may have inadvertently attracted therapists with pre-existing interests and competencies in this area. Furthermore, therapists who employ schema therapy, ACT, or narrative therapy, often consider the client's life context, including parenting, as integral to treatment (Young et al., 2003; Hayes et al., 2006; White & Epston, 1990). This holistic view may reduce apprehension about discussing parenting. Thus, the therapeutic models used in the study may inherently support discussing life roles, including parenting, as part of the therapeutic process. Further, the therapists who participated in the studies were not working with parents experiencing a mental health crisis. Parenting capacity is likely to be most compromised when parents are in crisis, and parents are most likely to fear custody loss at this time (Dolman et al., 2013; Jones et al., 2016; Montgomery et al., 2011; Nicholson & Miller, 2011). When parents are experiencing a mental health crisis their care is likely to be transferred to a public mental health service such as psychiatric facilities, rather than be serviced by individual one-on-one counselling in private practice. The ability of therapists in this study to openly discuss parenting without concerns about negatively impacting the therapeutic alliance likely results from their experience in the field, their client centred approaches and their private practice work settings.

The therapeutic alliance was not explicitly discussed in the interviews, which was surprising given the compelling evidence highlighting its importance in influencing outcomes (Duncan et al., 2015; Flückiger et al., 2018; Wampold & Imel, 2015). However, participants did not express concerns about the discussing parenting issues and clients' children, which potentially demonstrates that this cohort did not feel that addressing these topics in one-to-one counselling would risk harming the therapeutic alliance. It could be that the participants felt confident that the therapeutic alliance between themselves and their parent clients was already strong and sustained, and thereby able to withstand discussing potentially sensitive

and challenging topics such as parenting. Others have shown that mental health professionals are often concerned that discussing parenting issues will negatively impact the therapeutic alliance (Lauritzen & Reedtz, 2013; Maddocks et al., 2010; Strand & Rudolfsson, 2018; Tchernegovski et al., 2018a, 2018b). However, in the three studies outlined here, participants found that discussing parenting during therapy helped meet the unique needs of clients who are parents. These discussions enabled therapists to better support clients' mental health by addressing needs such as self-compassion, shame, parenting stress and intergenerational impacts of mental health. It is in this way, that incorporating conversations about parenting as part of therapy may lead to more comprehensive and effective treatment outcomes as per Cooper et al., (2023) and Jones et al., (2016).

8.4.7 Therapists' Parenting Status

The parenting status of mental health professionals has been shown to impact their knowledge, skills, and awareness of the needs of clients who are parents and the needs of their children (Foster & Isobel, 2018; Grant et al., 2019; Krumm et al., 2019; Leenman & Arblaster, 2020; Tchernegovski et al., 2018a, 2018b; Tuck et al., 2023). Of the 28 participants involved in the research in the thesis, across the three studies, 21 (75%) were parents (9 schema therapists were parents, 4 were not; 7 acceptance and commitment therapists were parents, 2 were not; 5 narrative therapists were parents, 1 was not). The 21 participants who were parents did not mention their parenting role as a factor that impacted their experience of working with parents, possibly because their role as a parent is so fundamental to their identity that they did not consider how it might impact work. Similarly, the seven participants who were not parents, did not describe their non-parenting status as a barrier for working with this population group. Leenman and Arblaster (2020) described how mental health professionals could overcome not being a parent themselves, by drawing on their many years of professional experience and training when working with parents with mental health challenges. Thus, for the seven participants who were not parents, it is possible that they felt that their professional experience and training compensated for the fact they were not parents themselves, or that using the therapeutic modality with parents did not require personal parenting experience.

8.5 Strengths

The interviews that form the data for this thesis were conducted online over Zoom, allowed for participation regardless of geographical location. Further, all of the data collected for Study 1 with schema therapists and some of the data for Study 2 with acceptance and

commitment therapists was collected during COVID-19 restrictions. Conducting interviews over Zoom enabled interviews to participate during times of lock-down when in-person meetings were limited. Outside of pandemic restrictions, conducting interviews over Zoom enabled participants to choose a location that best suited them, and participants who were geographically remote from the researcher were still able to participate. Moreover, participants were provided with range of time options to be interviewed, including before or after work hours, in-between counselling clients and over lunch breaks. The flexible range of times offered accommodated participants schedules.

The methodology of IPA was appropriate for the research aims of this thesis, to examine the experiences of mental health professionals working with parents (Smith et al., 2009). A particular strength of this methodology is its adherence to idiography (Smith et al., 2009). IPA is used to capture the commonalities and differences in participants' experiences, rather than identify generalised themes (Smith et al., 2009). This methodology therefore enabled rich insight into the diversity of experiences that therapists may have when working with parents with mental health challenges. Additionally, all three studies included similar interview questions, which allowed comparisons to be drawn between the different therapeutic modalities for working with parents with mental health challenges.

8.6 Limitations

Interview Duration

A possible limitation of this research was that some of the interviews were relatively short, e.g., Study 1 with schema therapists had an average interview length of 32 minutes (range = 19 to 53 minutes); Study 2 with acceptance and commitment therapists had an average interview length of 34 minutes (range = 17 to 42 minutes) and Study 3 with narrative therapists had an average interview length of 40 minutes (range = 24 to 61 minutes). The short interview lengths curtailed opportunities to explore participants' experiences in-depth, especially within an IPA framework (Smith et al., 2009). It is possible that with a shorter interview length, the complexities and detailed accounts of participants experiences may not have been fully explored and captured.

Across the three studies the average interview length increased with each subsequent study. This could be due to feeling more confident using interviewing techniques, such as asking probing questions, as I gained more experience conducting interviews.

Specific recommendation for interview length in an IPA approach is typically not provided (Eatough & Smith, 2007; Smith et al., 2009; Smith et al., 2011; Smith &

Shinebourne, 2012; Lincoln & Denzin, 1998; Shinebourne, 2011). Although some interviews were short in length, participants were afforded sufficient time to express their experiences fully, and probing questions were asked throughout all interviews to illicit more detailed responses. However, for some of the briefer interviews asking additional prompts to draw out more examples from working with parents could have benefited the studies. Brief interview durations were typically an outcome of participants being succinct and clear in their responses, a possible outcome of participants being sent the interview schedule prior to the interview. This gave participants time to reflect and consider their answers prior to the interviews taking place and hence some participants may have had well-thought-out pre-prepared answers. Additionally, member checking occurred, whereby participants had the chance to review, verify, delete or add to, their interview transcripts (Lincoln & Guba, 1985).

Interviews could have been extended in other ways. For example, participants in the research did not reflect upon their own parenting status and the utility of professional development or supervision to reflect on working with clients who were parents, as these areas were not directly asked about in the interview schedules. Given the shorter interview lengths from some participants, the studies could have been enhanced by asking additional questions in the interview schedules.

Reasons for Attending Therapy

According to the participating schema therapists, ACT therapists and narrative therapists, parent clients sought therapy for their mental health challenges. The specific mental health challenges parents experienced reportedly varied. The interview schedule did not directly ask what mental health challenges parents had nor the duration, chroncity or severity of these challenges. Exploring the reasons clients sought therapy in more detail and the severity, chroncity and duration of their mental health challenges could have provided additional clarity and nuance to the findings. However, in real-world practice, therapy often addresses interconnected issues, and clients' reasons for seeking therapy might evolve over time, particularly as underlying challenges—such as parenting stress—only come to light during the therapeutic process. Therefore, the therapists' reflections on their work with parents, regardless of the initial focus of therapy, can still provide valuable insights into the practical application of therapeutic approaches in diverse contexts. This broad scope ensures that the findings remain relevant to real-world therapeutic dynamics, where multiple issues are frequently intertwined.

The Broad Range of Factors that Influence Therapy Outcomes

This research is potentially limited by a lack of exploration into the broad range of factors that influence therapy outcomes, instead focusing solely on specific therapeutic modalities. The studies of the thesis investigated the utility and effectiveness of schema therapy, ACT or narrative therapy for parents, from the perspectives of therapists. Other factors that could have been explored to provide a deeper understanding of therapy processes and outcomes including the quality of the therapeutic relationship, which is a significant predictor of success (Duncan et al., 2015; Flückiger et al., 2018; Wampold & Imel, 2015). For example, participants were not asked questions about how forming and maintaining a therapeutic alliance with clients who parents are, or initiating discussions around parenting, might impact the therapeutic alliance. Therapists' and clients' cultural backgrounds were also not explored. Parenting-specific challenges such as single parenting, co-parenting dynamics and parenting a child with special needs, might also influence outcomes, as could external factors such as social support, financial constraints, access to therapy, and logistical barriers. Financial pressures and stigma may also play a role. Other influences might include the clients' parenting self-efficacy, identity, interpersonal relationships, and the broad context of their lives, all of which interact to shape the therapy process and outcomes.

The primary aim of the study, however, was to examine therapists' perspectives on the use of specific therapeutic modalities with parents experiencing mental health challenges, rather than to explore the broad factors affecting therapy outcomes. By focusing on this specific objective, the study provides targeted insights into how these modalities are applied in practice. Additionally, while broad factors such as the therapeutic relationship and cultural dynamics are undeniably important, their absence from the interview process does not negate the validity of the findings. Therapists did not emphasise these factors in their responses, suggesting that within the context of this study, they were not perceived as central to the questions being investigated. Finally, the study provides a foundation for future research to explore these broad factors in more depth.

Singular Interview

Some literature on phenomenological research emphasises ongoing contact with research participants and encourages multiple interviews with participants (Moustakas, 1994; van Manen, 1997). Given this perspective, the single interview approach used in the studies within this thesis might be seen as insufficient. However, other literature argues that multiple or ongoing contacts are not essential for phenomenological research. The IPA methodology guiding this thesis was informed by several sources, none of which required multiple interviews with participants, or suggested that this would lead to richer data from participants

(Braun & Clarke, 2013; Hammarberg et al., 2016; Larkin et al., 2008; Peat et al., 2019; Smith, 2004; Smith, 2011; Smith et al., 2009). There are numerous examples of phenomenological studies based on single interviews (e.g., Beks & Cairns, 2018; McCormack & Devine, 2016; McCormack & Sly, 2013; Yambo et al., 2016).

Personal Experience and Expertise of These Therapies

I have some training in schema therapy, ACT and narrative therapy, though limited experiences in practicing the three psychotherapies. However, I do not believe it is necessary to have expertise in practicing the three therapeutic modalities in order to empirically study them. Direct experience practicing each psychotherapy with clients undoubtedly offers insights into the nuances of psychotherapeutic techniques and lived experience of how clients receive the therapy in practice. However, whilst interviewing the mental health practitioners who were trained and had expertise in using either ACT, ST or NT with clients, I used my lack of experience as a way to be open, curious and with a perspective that had not been influenced by any particular approach. I was transparent with participants about both my lack of expertise and my interest in this topic. For example, I began each interview with each participant noting that I myself did not have training or experiencing practicing the therapy and I would be asking clarifying questions about practicing the psychotherapy to ensure that I was understanding them fully. Indeed, throughout the interviews, I asked questions to clarify my understanding and asked participants to explain the nuances of the psychotherapy that I did not initially grasp.

My position as an outsider, having no extensive experience or expertise in practicing ACT, ST or NT, brought a fresh, potentially non-biased viewpoint to the data collection and analysis. Indeed, I did not approach my analysis with any assumptions or impartiality from my past therapeutic work, rather, I approached and viewed each interview without any allegiances to any particular therapeutic approach. I had no personal vested interest in the research findings, such as for one therapy to be more suitable for practice with parents compared to the others, or other strengths and limitations of practicing the therapies with parents with mental health challenges. Indeed, my position as an 'outsider' offered a balanced viewpoint to compare the three modalities and empirically study them.

After conducting this research, I remain undecided about which therapeutic modality; schema therapy, ACT or narrative, is best suited to working with parents with mental health challenges. The findings from this thesis suggest that each modality has certain techniques that facilitate working with parents, alongside some challenges. I believe the three modalities I have investigated in this thesis are appropriate to use when working with parents on mental

health concerns and parenting issues. As an early career psychologist, I can foresee gaining more experience and undertaking further professional development in each of the modalities investigated.

Sampling Method

All participants across the three studies were recruited through convenience sampling and snowballing. Recruitment emails and social media advertisements were published with a link to explanatory statements and participants self-selected into the studies. The exact number of eligible mental health professionals reached by the recruitment methods is not able to be determined. Thirteen, nine and seven therapists participated in the respective ST, ACT and NT studies. The sampling approach may have meant that therapists who did not consider themselves to have sufficient experience working in parents with mental health challenges did not respond. Likewise, those not interested in the topic may not have responded. The self-selected sample may be skewed towards participants who had a particular interest in the area and competence in the area of parental mental health.

Another potential limitation of this study is practitioner bias towards their own theoretical approach, such as participants exhibiting overly positive accounts of their approach. Therapists who have trained and specialised in a therapeutic modality may be more inclined to speak to the benefits of the modality and its applicability for use with parents with mental health challenges to justify their own investment of time and money in learning the approach.

Broad definition mental health challenges

This thesis is limited by the broad definition used to categorise mental health challenges. It focused on parents experiencing any type of mental health issue who sought one-on-one counselling in a private practice setting. This broad definition included parents with enduring, chronic and significant mental health challenges as well as those experiencing single-episode issues. However, parents with different mental health conditions and histories may encounter distinct parenting challenges (Reupert et al., 2015b). The findings of this thesis are based on the collective insights of therapists working with a diverse range of parents facing various mental health challenges. The research could have been strengthened by probing participants further about their experiences of working with parents across this spectrum, comparing single-episode challenges to those with significant, long-term mental health issues and for parents with different mental health conditions, and with varying levels of severity and chronicity.

At the same time, this broad definition allows the research to capture insights into the diverse experiences of therapists working with a wide range of clients, reflecting real-world therapeutic practice. By focusing on overarching themes rather than specific subgroups, the findings remain relevant to the potential complexities therapists face in practice. While delving into detailed distinctions between different mental health presentations could have provided additional information, the approach taken ensures no significant client group was excluded and offers a foundation for future research to explore these differences more thoroughly.

8.7 Implications

The findings have implications for therapeutic work with parents including future iterations or adaptations of schema therapy, ACT and narrative therapy. The findings can also be used to guide further research as well as guide counselling professional development programs, supervision, and policy around accreditation and registration.

8.7.1 Utility of Schema Therapy, ACT and Narrative Therapy for Parents with Mental Health Challenges

One-on-one psychotherapy is a common treatment option for parents with mental health challenges in Australia (Australian Government Department of Health, 2019). According to the therapists interviewed, all three modalities appear to be suitable for working with parents, as they include specific techniques that are well suited to addressing parenting needs This finding might be used to guide counselling decisions, including choice of modality, when working with parents with mental health challenges.

Specific techniques drawn from schema therapy, ACT and narrative therapy were highlighted by participants to be well suited to working with parents. For example, discussions around the Vulnerable Child Mode in schema therapy (Young et al., 2003) were found to offer a dual focus to address the needs of clients internal ‘Vulnerable Child’ and the needs of their actual child. Identifying values, including parenting values was a process described by acceptance and commitment therapists to be useful for working with parents. Several narrative therapists highlighted the utility of using ‘externalising language’ with parents with mental health challenges to assist with parent-child relationship issues and reduce parenting guilt. These findings, which describe the utility of particular techniques across each modality, have implications for therapists who work with parents with mental health challenges.

Additionally, these findings have implications for therapists who have an integrated practice. An integrated practice combines elements from various therapeutic models to address client needs and is the most frequent orientation of mental health professions (Norcross & Marvin, 2019). There are many benefits of an integrative practice including the ability to meet the specific needs and preferences of individual clients (Ingram, 2011). Moreover, an integrative practice can be beneficial in treating clients with co-occurring disorders or complex presentations (Norcross & Marvin, 2019). An integrated approach may improve client outcomes by combining techniques from various therapeutic models, to comprehensively address the complex nature of mental health challenges (Ingram, 2011; Norcross & Marvin, 2019). The findings from this thesis could have broad applicability for integrated therapists who uses numerous therapeutic models, as they could draw on the schema therapy, narrative therapy and ACT techniques highlighted in the studies to be well suited to working with parents. Moreover, the findings from this study are important for working with parents who may be experiencing co-occurring issues, such as having mental health challenges alongside parenting issues. Parents could benefit from a comprehensive integrated practice, which draws upon numerous modalities and techniques to treat different concerns. For example, a therapist with an integrated practice may draw upon schema therapy in addition to ACT when working with parents and focus on techniques and processes such as modes (schema therapy) and values work (ACT) which were highlighted by participants to have utility working with parents with mental health challenges.

8.7.2 Future Research Directions

There are numerous future research directions for further investigation to expand on the research from this study. Exploring parents' perspectives of therapy, including of schema therapy, ACT and narrative therapy, is an obvious next step. This might entail semi-structured interviews with parents with mental health challenges who are undertaking therapy and investigating their experiences undertaking these therapies and their impact on their mental health, parenting and family dynamics. There is scope to conduct quantitative studies with parents with mental health challenges, and to quantitatively compare the effectiveness of different types of psychotherapeutic approaches for improving mental health and parenting related issues, including parenting stress and parenting practices as well as family functioning using validated psychometric instruments. Future research could extend beyond investigating the parent with mental health challenges, by investigating the experiences and outcomes of other family members, where parents undertake a psychotherapeutic intervention, including

schema therapy, ACT and narrative therapy. Outcomes such as child development and wellbeing, could be measured. Examining the experiences of family members of parents with mental health challenges is critical to further understanding how the family needs are being met through a parent undertaking a psychotherapy intervention. Through further research into the effectiveness of therapy with parents and additional family members, an understanding can be established about the effectiveness of schema therapy, ACT and narrative therapy for parents with mental health challenges, and whether more support is required.

In addition to the three different psychotherapies investigated in this thesis, there remains a great deal of scope to investigate other modalities of psychotherapy for working with parents with mental health challenges. The research methods of this thesis could be repeated with other therapeutic modalities, such as cognitive behavioural therapy or dialectical behavioural therapy. This additional research could investigate what other modalities and therapeutic techniques assist in meeting the needs of parents and how other therapies need to be adapted to better suit working with parents with mental health challenges. This additional research could be used to inform therapists' decisions about modalities to use when working with parents.

Whilst this thesis investigated the experiences and perceptions of schema, ACT and narrative therapists who work with parents with mental health challenges, it did not seek to quantitatively measure the efficacy of each therapy with this population group. For instance, participants throughout the interviews in this thesis gave anecdotal evidence for how they perceived schema therapy, ACT or narrative therapy leading to improvements in parents self-compassion and enhanced parent-child interactions. However, future research could investigate levels of self-compassion and parent-child relationships through quantitative measures to examine how the modalities affect measures relating to parenting. There remains considerable scope to further explore the efficiency of schema therapy, ACT and narrative therapy for parents with mental health challenges through using quantitative measures, such as validated scales, to compare pre, post and follow-up therapy treatment.

Future studies may also seek to triangulate the data by exploring how schema, ACT and narrative therapy was experienced and perceived by the parent clients who undertake the therapy. Gaining insights from parents about what they find useful or difficult about therapy, would add additional insights into how these modalities could be improved for practice with parents.

Additionally, although therapists interviewed in this thesis emphasised the utility of employing schema therapy, ACT or narrative therapy modalities with parents with mental

health challenges, only the therapist perspective have been gathered, the long-term impact of these interventions on parental mental health challenges and parenting behaviour remains unclear. Whilst therapists across studies described how techniques within schema therapy, narrative therapy or ACT could meet the needs of parents with mental health challenges, such as reducing parent-child conflict, the enduring effects on the overall well-being and behaviour of parents post therapy, remain unresearched. Further research into the sustained benefits and long-term impacts of schema therapy, narrative therapy or ACT on parents with mental health challenges is needed.

8.7.3 Additional Training and Resources

Across all three modalities, participants identified the need for additional training and resources tailored for working with parents (including both resources for therapists to use in session with parent clients, and resources such as handouts to provide to clients). At present, participants who practice across schema therapy, ACT and narrative therapy, draw on resources designed for families or couples, or made parent specific resources themselves. Participants described there being very limited resources, including both resources for therapists working with parents with mental health challenges and resources for parents to take home. However, there are evidence-based online resources for mental health professionals working with parents, children and families across Australia, such as those provided by Emerging Minds. These resources are not specific to schema therapy, ACT or narrative therapy, however, do cover issues relating to parental mental health challenges. It is notable that no participating therapists across the three modalities, described accessing these freely available resources, as it suggests that many therapists throughout Australia are unaware of resources and training opportunities pertaining to working with parents with mental health challenges.

Beyond generic resources relating to parental mental health challenges, participants across all three therapeutic modalities expressed a desire for resources specifically connecting the needs of parents with mental health challenges and theory from either schema therapy, ACT or narrative therapy. Therapists who participated in the studies included in this thesis, described wanting resources including books, worksheets and cards which are tailored for parents and each therapeutic modality. The findings from this thesis regarding what techniques and theoretical models work well with parents, could be used to create tailored resources for parents and therapists. For example, the findings from Study 1 with schema

therapy, suggest utility in worksheets for parents on how their Healthy Adult mode is expressed in their parenting role.

Participants expressed a desire for training and professional development specifically relating to working with parents with mental health challenges with either schema therapy, ACT or narrative therapy. This training could incorporate findings from this thesis such as the difficulties associated with working with parents with mental health challenges using schema therapy, ACT or narrative therapy. For example, training could emphasise the utility in developing parents' Healthy Adult mode in schema therapy, emphasise the importance of self-compassion in ACT and emphasise the use of the 'deconstruction of unique outcomes' process in narrative therapy as being helpful when working with parents.

Supervision

The findings from this thesis, particularly around what worked well within each modality and what therapists struggled with when working with parents with mental health challenges, could be used to inform supervision practices of schema therapists, ACT therapists and narrative therapists and potentially other modalities also. For example, using the challenges and strengths of the modalities highlighted in this thesis, supervisors might tailor their supervision strategies to better support therapists, such as by equipping supervisees with therapeutic techniques such as those found to work well with parents. Moreover, based on the challenges participants described facing when working with parents, supervisors could proactively support therapists who may encounter similar difficulties. For example, some narrative therapists found the explorative nature of narrative therapy difficult when working with parents with mental health challenges who require structure and direction. This challenge is likely to be faced by many other therapists working with parents and therefore supervisors can pre-empt this difficulty and proactively support therapists.

8.7.4 Policy Implications

The findings from this thesis have potential policy implications, particularly policy around therapists' counsellor registration requirements. Chu et al., (2022) argued that therapists must be competent in working with different population groups and presentations. Clear role descriptions and procedures for working with parents with mental health challenges which can be communicated through registration and accreditation guidelines might be informed by findings of this thesis. The therapists interviewed in the thesis received training from different professional bodies including psychology, social work and occupational therapy, and adhere to different professional registration standards. Therefore,

national policy standards across these different professions could be updated to promote therapists' competence for working with parents with mental health challenges.

8.8 Conclusion

This thesis highlighted the experiences of schema therapists, ACT therapists and narrative therapists when working with parents who have mental health challenges. Using an IPA methodology, the results highlighted that from the perspective of therapists, all three therapies can be beneficial for working with parents to meet their mental health and parenting needs. For therapists using schema therapy, ACT and narrative therapy, much needed self-compassion in parents can be promoted through the use of any of these therapies. Further, participants described using elements of these three modalities as tools to facilitate conversations about parenting issues, as well as address mental health concerns. Within each study, participants described their experiences of using techniques unique to schema therapy, ACT or narrative therapy which they found enabled them to work effectively with parents. Difficulties and challenges regarding using the different modalities with parents were noted which led to the adaptation of the traditional models. The utility of incorporating parenting programs and additional theory, such as attachment theory into schema therapy, ACT or narrative therapy to better meet the needs of parents, was expressed by participants. The findings from this thesis can be used to help inform future iterations of these therapeutic modalities specifically for parents with mental health challenges. Additionally, the findings can be used to inform policy around therapist competencies and used to support therapists in supervision and tailored professional development programs.

References

A-Tjak, J. G. L., Davis, M. L., Morina, N., Powers, M. B., Smits, J. A. J., & Emmelkamp, P. M. G. (2015). A meta-analysis of the efficacy of acceptance and commitment therapy for clinically relevant mental and physical health problems. *Psychotherapy and Psychosomatics, 84*(1), 30–36. https://doi.org/10.1159/000365764

Ahlström, B., Skärsäter, I., & Danielson, E. (2009). Living with major depression: Experiences from families' perspectives. *Scandinavian Journal of Caring Sciences, 23*(2), 309–316. https://doi.org/10.1111/j.1471-6712.2008.00624.x

Aldridge, J. (2006). The experiences of children living with and caring for parents with mental illness. *Child Abuse Review, 15*(2), 79-88. https://doi.org/10.1002/car.904

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal, 16*(1), 11–23. http://dx.doi.org/10.1037/h0095655

Archibald, M. M., Ambagtsheer, R. C., Casey, M. G., & Lawless, M. (2019). Using zoom videoconferencing for qualitative data collection: Perceptions and experiences of Researchers and Participants. *International Journal of Qualitative Methods, 18.* https://doi.org/10.1177/1609406919874596

Australian Government Department of Health. (2013). Mental health: A guide for general practitioners. Retrieved from https://www.health.gov.au/resources/publications/mental-health-a-guide-for-general-practitioners

Australian Government Department of Health. (2019). The mental health workforce in Australia: An overview.

Australian Government. (2023, May 25). *Occupation profiles.* Australian Government. https://labourmarketinsights.gov.au/occupations/occupation-search?keyword=counsellor

Australian Institute of Health and Welfare. (2009). *Mental health services in Australia 2006–07* (AIHW Cat. No. HSE 14; Mental Health Series No. 11). Canberra: AIHW. http://www.aihw.gov.au/publicationdetail/?id=6442468277&tab=2

Australian Institute of Health and Welfare. (2022). Expenditure on mental health-related services. https://www.aihw.gov.au/mental-health/topic-areas/expenditure#Aus_govt_exp_MBS

Australian Institute of Health and Welfare. (2023). *Mental health services in Australia*. AIHW. https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia

Australian Psychological Society. (2014). *Ethical guidelines: Complementing the APS code of ethics* (12th ed.). Melbourne.

Baldwin, S. A., & Imel, Z. E. (2013). Therapist effects: Findings and methods. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (6th ed., pp. 258–297). Wiley.

Ballal, D. (2018). Understanding the experiences of children as young carers: Implications for policy and practice. *Journal of Child Health Care, 22*(1), 77-86. https://doi.org/10.1177/1367493517728371

Banker, J. E., & Goldenson, D. (2023). Clinical application of narrative therapy in the treatment of perinatal mood and anxiety disorder. *The Family Journal, 31*(2), 237-244. https://doi.org/10.1177/000134552311973

Barak, A., Hen, L., Boniel-Nissim, M., & Shapira, N. A. (2008). A comprehensive review and a meta-analysis of the effectiveness of internet-based psychotherapeutic interventions. *Journal of Technology in Human Services, 26*, 109–160. https://doi.org/10.1080/15228830802094429

Barak, A., Klein, B., & Proudfoot, J. (2009). Defining internet-supported therapeutic interventions. *Annals of Behavioral Medicine, 38*, 4-17. https://doi.org/10.1007/s12160-009-9130-7

Barlow, J., Bennett, C., Midgley, N., Larkin, S. K., & Wei, Y. (2015). Parent-infant psychotherapy for improving parental and infant mental health: A systematic review. *Campbell Systematic Reviews, 11*(1), 1-223.

Beardslee, W. R., Gladstone, T. R., Wright, E. J., & Cooper, A. B. (2003). A family-based approach to the prevention of depressive symptoms in children at risk: Evidence of parental and child change. *Pediatrics, 112*(2), 119–e131. https://doi.org/10.1542/peds.112.2.e119

Beardslee, W. R., Solantaus, T. S., Morgan, B. S., Gladstone, T. R., & Kowalenko, N. M. (2013). Preventive interventions for children of parents with depression: International perspectives. *Medical Journal of Australia, 199*(3), 23–25. https://doi.org/10.5694/mja11.11289

Beardslee, W. R., Wright, E. J., Gladstone, T. R., & Forbes, P. (2007). Long-term effects from a randomized trial of two public health preventive interventions for parental

depression. *Journal of Family Psychology, 21*(4), 703–713. https://doi.org/10.1037/0893-3200.21.4.703

Bee, P., Bower, P., Byford, S., Churchill, R., Calam, R., Stallard, P., Pryjmachuk, S., Berzins, K., Cary, M., Wan, M., & Abel, K. (2014). The clinical effectiveness, cost-effectiveness and acceptability of community-based interventions aimed at improving or maintaining quality of life in children of parents with serious mental illness: a systematic review. *Health technology assessment*, *18*(8), 1–250. https://doi.org/10.3310/hta18080

Bellamy, C., Schmutte, T., & Davidson, L. (2017). An update on the growing evidence base for peer support. *Mental Health and Social Inclusion, 21*(3), 161–167. https://doi.org/10.1108/MHSI-03-2017-0014

Benders-Hadi, N., Barber, M., & Alexander, M. J. (2013). Motherhood in women with serious mental illness. *Psychiatric Quarterly, 84*(1), 65–72. https://doi.org/10.1007/s11126-012-9227-1

Benish, S. G., Quintana, S. & Wampold, B. E. (2011). Culturally adapted psychotherapy and the legitimacy of myth. *Journal of Counseling Psychology, 58* (3), 279-289. http://doi.org/10.1037/a0023626

Beutler, L. E., Malik, M. L., Alimohamed, S., Harwood, T. M., Talebi, H., Noble, S., & Wong, E. (2004). Therapist variables. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 227–306). Wiley.

Biernacki, P., & Waldorf, D. (1981). Snowball sampling: Problems and techniques of chain referral sampling. *Sociological Methods & Research, 10*(2), 141-163. https://doi.org/10.1177/004912418101000205

Bloch-Atefi, A., Day, E., Snell, T., & O'Neill, G. (2021). A snapshot of the counselling and psychotherapy workforce in Australia in 2020: Underutilised and poorly remunerated, yet highly qualified and desperately needed. *Psychotherapy and Counselling Journal of Australia, 9*, https://doi.org/10.59158/001c.71216

Borders, L. D., & Brown, L. L. (2022). *The new handbook of counseling supervision.* Routledge.

Borkovec, T. D., & Castonguay, L. G. (2018). Effects of initial severity on psychotherapy outcomes: Implications for evidence-based practice. *Journal of Consulting and Clinical Psychology, 86*(3), 203–212. https://doi.org/10.1037/ccp0000291

Bowen, M. (1978). *Family therapy in clinical practice*. Jason Aronson.

Bowlby, J. (1969). *Attachment and loss: Vol. 1. Attachment*. Basic Books.

Bright, K. S., Charrois, E. M., Mughal, M. K., Wajid, A., McNeil, D., Stuart, S., Hayden, K. A., & Kingston, D. (2020). Interpersonal psychotherapy to reduce psychological distress in perinatal women: A systematic review. *International Journal of Environmental Research and Public Health, 17*(22), 8421. https://doi.org/10.3390/ijerph17228421

Brockington, I. (2011). Motherhood and mental health. *Oxford University Press.*

Cabral, R. R., & Smith, T. B. (2011). Racial/ethnic matching of clients and therapists in mental health services: A meta-analytic review of preferences, perceptions, and outcomes. *Journal of Counseling Psychology, 58*(4), 537-554. https://doi.org/10.1037/a0025266

Carr, A. (2009). The effectiveness of family therapy and systemic interventions for adult-focused problems. *Journal of Family Therapy, 31*(1), 46–74. https://doi.org/10.1111/j.1467-6427.2008.00452.x

Carr, A. (2012). *Family therapy* (3rd ed.) [EPUB]. John Wiley & Sons.

Castonguay, L. G., Boswell, J. F., Constantino, M. J., Goldfried, M. R., & Hill, C. E. (2010). Training implications of harmful effects of psychological treatments. *American Psychologist, 65*(1), 34–49. https://doi.org/10.1037/a0017330

Chang, D. F., & Berk, A. (2009). Making cross-racial therapy work: A phenomenological study of clients' experiences of cross-racial therapy. *Journal of Counseling Psychology, 56(*4), 521-536.

Choi, G., Mallinckrodt, B., & Richardson, J. D. (2015). Effect of international student counselors' broaching statements about cultural and language differences on participants' perceptions of counselors. *Journal of Multicultural Counseling and Development, 43,* 25–37.

Chu, W., Wippold, G., & Becker, K. D. (2022). A systematic review of cultural competence trainings for mental health providers. *Professional Psychology: Research and Practice, 53*(4), 362–371. https://doi.org/10.1037/pro0000469

Cloitre, M., Cohen, L. R., Ortigo, K. M., Jackson, C., & Koenen, K. C. (2020). *Treating survivors of childhood abuse and interpersonal trauma: STAIR narrative therapy*. Guilford Publications.

Cluxton-Keller, F., & Bruce, M. L. (2018). Clinical effectiveness of family therapeutic interventions in the prevention and treatment of perinatal depression: A systematic review and meta-analysis. *PLoS One, 13*(6), e0198730. https://doi.org/10.1371/journal.pone.0198730

Cohen, J. A. S., & Semple, R. J. (2010). Mindful parenting: A call for research. *Journal of Child and Family Studies, 19*(2), 145–151. https://doi.org/10.1007/s10826-009-9285-7

Coiro, M. J., Riley, A., Broitman, M., & Miranda, J. (2012). Effects on children of treating their mothers' depression: Results of a 12-month follow-up. Psychiatric Services, 63, 357–363. https://doi.org/10.1176/appi.ps.201100126

Constantino, M. J., Arnkoff, D. B., Glass, C. R., Ametrano, R. M., & Smith, J. Z. (2011). Expectations. *Journal of Clinical Psychology, 67*(2), 184–192. https://doi.org/10.1002/jclp.20754

Cook, J. A. & Mueser, K. (2014). Improving services for parents with psychiatric disabilities: Three new opportunities in the field of psychiatric rehabilitation. *Psychiatric Rehabilitation Journal*, *37*, 1–3.

Cooklin, A. (2013). Promoting children's resilience to parental mental illness: Engaging the child's thinking. *Advances in Psychiatric Treatment, 19*(3), 229-240. https://doi.org/10.1192/apt.bp.111.009050

Coombs, N. C., Meriwether, W. E., Caringi, J., & Newcomer, S. R. (2021). Barriers to healthcare access among US adults with mental health challenges: A population-based study. *SSM-population health, 15*, 100847. https://doi.org/10.1016/j.ssmph.2021.100847

Cooper, C., Tchernegovski, P., & Hine, R. (2023). "The validation is not enough": Australian mothers' views and perceptions of mental health support from psychologists in private practice. *Clinical Psychologist, 27*(3), 392–403. https://doi.org/10.1080/13284207.2023.2259053

Corey, G. (2017). *Theory and practice of counseling and psychotherapy* (10th ed.). Cengage Learning.

Corey, G., Haynes, R. H., Moulton, P., & Muratori, M. (2020). *Clinical supervision in the helping professions: A practical guide*. John Wiley & Sons.

Corrigan, P. W., Morris, S. B., Michaels, P. J., Rafacz, J. D., & Rüsch, N. (2012). Challenging the public stigma of mental illness: A meta-analysis of outcome studies. *Psychiatric Services, 63*(10), 963–973. https://doi.org/10.1176/appi.ps.201100529

Cosci, F., Guidi, J., Mansueto, G., & Fava, G. A. (2020). Psychotherapy in recurrent depression: Efficacy, pitfalls, and recommendations. *Expert Review of*

Neurotherapeutics, 20(11), 1169-1175. https://doi.org/10.1080/14737175.2020.1804870

Cost, K. T., Mudiyanselage, P., Unternaehrer, E., Korczak, D. J., Crosbie, J., Anagnastou, E., Monga, S., Kelley, E., Schachar, R., Maguire, J., Arnold, P., Burton, C. L., Georgiades, S., Nicolson, R., Birken, C. S., & Charach, A. (2023). The role of parenting practices in parent and child mental health over time. *BJPsych open*, *9*(5), e147. https://doi.org/10.1192/bjo.2023.529

Crits-Christoph, P., & Gallop, R. (2006). Therapist effects in the National Institute of Mental Health Treatment of Depression Collaborative Research Program and other psychotherapy studies. *Psychotherapy Research, 16*, 178–181. https://doi.org/10.1080/10503300500265025

Crits-Christoph, P., Gibbons, M. B. C., Crits-Christoph, K., Narducci, J., Schamberger, M., & Gallop, R. (2006). Can therapists be trained to improve their alliances? A preliminary study of alliance-fostering psychotherapy. *Psychotherapy Research, 16*, 268–281.

Cuijpers, P., Karyotaki, E., Weitz, E., Andersson, G., Hollon, S. D., & van Straten, A. (2014). The effects of psychotherapies for major depression in adults on remission, recovery, and improvement: A meta-analysis. *Journal of Affective Disorders, 159*, 118–126. https://doi.org/10.1016/j.jad.2014.02.026

Cuijpers, P., Weitz, E., Karyotaki, E., et al. (2015). The effects of psychological treatment of maternal depression on children and parental functioning: A meta-analysis. *European Child and Adolescent Psychiatry, 24*, 237–245. https://doi.org/10.1007/s00787-014-0660-6

Cuijpers, P., Weitz, E., Karyotaki, E., et al. (2015). The effects of psychological treatment of maternal depression on children and parental functioning: A meta-analysis. *European Child & Adolescent Psychiatry, 24*, 237–245. https://doi.org/10.1007/s00787-014-0660-6

Curtis, J., Teasdale, S. B., Morell, R., Wadhwa, P., & Watkins, A. (2016). Implementation of a lifestyle and life-skills intervention to prevent weight-gain and cardiometabolic abnormalities in young people with first-episode psychosis as part of routine care: The Keeping the Body in Mind program. *Early Intervention in Psychiatry*, 10(3), 267-275. https://doi.org/10.1111/eip.12251

Dallos, R., & Denford, S. (2018). Family attachment narratives and eating disorder. *Psychotherapy Section Review, 1*(1), 61-68. https://doi.org/10.53841/bpspsr.2018.1.62.61

Dam, K., & Hall, E. O. (2016). Navigating in an unpredictable daily life: a metasynthesis on children's experiences living with a parent with severe mental illness. *Scandinavian journal of caring sciences*, *30*(3), 442–457. https://doi.org/10.1111/scs.12285

Dam, S., & Hall, R. (2016). Children's internalizing symptoms and the impact of keeping parental mental health challenges a secret. *Journal of Child Psychology and Psychiatry, 57*(8), 893-902. https://doi.org/10.1111/jcpp.12514

Diaz-Caneja, A., & Johnson, S. (2004). The views and experiences of severely mentally ill mothers: A qualitative study. *Social Psychiatry and Psychiatric Epidemiology, 39*(6), 472-482. https://doi.org/10.1007/s00127-004-0772-2

Dixon, L., McFarlane, W. R., Lefley, H., Lucksted, A., Cohen, M., Falloon, I., Miklowitz, D., Solomon, P., & Sondheimer, D. (2001). Evidence-based practices for services to families of people with psychiatric disabilities. *Psychiatric Services, 52*(7), 903–910. https://doi.org/10.1176/appi.ps.52.7.903

Dolman, C., Jones, I., & Howard, L. M. (2013). Pre-conception to parenting: A systematic review and meta-synthesis of the qualitative literature on motherhood for women with severe mental illness. *Archives of Women's Mental Health, 16*(3), 173-196. https://doi.org/10.1007/s00737-013-0336-0

Doss, B. D., Atkins, D. C., & Christensen, A. (2019). Couple and family therapy for adults with depression: A meta-analysis. *Journal of Family Psychology, 33*(2), 114-126. https://doi.org/10.1037/fam0000501

Doss, B. D., Cicila, L. N., Georgia, E. J., Roddy, M. K., Nowlan, K. M., Benson, L. A., & Christensen, A. (2019). A meta-analysis of the effectiveness of couple and family therapies for depression: An update. *Journal of Marital and Family Therapy, 45*(3), 344-360. https://doi.org/10.1111/jmft.12344

Duncan, B. L., Miller, S. D., Wampold, B. E., & Hubble, M. A. (Eds.). (2015). *The heart and soul of change: Delivering what works in therapy (2nd ed.).* American Psychological Association.

Eatough, V., & Smith, J. A. (2008). Interpretative phenomenological analysis. In The SAGE Handbook of Qualitative Research in Psychology. London: SAGE Publications Ltd.

Elliott, R., Bohart, A. C., Watson, J. C., & Murphy, D. (2018). Empathy. In J. C. Norcross & M. J. Lambert (Eds.), *Psychotherapy relationships that work* (3rd ed., pp. 135–178). Oxford University Press.

Emerging Minds. (n.d.). *Organisations*. Retrieved August 20, 2024, from https://emergingminds.com.au/organisations/

Etchison, M., & Kleist, D. M. (2000). Review of narrative therapy: Research and utility. *The Family Journal, 8*(1), 61–66. https://doi.org/10.1177/1066480700081008

Farkas, M., & Boevink, W. (2018). Peer delivered services in mental health care in 2018: Infancy or adolescence? *World Psychiatry, 17*(2), 222–224. https://doi.org/10.1002/wps.20530

Fearon, R. P., Bakermans-Kranenburg, M. J., van Ijzendoorn, M. H., Lapsley, A. M., & Roisman, G. I. (2010). The significance of insecure attachment and disorganization in the development of children's externalizing behavior: A meta-analytic study. *Child Development, 81*(2), 435–456. https://doi.org/10.1111/j.1467-8624.2009.01405.x

Finlay, A. J. F., & Looi, J. C. L. (2020). Public and private mental healthcare for the population mental health effects of COVID-19 measures. *Australian & New Zealand Journal of Psychiatry*, 54(12), 1127-1128. https://doi.org/10.1177/0004867420946846

Fjone, H. H., Ytterhus, B., & Almvik, A. (2009). How children with parents suffering from mental health distress search for 'normality' and avoid stigma: To be or not to be... is not the question. *Childhood, 16*(4), 461–477. https://doi.org/10.1177/090756820934374

Fjone, H. H., Ytterhus, B., & Almvik, A. (2009). How children with parents suffering from mental health distress search for 'normality' and avoid being stigmatised. *Child & Family Social Work, 14*(3), 333-342. https://doi.org/10.1111/j.1365-2206.2008.00598.x

Flückiger, C., Del Re, A. C., Wampold, B. E., & Horvath, A. O. (2018). The alliance in adult psychotherapy: A meta-analytic synthesis. *Psychotherapy, 55*(4), 316-340. https://doi.org/10.1037/pst0000172

Flujas-Contreras, J. M., García-Palacios, A., & Gómez, I. (2022). Parenting Intervention for Psychological Flexibility and Emotion Regulation: Clinical Protocol and an Evidence-Based Case Study. *International journal of environmental research and public health*, *19*(9), 5014. https://doi.org/10.3390/ijerph19095014

Foster, K., Maybery, D., Reupert, A., Gladstone, B., Grant, A., Ruud, T., Falkov, A., & Kowalenko, N. (2016). Family-focused practice in mental health care: An integrative review. *Child & Youth Services*, *37*(2), 129-155. https://doi.org/10.1080/0145935X.2016.1104048

Foster, K., McPhee, I., Fethney, J., & McCloughen, A. (2014). Outcomes of the ON FIRE peer support programme for children and adolescents in families with mental health

problems. *Child & Family Social Work, 19*(4), 416-426. https://doi.org/10.1111/cfs.12143

Foster, K., O'Brien, L., & Korhonen, T. (2012). Developing resilient children and families when parents have mental illness: A family-focused approach. *International Journal of Mental Health Nursing, 21*(1), 3–11. https://doi.org/10.1111/j.1447-0349.2011.00754.x

Fraenkel, P., Hameline, T., & Shannon, M. (2009). Narrative and collaborative practices in work with families that are homeless. *Journal of marital and family therapy*, *35*(3), 325–342. https://doi.org/10.1111/j.1752-0606.2009.00119.x

Fraser, E., & Pakenham, K. I. (2008). Evaluation of a resilience-based intervention for children of parents with mental illness. *Australian & New Zealand Journal of Psychiatry, 42*(12), 1041–1050. https://doi.org/10.1080/00048670802415303

Freedman, J., & Combs, G. (1996). *Narrative therapy: The social construction of preferred realities*. Norton.

Gallant, P., & Strauss, I. (2011). Narrative therapy with couples. In D. K. Carson & M. Casado- Kehoe (Eds.), *Case studies in couples therapy: Theory-based approaches* (pp. 289–301). Routledge.

Gatsou, L., Yates, S., Hussain, S., Barrett, M., Gangavati, S., & Ghafoor, R. (2016). Parental mental illness: Incidence, assessment and practice. *Mental Health Practice, 19*(5), 25–27. https://doi.org/10.7748/mhp.19.5.25.s18

Gellatly, J., Bower, P., Hennessy, S., Richards, D., Gilbody, S., & Lovell, K. (2007). What makes self-help interventions effective in the management of depressive symptoms? Meta-analysis and meta-regression. *Psychological Medicine, 37*, 1217–1228. https://doi.org/10.1017/S0033291707000062

Gewurtz, R., Krupa, T., Eastabrook, S., & Horgan, S. (2004). Prevalence and characteristics of parenting among people served by assertive community treatment. *Psychiatric Rehabilitation Journal, 28*(1), 63–65. https://doi.org/10.2975/28.2004.63.65

Ginsburg, G. S. (2009). The Child Anxiety Prevention Study: Intervention model and primary outcomes. *Journal of Consulting and Clinical Psychology, 77*(3), 580–587. https://doi.org/10.1037/a0014418

Gladstone, B. M., Boydell, K. M., & McKeever, P. (2011). Recasting research into children's experiences of parental mental illness: Beyond risk and resilience. *Social Science & Medicine, 73*(10), 1565-1573. https://doi.org/10.1016/j.socscimed.2011.08.038

Gold, J. M. (2016). *Stepping in, stepping out: Creating stepfamily rhythm*. Alexandria, VA: American Counseling Association.

Golden, C., Killion, M. G., & McGregor, C. (2020). An evaluation of training for health and social care professionals when working with families where a parent has a mental illness. *Advances in Mental Health, 18*(3), 276–288. https://doi.org/10.1080/18387357.2020.1829492

Goodman, S. H., Rouse, M. H., & Connell, A. M. (2011). The impact of parental depression on children: A meta-analysis. *Clinical Child and Family Psychology Review, 14*(1), 1-15. https://doi.org/10.1007/s10567-010-0088-3

Goodyear, M., Cuff, R., Maybery, D., & Reupert, A. (2009). CHAMPS: A peer support program for children of parents with a mental illness. Australian e-Journal for the Advancement of Mental Health, *Advances in Mental Health, 8*(3), 296–304. https://doi.org/10.5172/jamh.8.3.296

Gopfert, M. (1996). The effects on children of mentally ill parents: A review of research and practice. *Journal of Child Psychology and Psychiatry, 37*(7), 819-831. https://doi.org/10.1111/j.1469-7610.1996.tb01480.x

Gottschalk, M. G., & Domschke, K. (2017). Genetics of generalized anxiety disorder and related traits. *Dialogues in Clinical Neuroscience*, *19*(2), 159–168. https://doi.org/10.31887/DCNS.2017.19.2/kdomschke

Grové, C., Reupert, A. E., & Maybery, D. (2015). Gaining knowledge about parental mental illness: How does it empower children? *Child & Family Social Work, 20*(4), 377-386. https://doi.org/10.1111/cfs.12086

Guendelman, S., Medeiros, S., & Rampes, H. (2017). Mindfulness and emotion regulation: Insights from neurobiological, psychological, and clinical studies. *Frontiers in Psychology, 8*, 220. https://doi.org/10.3389/fpsyg.2017.00220

Haley, J. (1976). *Problem-solving therapy: New strategies for effective family therapy*. Jossey-Bass.

Halsa, A. (2018). Trapped between madness and motherhood: Mothering alone. *Social Work in Mental Health, 16*(1), 46–61. https://doi.org/10.1080/15332985.2017.1317688

Hammarberg, K., Kirkman, M., & De Lacey, S. (2016). Qualitative research methods: when to use them and how to judge them. *Human reproduction*, *31*(3), 498-501. https://doi.org/10.1093/humrep/dev334

Hammond, S. W., Martin, L. A., Zogby, A., Kim, S., & Jacobson, R. (2018). Effects of mindfulness-based stress reduction on psychological health: A review of research and

theory. *Journal of Psychology and Behavioral Science, 6*(2), 45–58. https://doi.org/10.1111/jpbs.2018.0625

Harding, K. E., Lewis, A. K., & Taylor, N. F. (2023). 'I just need a plan': Consumer perceptions of waiting for healthcare. *Journal of Evaluation in Clinical Practice*, *29*(6), 976–983. https://doi.org/10.1111/jep.13821

Hargreaves, J., Bond, L., O'Brien, M., Forer, D., & Davies, L. (2008). The PATS peer support program: Prevention/early intervention for adolescents who have a parent with a mental illness. Youth Studies Australia, 27, 43–51. https://doi.org/10.3316/ielapa.025092333307826

Hawke, L. D., & Provencher, M. D. (2011). Schema therapy for depression: A systematic review. *Journal of Cognitive Psychotherapy, 25*(3), 228-241. https://doi.org/10.1891/0889-8391.25.3.228

Hayman, F. (2009). Kids with confidence: A program for adolescents living in families affected by mental illness. *Australian Journal of Rural Health, 17*(5), 268–272. https://doi.org/10.1111/j.1440-1584.2009.01108.x

Hearle, J., Plant, K., Jenner, L., Barkla, J., & McGrath, J. (1999). A survey of contact with offspring and assistance with child care among parents with psychotic disorder. *Psychiatric Services, 50*(10), 1354–1356. https://doi.org/10.1176/ps.50.10.1354

Heiselberg, L., & Stępińska, A. (2023). Transforming Qualitative Interviewing Techniques for Video Conferencing Platforms. *Digital Journalism*, *11*(7), 1353–1364. https://doi.org/10.1080/21670811.2022.2047083

Hennink, M. M., & Kaiser, B. N. (2020). *Saturation in qualitative research* (P. Atkinson, S. Delamont, A. Cernat, J. W. Sakshaug, & R. A. Williams, Eds.). SAGE Publications Ltd.

Heywood, L., Conti, J., & Hay, P. (2022). Paper 1: A systematic synthesis of narrative therapy treatment components for the treatment of eating disorders. *Journal of Eating Disorders, 10*(1), 137. https://doi.org/10.1186/s40337-022-00635-5

Hill, C. E., & Norcross, J. C. (2023). *Research evidence on psychotherapist skills and methods: Foreword and afterword. Psychotherapy Research, 33*(7), 821–840. https://doi.org/10.1080/10503307.2023.2186281

Hilsenroth, M. J., Ackerman, S. J., Clemence, A. J., Strassle, C. G., & Handler, L. (2002). Effects of structured clinician training on patient and therapist perspectives of alliance

early in psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 39*, 309–323. https://doi.org/10.1037/0033-3204.39.4.309

Hine, R., & Jewell, H. (2024). Parenting through mental health challenges: Intersections of gender, race, class, and power. In S. W. Collins (Ed.), *The Routledge International Handbook of Feminisms in Social Work* (1st ed., pp. 13). Routledge. https://doi.org/10.4324/9781003317371

Hine, R., Maybery, D., & Goodyear, M. (2018). Resourcefulness and resilience: The experience of personal recovery for mothers with a mental illness. *The British Journal of Social Work, 48*(5), 1257–1276. https://doi.org/10.1093/bjsw/bcx099

Hine, R. H., Maybery, D., & Goodyear, M. J. (2018). Challenges of connectedness in personal recovery for rural mothers with mental illness. *International Journal of Mental Health Nursing*, *27*(2), 672-682. https://doi.org/10.1111/inm.12353

Hine, R. H., Maybery, D. J., & Goodyear, M. J. (2018). Identity in recovery for mothers with a mental illness: A literature review. *Psychiatric Rehabilitation Journal, 41*(1), 16–28. https://doi.org/10.1037/prj0000287

Hine, R. H., Maybery, D. J., & Goodyear, M. J. (2019). Identity in personal recovery for mothers with a mental illness. *Frontiers in Psychiatry, 10*, 89. https://doi.org/10.3389/fpsyt.2019.00089

Hine, R., & Jewell, H. Parenting through mental health challenges: Intersections of gender, race, class and power. In *The Routledge International Handbook of Feminisms in Social Work* (pp. 360-372). Routledge. https://www.taylorfrancis.com/chapters/edit/10.4324/9781003317371-36/parenting-mental-health-challenges-rochelle-hine-hanna-jewell

Hjen, J., Sundh, M., & Stretmo, J. (2013). The impact of parental mental illness on children's academic performance and mental health. *Journal of Child Psychology and Psychiatry, 54*(6), 606-616. https://doi.org/10.1111/jcpp.12039

Hoffman, K. T., Marvin, R. S., Cooper, G., & Powell, B. (2006). Changing toddlers' and preschoolers' attachment classifications: The Circle of Security intervention. *Journal of Consulting and Clinical Psychology, 74*(6), 1017–1026. https://doi.org/10.1037/0022-006X.74.6.1017

Holford, T. A., Reupert, A. E., Tchernegovski, P., et al. (2023). Parental mental illness in the family courts: A scoping review. *Journal of Child and Family Studies, 32*, 3892–3907. https://doi.org/10.1007/s10826-023-02708-8

Hollingsworth, L. D. (2004). Child custody loss among women with persistent severe mental illness. Social Work Research, 28(4), 199–209. https://doi.org/10.1093/swr/28.4.199

Holt-Lunstad, J., Smith, T. B., & Layton, J. B. (2010). Social relationships and mortality risk: A meta-analytic review. *PLoS Medicine, 7*(7), e1000316. https://doi.org/10.1371/journal.pmed.1000316

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology, 38*(2), 139–149. https://doi.org/10.1037/0022-0167.38.2.139

Horvath, A. O., & Bedi, R. P. (2002). The alliance. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 37–69). Oxford University Press.

Horvath, A. O., Del Re, A. C., Flückiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy, 48*(1), 9–16. https://doi.org/10.1037/a0022186

Hosman, C. M. H., van Doesum, K. T. M., & van Santvoort, F. (2009). Prevention of emotional problems and psychiatric risks in children of parents with a mental illness in the Netherlands: I. The scientific basis to a comprehensive approach. *Australian e-Journal for the Advancement of Mental Health Promotion*, *8*, 250–263. https://doi.org/10.5172/jamh.8.3.250

Howe, D. (2006). Final report of the Parent Link Project. Sydney: Children and Young People's Mental Health, Northern Sydney Central Coast Health Service.

Howe, D., Batchelor, S., & Bochynska, K. (2012). Prevalence of parents within an adult mental health service: Census results 2008-2011. *Australasian Psychiatry, 20*(5), 413–418. https://doi.org/10.1177/1039856212459583

Huber, A., McMahon, C. & Sweller, N. (2016). Improved Parental Emotional Functioning After Circle of Security 20-Week Parent–Child Relationship Intervention. *Journal of Child and Family Studies, 25*, 2526–2540. https://doi.org/10.1007/s10826-016-0426-5

Ingram, B. L. (2011). *Clinical case formulations: Matching the integrative treatment plan to the client*. John Wiley & Sons.

ISST. (2024, May). ISST Certification in Schema Therapy. *Schema therapy society*. https://schematherapysociety.org/Certification

Jefferson, F. A., Shires, A., & McAloon, J. (2020). Parenting self-compassion: A systematic review and meta-analysis. *Mindfulness, 11*(9), 2067–2088. https://doi.org/10.1007/s12671-020-01401-x

Jeffery, D., Clement, S., Corker, E., Howard, L. M., Murray, J., & Thornicroft, G. (2013). Discrimination in relation to parenthood reported by community psychiatric service users in the UK: A framework analysis. *BMC Psychiatry, 13*(1), 120. https://doi.org/10.1186/1471-244X-13-120

Jones, M., Pietilä, I., Joronen, K., Simpson, W., Gray, S., & Kaunonen, M. (2016). Parents with mental illness – a qualitative study of identities and experiences with support services. *Journal of Psychiatric and Mental Health Nursing, 23*(7), 471–478. https://doi.org/10.1111/jpm.12336

Jørgensen, C. B., Behrmann, J. T., Blaabjerg, J., Pettersen, K. A., & Jensen de López, K. M. (2024). Narrative therapy with children: A qualitative interview study with Danish therapists about the application of narrative practices. *Counselling and Psychotherapy Research, 24*(1), 295–307. https://doi.org/10.1002/capr.12656

Juvin, J., Sadeg, S., Julien-Sweerts, S., & Zebdi, R. (2022). A systematic review: acceptance and commitment therapy for the parents of children and adolescents with autism spectrum disorder. *Journal of Autism and Developmental Disorders, 52*(1), 124–141. https://doi.org/10.1007/s10803-021-04923-y

Kabat-Zinn, J., & Kabat-Zinn, M. (2014). *Everyday blessings: The inner work of mindful parenting*. Hachette Books.

Kavanagh, B. E., Corney, K. B., Beks, H., & Munro, C. L. (2023). A scoping review of the barriers and facilitators to accessing and utilizing mental health services across regional, rural, and remote Australia. *BMC Health Services Research, 23*, 1060. https://doi.org/10.1186/s12913-023-10034-4

Kavanagh, B. E., Corney, K. B., Beks, H., Williams, L. J., Quirk, S. E., & Versace, V. L. (2023). A scoping review of the barriers and facilitators to accessing and utilising mental health services across regional, rural, and remote Australia. *BMC Health Services Research, 23*(1), 1–1060. https://doi.org/10.1186/s12913-023-10034-4

Kingston, A. H., & Morgan, A. J. (2018). Access to mental health care in Australia: What can be done to improve outcomes? *Australian Health Review, 42*(2), 187-192. https://doi.org/10.1071/AH16174

Kirby, J. N., Grzazek, O., & Gilbert, P. (2019). The role of compassionate and self-image goals in predicting psychological controlling and facilitative parenting styles. *Frontiers in Psychology, 10,* Article 1041. https://doi.org/10.3389/fpsyg.2019.01041

Klerman, G. L., & Weissman, M. M. (1994). *Interpersonal psychotherapy of depression: A brief, focused, specific strategy*. Jason Aronson, Incorporated.

Knapp, M., & Wong, G. (2020). Economics and mental health: The current scenario. *World Psychiatry, 19*(1), 3-14. https://doi.org/10.1002/wps.20692

Korhonen, T., Vehviläinen-Julkunen, K., & Pietilä, A. (2008). Do nurses working in adult psychiatry take into consideration the support network of families affected by parental mental disorder? *Journal of Psychiatric and Mental Health Nursing, 15*(8), 767–776. https://doi.org/10.1111/j.1365-2850.2008.01309.x

Körük, Ö., & Özabacı, N. (2018). The effectiveness of schema therapy in the treatment of depression: A meta-analysis. *Journal of Affective Disorders, 227*, 865-872. https://doi.org/10.1016/j.jad.2017.11.005

Kraus, D. R., Castonguay, L., Boswell, J. F., Nordberg, S. S., & Hayes, J. A. (2011). Therapist effectiveness: Implications for accountability and patient care. *Psychotherapy Research, 21*(3), 267-276. https://doi.org/10.1080/10503307.2011.563249

Lacey, M., Paolini, S., Hanlon, M. C., Melville, J., Galletly, C., & Campbell, L. E. (2015). Parents with serious mental illness: Differences in internalised and externalised mental illness stigma and gender stigma between mothers and fathers. *Psychiatry Research, 225*(3), 723–733. https://doi.org/10.1016/j.psychres.2014.09.010

Lam, C. W., & O'Farrell, T. J. (2011). The impact of parental mental health problems on children's self-regulation and emotional development. *Journal of Child Psychology and Psychiatry, 52*(9), 987-997. https://doi.org/10.1111/j.1469-7610.2011.02415.x

Langdridge, D. (2007). *Narrative therapy and identity*. The SAGE Handbook of Qualitative Research in Psychology.

Larkin, M., Watts, S., & Clifton, E. (2008). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology, 16*(4), 646-667. https://doi.org/10.1191/1478088706qp062oa

Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: Systematic review and narrative synthesis. *The British Journal of Psychiatry, 199*, 445–452. https://doi.org/10.1192/bjp.bp.110.083733

Lee, G. C., Platow, M. J., Haslam, S. A., Reicher, S. D., Grace, D. M., & Cruwys, T. (2021). Facilitating goals, tasks, and bonds via identity leadership: Understanding the therapeutic working alliance as the outcome of social identity processes. *Group*

Dynamics: Theory, Research, and Practice, 25(4), 271–287. https://doi.org/10.1037/gdn0000170

Leenman, G., & Arblaster, K. (2020). Navigating rocky terrain: A thematic analysis of mental health clinician experiences of family-focused practice. *The Journal of Mental Health Training, Education and Practice, 15*(2), 71–83. https://doi.org/10.1108/JMHTEP-04-2019-0022

Leichsenring, F., Steinert, C., Rabung, S., & Ioannidis, J. P. (2022). The efficacy of psychotherapies and pharmacotherapies for mental disorders in adults: An umbrella review and meta-analytic evaluation of recent meta-analyses. *World Psychiatry, 21*(1), 133-145. https://doi.org/10.1002/wps.20941

Leinonen, J. A., Solantaus, T. & Punam€aki, R.L. (2003). Parental mental health and children's adjustment: The quality of marital interaction and parenting as mediating factors. *Journal of Child Psychology and Psychiatry, 44* (2), 227–241. https://doi.org/10.1111/1469-7610.t01-1-00116

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Sage Publications.

Lloyd-Evans, B., Mayo-Wilson, E., Harrison, B., Istead, H., Brown, E., Pilling, S., Johnson, S., Kendall, T. (2014). A systematic review and meta-analysis of randomised controlled trials of peer support for people with severe mental illness. *BMC Psychiatry, 14*(1), 1–12. https://doi.org/10.1186/1471-244X-14-39

Lopes, R. T., Gonçalves, M. M., Fassnacht, D. B., Machado, P. P., & Sousa, I. (2014). Long-term effects of psychotherapy on moderate depression: A comparative study of narrative therapy and cognitive-behavioral therapy. *Journal of Affective Disorders, 167*, 64-73. https://doi.org/10.1016/j.jad.2014.05.042

Louis, J. P., Ortiz, V., Barlas, J., Lee, J. S., Lockwood, G., Chong, W. F., Louis, K. M., & Sim, P. (2021). The Good Enough Parenting early intervention schema therapy-based program: Participant experience. *PloS one*, *16*(1), e0243508. https://doi.org/10.1371/journal.pone.0243508

Madanes, C. (1981). *Strategic family therapy*. Jossey-Bass.

Maddocks, S., Johnson, S., Wright, N., & Stickley, T. (2010). A phenomenological exploration of the lived experience of mental health nurses who care for clients with enduring mental health problems who are parents. *Journal of Psychiatric and Mental Health Nursing, 17*(8), 674–682. https://doi.org/10.1111/j.1365- 2850.2010.01582.x

Marks, I., Cavanagh, K., & Gega, L. (2007). Computer-aided psychotherapy: Revolution or bubble? *British Journal of Psychiatry, 191*, 471–473. https://doi.org/10.1192/bjp.bp.107.041152

Marston, N., Stavnes, K., Van Loon, L. M. A., Drost, L. M., Maybery, D. J., Mosek, A., Reupert, A. E. (2016). A content analysis of Intervention Key Elements and Assessments (IKEA): What's in the black box in the interventions directed to families where a parent has a mental illness? *Child & Youth Services, 37*(2), 112–128. https://doi.org/10.1080/0145935X.2016.1104041

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 68*(3), 438–450. https://doi.org/10.1037/0022-006X.68.3.438

Maybery, D., & Reupert, A. (2009). Parental mental illness: a review of barriers and issues for working with families and children. *Journal of Psychiatric and Mental Health Nursing*, *16*(9), 784–791. https://doi.org/10.1111/j.1365-2850.2009.01456.x

Maybery, D., & Reupert, A. (2018a). A family-focused, recovery approach when working with families when a parent has a history of mental health problems: From theory to practice. In J.C. Santos & J.R. Cutcliffe (Eds), *European Psychiatric/Mental Health nursing in the 2st century: A person-centred evidence-based approach* (pp. 283-291). Switzerland: Springer.

Maybery, D., & Reupert, A. (2018b). The number of parents who are patients attending psychiatric services. *Current Opinion in Psychiatry, 31*(4), 358–362. https://doi.org/10.1097/YCO.0000000000000427

Maybery, D., Goodyear, M., Reupert, A. E., & Grant, A. (2016). Worker, workplace or families: What influences family focused practices in adult mental health? *Journal of Psychiatric and Mental Health Nursing, 23*(4), 163–171. https://doi.org/10.1111/jpm.12294

Maybery, D., Goodyear, M., Reupert, A., & Harkness, M. (2015). The importance of being child-focused: Helping children whose parents have mental illness. *Australian & New Zealand Journal of Family Therapy, 36*(1), 138-154. https://doi.org/10.1002/anzf.1095

Maybery, D., Goodyear, M., Reupert, A., Sheen, J., Cann, W., O'Hanlon, B., & Cuff, R. (2019). A mixed method evaluation of an intervention for parents with mental illness. *Clinical Child Psychology and Psychiatry, 24*(4), 717-727. https://doi.org/10.1177/1359104518822676

Maybery, D., Ling, L., Szakacs, E., & Reupert, A. (2005). Children of a parent with a mental illness: Perspectives on need. *Australian e-Journal for the Advancement of Mental Health, 4*(2), 1–11.

Maybery, D., Reupert, A., Goodyear, M., et al. (2009). Investigating the strengths and difficulties of children from families with a parental mental illness. *Advances in Mental Health, 8*, 165–174.

Maybery, D., Reupert, A., Goodyear, M., Ritchie, R., Brann, P., & Maybery, D. (2015). Investigating the strengths and difficulties of children in families with a parental mental illness. *Journal of Psychiatric and Mental Health Nursing, 22*(1), 3-12. https://doi.org/10.1111/jpm.12174

McCormack, B., & McCance, T. (2010). *Person-Centred Nursing: Theory and Practice.* Wiley-Blackwell. https://doi.org/10.1002/9781444390506

McLeod, J. (2011). An introduction to counselling. McGraw-Hill Education.

McQueen, J., & Hobbs, C. (2014). Working with parents: Using narrative therapy to work towards genuine partnership*. Educational and Child Psychology, 31*(4), 9-17. https://doi.org/10.53841/bpsecp.2014.31.4.9

Melville, K. M., Casey, L. M., & Kavanagh, D. J. (2010). Dropout from internet-based treatment for psychological disorders. *British Journal of Clinical Psychology, 49*, 455–471. https://doi.org/10.1348/014466509X472138

Miller, W. R., & Rollnick, S. (2019). *Motivational interviewing: Helping people change (3rd ed.).* The Guilford Press.

Minuchin, S. (1974). *Families and family therapy*. Harvard University Press.

Moltrecht, B., Lange, A. M. C., Merrick, H., & Radley, J. (2024). Whole-family programmes for families living with parental mental illness: A systematic review and meta-analysis. *European Child & Adolescent Psychiatry*. https://doi.org/10.1007/s00787-024-02380-3

Moreira, H. (2023). Self-compassion in parenting. In A. Finlay-Jones, K. Bluth, & K. Neff (Eds.), *Self-compassion in psychotherapy: Clinical integration, evidence base, and mechanisms of change* (pp. 379–415). Springer Nature Switzerland AG. https://doi.org/10.1007/978-3-031-22348-8_22

Morgan, A. (2000). *What is narrative therapy?* Dulwich Centre Publications.

Moroz, N., Moroz, I., & D'Angelo, M. S. (2020). Mental health services in Canada: Barriers and cost-effective solutions to increase access. *Healthcare Management Forum*, *33*(6), 282–287. https://doi.org/10.1177/0840470420933911

Mottaghipour, Y., & Bickerton, A. (2005). The Pyramid of Family Care: A framework for family involvement with adult mental health services. *Australian e-Journal for the Advancement of Mental Health, 4*(3), 210–217. https://doi.org/10.5172/jamh.4.3.210

Moustakas, C. E. (1994). *Phenomenological research methods.* Sage Publications.

Mulligan, C., Furlong, M., McGarr, S., O'Connor, S., & McGilloway, S. (2021). The Family Talk Programme in Ireland: A qualitative analysis of the experiences of families with parental mental illness. *Frontiers in Psychiatry*, *12*, 783189. https://doi.org/10.3389/fpsyt.2021.783189

Muran, J. C., & Barber, J. P. (2010). *The therapeutic alliance: An evidence-based guide to practice.* Guilford Press.

Murphy, D., Hagan, J., & Cahill, L. (2016). The effects of parental mental illness on children's self-perception and stigma: A review. *Child Psychiatry & Human Development, 47*(6), 917-926. https://doi.org/10.1007/s10578-016-0623-1

Naccarella, L., & Loh, E. (2021). Mental health service access, utilisation and waiting times in Australia in 2021: A literature review. *Australian Health Review, 45*(6), 775-784. https://doi.org/10.1071/AH21005

Nichols, M. P. (2013). *Family therapy: Concepts and methods* (10th ed.). Pearson.

Nicholson, J. (2001). Parents with mental illness: The implications for families and children. *Journal of Clinical Psychiatry, 62*(19), 37-42.

Nicholson, J. (2014). Supporting mothers living with mental illness in recovery. In N. Benders-Hadi & M. E. Barber (Eds.), Motherhood, mental illness and recovery: Stories of Hope (pp. 3–17). Orangeburg, NY: Springer.

Nicholson, J., & Valentine, A. (2018). Defining "peerness": Developing peer supports for parents with mental illnesses. *Psychiatric Rehabilitation Journal, 41*(2), 157–159. https://doi.org/10.1037/prj0000301

Nicholson, J., Albert, K., Gershenson, B., Williams, V., & Biebel, K. (2009). Family options for parents with mental illnesses: a developmental, mixed methods pilot study. *Psychiatric Rehabilitation Journal*, *33*(2), 106–114. https://doi.org/10.2975/33.2.2009.106.114

Nicholson, J., Hager, K., & Lutz, A. (2009). Parental mental illness and child outcomes: A comprehensive review of the literature. *Children and Youth Services Review, 31*(6), 668-676. https://doi.org/10.1016/j.childyouth.2009.01.007

Norcross, J. C., & Lambert, M. J. (2018). Psychotherapy relationships that work III. *Psychotherapy, 55*(4), 303–315. https://doi.org/10.1037/pst0000193

Norcross, J. C., & Goldfried, M. R. (Eds.). (2019). *Handbook of psychotherapy integration* (3rd ed.). Oxford Academic. https://doi.org/10.1093/med-psych/9780190690465.001.0001

O'Shea, A., Kaplan, K., Solomon, P., & Salzer, M. S. (2019). Randomized controlled trial of an internet-based educational intervention for mothers with mental illnesses: An 18-month follow-up. *Psychiatric Services, 70*(8), 751-757. https://doi.org/10.1176/appi.ps.201800391

Packer, M., & Goicoechea, J. (2000). Sociocultural and constructivist theories of learning: Ontology, not just epistemology. *Educational Psychologist, 35*(4), 227–241. https://doi.org/10.1207/S15326985EP3504_02

Patton, M. Q. (2015). *Qualitative research & evaluation methods: Integrating theory and practice*. Sage Publications.

Payne, M. (2006). *Narrative therapy*. Sage.

Peat, G., Rodriguez, A., & Smith, J. (2019). Interpretive phenomenological analysis applied to healthcare research. *Evidence-Based Nursing*, *22*(1), 7–9. https://doi.org/10.1136/ebnurs-2018-103017

Pedersen, P. B., Draguns, J. G., Lonner, W. J., & Trimble, J. E. (2008). *Counseling across cultures* (6th ed.). SAGE Publications.

Peeters, N., van Passel, B., & Krans, J. (2021). The effectiveness of schema therapy for patients with anxiety disorders, OCD, or PTSD: A systematic review and research agenda. *British Journal of Clinical Psychology*, *60*(3), 329-357. https://doi.org/10.1111/bjc.12324

Pilowsky, D. J., Wickramaratne, P., Nomura, Y., & Weissman, M. M. (2006). Family discord, parental depression, and psychopathology in offspring: 20-year follow-up. *Journal of the American Academy of Child & Adolescent Psychiatry, 45*(4), 452-460. http://dx.doi.org/10.1097/01.chi.0000198592.23078.8d

Pitman, E., & Matthey, S. (2004). The SMILES Program: A group program for children with mentally ill parents or siblings. *American Journal of Orthopsychiatry, 74*(3), 383–388. https://doi.org/10.1037/0002-9432.74.3.383

Pölkki, P., Ervast, S.-A., & Huupponen, M. (2005). Coping and resilience of children of a mentally ill parent. *Social Work in Health Care, 39*(1), 151-163. http://dx.doi.org/10.1300/j010v39n01_10

Powell, R. M., Mitra, M., Nicholson, J., & Parish, S. L. (2020). Perceived community-based needs of low-income parents with psychiatric disabilities who experienced legal

challenges to their parenting rights. *Children and Youth Services Review, 112*, 104902. https://doi.org/10.1016/j.childyouth.2020.104902

Power, J., Goodyear, M. J., Maybery, D. J., Reupert, A. E., O'Hanlon, B., Cuff, R., & Perlesz, A. (2016). Family resilience in families where a parent has a mental illness. *Journal of Social Work*, *16*(1), 66–82. https://doi.org/10.1177/1468017314568081

Prochaska, J. O., & Norcross, J. C. (2018). *Systems of psychotherapy: A transtheoretical analysis* (9th ed.). Oxford University Press.

Prochaska, J. O., & Velicer, W. F. (1997). The transtheoretical model of health behavior change. American *Journal of Health Promotion, 12*(1), 38-48.

Rabiee, S., Zadeh, M. F., & Bahrami, F. (2008). The effect of narrative couple therapy on couples family functioning in Isfahan. *Journal of Family Research, 4,* 179–191. Retrieved from http://en.sbu.ac.ir/Research_Institutes/Family_Research/Pages/Journal-of-Family-Research-.aspx

Radley, J., Barlow, J., & Johns, L. (2021). Mental health profession- als' experiences of working with parents with psychosis and their families: A qualitative study. *BMC Health Services Research, 21*(1), 1–11. https://doi.org/10.1186/s12913-021-06416-1

Ramey, H. L., Tarulli, D., Frijters, J. C., & Fisher, L. (2009). A sequential analysis of externalizing in narrative therapy with children. *Contemporary Family Therapy, 31*(4), 262-279. http://doi.org/10.1007/s10591-009-9095-5

Reupert, A., Bee, P., Hosman, C., van Doesum, K., Drost, L. M., Falkov, A., Foster, K., Gatsou, L., Gladstone, B., Goodyear, M., Grant, A., Grove, C., Isobel, S., Kowalenko, N., Lauritzen, C., Mayberry, D., Mordoch, E., Nicholson, J., Reedtz, C., et al. (2021). Editorial perspective: Prato research collaborative for change in parent and child mental health–principles and recommendations for working with children and parents living with parental mental illness. *Journal of Child Psychology and Psychiatry, 63*(3), 350–353. https://doi.org/10.1111/jcpp.13521

Reupert, A., Gladstone, B., Helena Hine, R., Yates, S., McGaw, V., Charles, G., & Foster, K. (2021). Stigma in relation to families living with parental mental illness: An integrative review. *International Journal of Mental Health Nursing*, *30*(1), 6-26. https://doi.org/10.1111/inm.12820

Reupert, A., Hine, R. & Maybery, D. (2021). Working with rural families: issues and responses when a family member has a mental illness. In T. Carey & J. Gulifer (Eds). *Handbook of Rural, Remote and Very Remote Rural health*. Springer.

Reupert, A., & Maybery, D. (2011). Families affected by parental mental illness: A multiperspective account of issues and interventions. *American Journal of Orthopsychiatry, 81*(1), 38-47. https://doi.org/10.1111/j.1939-0025.2010.01073.x

Reupert, A., Maybery, D., Bartholomew, C., Cuff, R., Foster, K., Matar, J., & Pettenuzzo, L. (2020). The acceptability and effectiveness of an online intervention for youth with parents with a mental illness and/or substance use issue. *Journal of Adolescent Health, 66*(5), 551-558. https://doi.org/10.1016/j.jadohealth.2019.11.309

Reupert, A., Maybery, D., Bartholomew, C., Cuff, R., Matar, J., Pettenuzzo, L., & Foster, K. (2022). An online intervention for vulnerable young adults: Identifying mechanisms of change using a grounded theory approach. *Social Psychiatry and Psychiatric Epidemiology, 57*(2), 293-303. https://doi.org/10.1007/s00127-021-02082-0

Reupert, A., Maybery, D., Cox, M., Scott, Stokes, M., & Kowalenko, N. (2015). Place of family in recovery models for those with a mental illness. *International Journal of Mental Health Nursing, 24*, 495-508. https://doi.org/10.1111/inm.12146

Reupert, A., Maybery, D., Nicholson, J., Göpfert, M., & Seeman, M. V. (Eds.). (2015b). *Parental Psychiatric Disorder: Distressed Parents and their Families* (3rd ed.). Cambridge: Cambridge University Press.

Reupert, A., Price-Robertson, R., & Maybery, D. (2017). Parenting as a focus of recovery: A systematic review of current practice. *Psychiatric Rehabilitation Journal, 40*(4), 361-370. https://doi.org/10.1037/prj0000240

Reupert, A., Straussner, S., Weimand, B., & Maybery, D. (2022). It takes a village to raise a child: Understanding and expanding the concept of the "village." *Frontiers in Public Health, 10*, Article 756066. https://doi.org/10.3389/fpubh.2022.756066

Rivett, M., & Buchmüller, J. (2017). *Family therapy skills and techniques in action*. Taylor & Francis Group.

Robinson, A. H., & Rickard, H. C. (2018). The influence of baseline severity on therapy outcome: An updated meta-analysis. *Clinical Psychology Review, 66*, 22–33. https://doi.org/10.1016/j.cpr.2018.03.001

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21(2), 95–103.* https://doi.org/10.1037/h0045357

Russell, A. E., Ford, T., Williams, R., & Russell, G. (2016). The association between socioeconomic disadvantage and attention deficit/hyperactivity disorder (ADHD): A

systematic review. *Child Psychiatry and Human Development, 47*(3), 440–458. https://doi.org/10.1007/s10578-015-0578-3

Sanders, M. R., & Turner, K. M. T. (2018). The Triple P-Positive Parenting Program: A review of its effectiveness and implications for clinical practice. *Australian & New Zealand Journal of Psychiatry, 52*(7), 618-626. https://doi.org/10.1177/000486741876494

Savvidou, I., Bozikas, V., Hatzigeleki, S., & Karavatos, A. (2003). Narratives about their children by mothers hospitalized on a psychiatric unit. *Family Process, 42*(3), 391. https://doi.org/10.1111/j.1545-5300.2003.00391.x

Schofield, M. J. (2008). Australian counsellors and psychotherapists: A profile of the profession. *Counselling and Psychotherapy Research, 8*(1), 4–11. https://doi.org/10.1080/14733140801936369

Seeman, M. V. (2012). Intervention to prevent child custody loss in mothers with schizophrenia. *Schizophrenia Research and Treatment*, *2012,* 1–6. https://doi.org/10.1155/2012/796763

Selvini-Palazzoli, M., Boscolo, L., Cecchin, G., & Prata, G. (1980). Hypothesizing-circularity-neutrality: Three guidelines for the conductor of the session. *Family Process*, *19*(1), 3-12. https://doi.org/10.1111/j.1545-5300.1980.00003.x

Shalay, N., & Brownlee, K. (2007). Narrative family therapy with blended families. *Journal of Family Psychotherapy, 18*(2), 17-30. https://doi.org/10.1300/J085v18n02_02

Siegel, D. J., & Hartzell, M. (2014). *Parenting from the inside out: how a deeper self-understanding can help you raise children who thrive.* Penguin.

Skundberg-Kletthagen, H., Gonzalez, M. T., Schröder, A., & Moen, Ø. L. (2020). Mental health professionals' experiences with applying a family-centred care focus in their clinical work. *Issues in Mental Health Nursing, 41*(9), 815–823. https://doi.org/10.1080/01612 840.2020.1731028

Smith, B., & Sparkes, A. C. (2008). Narrative and its potential contribution to disability studies. *Disability & Society*, *23*(1), 17-28. http://doi.org/10.1080/09687590701725542

Solantaus-Simula, T., Punamäki, R. L., & Beardslee, W. R. (2002). Children's responses to low parental mood. II: Associations with family perceptions of parenting styles and child distress. *Journal of the American Academy of Child and Adolescent Psychiatry*, *41*(3), 287–295. https://doi.org/10.1097/00004583-200203000-00008

Solantaus, T., Paavonen, E. J., Toikka, S., & Punamäki, R.-L. (2010). Preventive interventions in families with parental depression: Children's psychosocial symptoms and prosocial behaviour. *European Child & Adolescent Psychiatry, 19*(12), 883–892. https://doi.org/10.1007/s00787-010-0135-3

Spinhoven, P., van Lieshout, P., de Rooij, M., & van Veen, T. (2007). The efficacy of schema-focused therapy for borderline personality disorder: A randomized controlled trial. *Journal of Clinical Psychology, 63*(6), 759-767. https://doi.org/10.1002/jclp.20355

Stokes, D., Mathews, R., Grenyer, B. F., & Crea, K. (2010). The Australian psychology workforce 3: A national profile of psychologists in salaried employment or in independent private practice. *Australian Psychologist, 45*(3), 178–188. https://doi.org/10.1080/00050061003777126

Strand, J., & Rudolfsson, L. (2018). Professionals' experiences of integrating a child perspective in adult psychosis service. *American Journal of Psychiatric Rehabilitation, 21*(1), 57–78.

Stuart, S., & O'Hara, M. W. (1995). Interpersonal psychotherapy for postpartum depression: a treatment program. *The Journal of Psychotherapy Practice and Research*, *4*(1), 18.

Suddeath, E. G., Kerwin, A. K., & Dugger, S. M. (2017). Narrative family therapy: Practical techniques for more effective work with couples and families. *Journal of Mental Health Counseling, 39*(2)*,* 116-131. http://doi.org/10.17744/mehc.39.2.03

Sue, D. W., & Sue, D. (2016). *Counseling the culturally diverse: Theory and practice* (7th ed.). Wiley.

Tabak, I., Zabłocka-Żytka, L., Ryan, P., Poma, S. Z., Joronen, K., Viganò, G., Simpson, W., Paavilainen, E., Scherbaum, N., Smith, M., Dawson, I. (2016). Needs, expectations and consequences for children growing up in a family where the parent has a mental illness. *International Journal Mental Health Nursing 25*(4), 319–329. https://doi.org/10.1111/inm.12194

Tadros, E., Cappetto, M., & Aguirre, N. (2022). Treating specific phobia fear of injury through narrative therapy post-release: A clinical case study. *The Journal of Forensic Psychiatry & Psychology, 33*(3), 445-460. https://doi.org/10.1080/14789949.2022.2065332

Tchernegovski, P., Reupert, A. E., & Maybery, D. J. (2018). Adult mental health clinicians' perspectives of parents with a mental illness and their children: Single and dual focus

perspectives. *BMC Health Services Research, 18*(1), 611-621. https://doi.org/10.1186/s12913-018-3428-8

Tchernegovski, P., Reupert, A. E., & Maybery, D. J. (2018). How do Australian adult mental health clinicians manage the challenges of working with parental mental illness? A phenomenological study. *Child & Family Social Work, 23*(3), 381–389. https://doi.org/10.1111/cfs.12426

Titchen, A., Cardiff, S., & Biong, S. (2017). The knowing and being of person-centred research practice across worldviews. In *Person-Centred Healthcare Research* (pp. 31–50). John Wiley & Sons. https://doi.org/10.1002/9781119099635.ch3

Tuffour, I. (2017). A critical overview of interpretative phenomenological analysis: A contemporary qualitative research approach. *Journal of Healthcare Communications*, *2*(4), 52.

van der Ende, P. C., van Busschbach, J. T., Nicholson, J., Korevaar E. L., & van Weeghel, J. (2016). Strategies for parenting by mothers and fathers with a mental illness. *Journal of Psychiatric and Mental Health Nursing, 23*(2)*,* 86-97. https://doi.org/10.1111/jpm.12283

van Manen, M. (1997). *Researching lived experience: Human science for an action sensitive pedagogy* (2nd ed.). Routledge. https://doi.org/10.4324/9781315421056

van Santvoort, F., O'Leary, R., & Koot, H. M. (2015). Genetic and temperamental risks for mental illness in children: The role of parent-child transmission. *Behavior Genetics, 45*(2), 150-163. https://doi.org/10.1007/s10519-014-9703-7

Victorian Government Department of Health. (2013). *National practice standards for the mental health workforce 2013*. Victorian Government Department of Health. https://www.health.gov.au

Von Doussa, H., Hegarty, M., Sanders, B., Cuff, R., Tivendale, K., McLean, S. A., & Goodyear, M. (2023). Peer support for children of parents with mental illness (COPMI) in Australia: Responses from children, parents, and facilitators of the CHAMPS peer support program. *Advances in Mental Health, 21*(1), 55-66. https://doi.org/10.1080/18387357.2022.2075411

Vromans, L. P., & Schweitzer, R. D. (2011). Narrative therapy for adults with major depressive disorder: Improved symptom and interpersonal outcomes. *Psychotherapy Research, 21*(1), 4-15. https://doi.org/10.1080/10503301003591792

Vromans, L. P., Schweitzer, R. D., & Brough, M. (2016). Narrative therapy for refugees: Developing practice guidelines based on qualitative research in Australia. *Journal of*

Ethnic & Cultural Diversity in Social Work, 25(3), 158-173. https://doi.org/10.1080/15313204.2015.1132968

Wampold, B. E., & Imel, Z. E. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work* (2nd ed.). Routledge.

Wark, S. (2012). Counselling support for people with intellectual disabilities: The use of narrative therapy. *The Australian Journal of Rehabilitation Counselling, 18*(1), 37-49.

Webb, R. T., Scourfield, J., & Biddle, L. (2016). Children of parents with mental illness: Academic and social outcomes. *British Journal of Psychiatry, 208*(5), 485-490. https://doi.org/10.1192/bjp.bp.114.155539

Weissman, M. M., Wickramaratne, P., Gameroff, M. J., Warner, V., Pilowsky, D., Kohad, R. G., & Talati, A. (2016). Offspring of Depressed Parents: 30 Years Later. *American Journal of Psychiatry, 173*(10), 1024–1032. https://doi.org/10.1176/appi.ajp.2016.15101327

Weitzman, C., & Wilson, J. (2011). Children of parents with mental health issues: An overview of risk factors and outcomes. *Child Psychiatry & Human Development, 42*(1), 56-68. https://doi.org/10.1007/s10578-010-0190-1

Wendt, S., & Gone, J. P. (2017). Rethinking cultural competence: Insights from indigenous community treatment settings. *Culture, Medicine, and Psychiatry, 41*(4), 581-605. https://doi.org/10.1007/s11013-017-9517-2

Werner, A. M., Tibubos, A. N., Rohrmann, S., & Reiss, N. (2019). The clinical trait self-criticism and its relation to psychopathology: A systematic review – Update. *Journal of Affective Disorders, 246*, 530-547. https://doi.org/10.1016/j.jad.2018.12.069

White, M. (2007). *Maps of narrative practice*. Norton.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. Norton & Company.

Williams, R.F., & Doessel, D. (2008). The Australian mental health system: An economic overview and some research issues. *International Journal of Mental Health Systems, 2*(1), 4. https://doi.org/10.1186/1752-4458-2-4

Willig, C., & Rogers, W. S. (2017). *The SAGE handbook of qualitative research in psychology* (2nd ed.). SAGE Publications. https://doi.org/10.4135/9781526405555

Zhang, N., & Burkard, A. (2008). Client and counselor discussions of racial and ethnic differences in counselling: an exploratory investigation. *Journal of Multicultural Counselling and Development, 36*, 77–87.

Appendices

A. Research Journal Excerpt
B. Ethics Approval Documents
C. Explanatory Statements
D. Interview Schedules

Appendix A: Research Journal Excerpt

Research Journal Entry: Interview 1 - ACT

Date: [redacted]

Participant: [redacted]

Reflections:

[redacted] joined the waiting-room of the Zoom call a couple minutes prior to the scheduled 12:30p.m. interview which caught me off-guard, and I jumped onto Zoom without opening up the interview schedule or my notes.

She was very friendly, and rapport was readily established in the first few minutes of chatting about our days. I felt relaxed upon telling her about my limited experience using ACT and by the time I began asking interview questions I felt calm.

[redacted] appeared very knowledgably in the ACT process and readily drew from client examples. Her examples of applying ACT processes in real-life client situations appeared well-thought out and she had made notes about discussion points from the interview schedule prior to jumping on the call with me. [redacted] had a great ability in explaining the ACT terminology and metaphors to me in a simple, easily understandable way, such as when I asked through a probing question if she could speak more about the 'passenger on the bus' metaphor. [redacted] noted that she had been practicing ACT for 13 years across a number of different settings and appeared extremely well-versed in the theory. I found myself feeling somewhat in awe and very impressed by her career experience including her work at [redacted]

I really enjoyed conducting this interview with [redacted] – I felt confident asking clarifying questions and she clearly respond to my questions and offered detailed insight about her personal experiences.

Appendix B: Ethics Approval Documents
Study 1 (Schema Therapy)

Monash University Human Research Ethics Committee

Approval Certificate

This is to certify that the project below was considered by the Monash University Human Research Ethics Committee. The Committee was satisfied that the proposal meets the requirements of the *National Statement on Ethical Conduct in Human Research* and has granted approval.

Project ID: 27250
Project Title: Schema therapists' perspectives and experiences of practice with parents who have a mental illness.
Chief Investigator: Dr Phillip Tchernegovski
Approval Date: 04/06/2021
Expiry Date: 04/06/2026

Terms of approval - failure to comply with the terms below is in breach of your approval and the *Australian Code for the Responsible Conduct of Research*.

1. The Chief Investigator is responsible for ensuring that permission letters are obtained, if relevant, before any data collection can occur at the specified organisation.
2. Approval is only valid whilst you hold a position at Monash University.
3. It is responsibility of the Chief Investigator to ensure that all investigators are aware of the terms of approval and to ensure the project is conducted as approved by MUHREC.
4. You should notify MUHREC immediately of any serious or unexpected adverse effects on participants or unforeseen events affecting the ethical acceptability of the project.
5. The Explanatory Statement must be on Monash letterhead and the Monash University complaints clause must include your project number.
6. Amendments to approved projects including changes to personnel must not commence without written approval from MUHREC.
7. Annual Report - continued approval of this project is dependent on the submission of an Annual Report.
8. Final Report - should be provided at the conclusion of the project. MUHREC should be notified if the project is discontinued before the expected completion date.
9. Monitoring - project may be subject to an audit or any other form of monitoring by MUHREC at any time.
10. Retention and storage of data - The Chief Investigator is responsible for the storage and retention of the original data pertaining to the project for a minimum period of five years.

Kind Regards,

Professor Nip Thomson

Chair, MUHREC

CC: Miss Ciara Hart, Miss Irene Martin, Professor Andrea Reupert

List of approved documents:

Document Type	File Name	Date	Version
Explanatory Statement	Explanatory Statement - Ethics	26/04/2021	1
Supporting Documentation	Social media flyer	21/05/2021	2
Supporting Documentation	Email Template for Professional Schema Therapy Groups - Ethics Application	21/05/2021	2
Questionnaires / Surveys	Demographics and consent survey - Qualtrics	21/05/2021	2
Supporting Documentation	Schema Therapists Interview Schedule - Ethics Application	21/05/2021	2

Ethics approval for Study 2 (Acceptance and Commitment Therapy) and Study 3 (Narrative Therapy) was applied for as an amendment to Study 1 because the study design remained the same.

Appendix C: Explanatory Statements
Study 1 (Schema Therapy)

MONASH University

EXPLANATORY STATEMENT

Project title: Schema therapists' perspectives and experiences of practice with parents who have a mental illness
Project ID: 27250

You are invited to take part in this study. Please read this Explanatory Statement in full before deciding whether or not to participate in this research. If you would like further information regarding any aspect of this project, you are encouraged to contact the researchers listed below.

What does the research involve?
This study aims to investigate schema therapists' views and experiences of practicing schema therapy with parents who have a mental illness. Participation will involve an interview about your views and experiences of schema therapy with parents. This interview will be conducted either over the phone or on Zoom and will take approximately 40-60 minutes. The interview will be recorded with your consent and you will receive a copy of the written transcript. You will be able to make amendments to the transcript if you wish.

Why were you chosen for this research?
You are invited to participate in this study because you are a certified schema therapist or are undergoing certification.

Consenting to participate in the project and withdrawing from the research

If you agree to participate in this research, please follow the below link to provide your consent and demographic information in an online survey:

monash.edu/education/schema-parent

You are free to withdraw from the research at any stage until you have approved your interview transcript. Your approval will be assumed if you do not respond with any amendments within two weeks of being sent the transcript (unless you ask for more time). Your decision to take part (or not to take part), or to withdraw, will not affect any existing or future relationship what you may have with Monash University. If you chose to withdraw from the study, any information that you have supplied will be deleted.

Possible benefits and risks to participants
We cannot guarantee that you will receive any benefits from this research, however, it may encourage professional reflection on the research topic. An understanding of this topic may inform future training and professional development opportunities as well as practice resources.

It is not expected that participation in the study will cause you any discomfort. If this does occur please inform the researcher who will modify, pause or stop the survey or interview. In the rare event that distress continues or is experienced after the interview, we recommend that you speak to your supervisor or call lifeline on 131 114.

Confidentiality
Any identifying details will be omitted from your interview transcription. You will also be provided with a transcription of the interview to amend any information that you believe identifies yourself. Any data published or reported will remain de-identified. Group findings will be reported as part of the student researchers' theses for the qualification of a Master / Doctor of Philosophy in Psychology (Educational and Developmental). Findings may also be submitted for publication or used in conference presentations, but individual participants will not be identifiable in any such publications.

Storage of data

Storage of data will adhere to the University regulations. Paper documents will be scanned to electronic format and shredded. All electronic documents will be stored in a password protected Monash University server and will only be available to the researchers on this form. It will be deleted after 5 years.

Results

If you would like to receive a summary of the results of this study, please let the student researcher (Ciara) know (Ciara.hart@monash.edu).

Complaints
Should you have any concerns or complaints about the conduct of the project, you are welcome to contact the Executive Officer, Monash University Human Research Ethics Committee (MUHREC):

Executive Officer
Monash University Human Research Ethics Committee (MUHREC)
Room 111, Chancellery Building D,
26 Sports Walk, Clayton Campus
Research Office
Monash University VIC 3800

Tel: +61 3 9905 2052 Email: muhrec@monash.edu Fax: +61 3 9905 3831

Thank you,

For further information:
If you would like any further information concerning this project, you can contact any of the researchers listed below.

Prof Andrea Reupert

Chief Investigator
Faculty of Education

Clayton Campus
Monash University
andrea.reupert@monash.edu

Dr Rochelle Hine

Co-Investigator
Faculty of Medicine, Nursing and Health Sciences
Clayton Campus
Monash University
Rochelle.hine1@monash.edu

Ciara Hart

Student researcher
Faculty of Education
Clayton Campus
Monash University
ciara.hart@monash.edu

Irene Martin

Student researcher
Faculty of Education
Clayton Campus
Monash University
Irene.martin@monash.edu

Study 2 (Acceptance and Commitment Therapy)

MONASH University

EXPLANATORY STATEMENT

Project title: Acceptance and commitment therapists' perspectives and experiences of practice with parents who have a mental illness
Project ID: 27250

You are invited to take part in this study. Please read this Explanatory Statement in full before deciding whether or not to participate in this research. If you would like further information regarding any aspect of this project, you are encouraged to contact the researchers listed below.

What does the research involve?
This study aims to investigate acceptance and commitment therapists' views and experiences of practicing acceptance and commitment therapy with parents who have a mental illness. Participation will involve an interview about your views and experiences of acceptance and commitment therapy with parents. This interview will be conducted either over the phone or on Zoom and will take approximately 40-60 minutes. The interview will be recorded with your consent and you will receive a copy of the written transcript. You will be able to make amendments to the transcript if you wish.

Why were you chosen for this research?
You are invited to participate in this study because you are a therapist practicing acceptance and commitment therapy.

Consenting to participate in the project and withdrawing from the research

If you agree to participate in this research, please follow the below link to provide your consent and demographic information in an online survey:

https://monash.az1.qualtrics.com/jfe/form/SV_08sH8ljIkqPQuuG

You are free to withdraw from the research at any stage until you have approved your interview transcript. Your approval will be assumed if you do not respond with any amendments within two weeks of being sent the transcript (unless you ask for more time). Your decision to take part (or not to take part), or to withdraw, will not affect any existing or future relationship what you may have with Monash University. If you chose to withdraw from the study, any information that you have supplied will be deleted.

Possible benefits and risks to participants
We cannot guarantee that you will receive any benefits from this research, however, it may encourage professional reflection on the research topic. An understanding of this topic may inform future training and professional development opportunities as well as practice resources.

It is not expected that participation in the study will cause you any discomfort. If this does occur please inform the researcher who will modify, pause or stop the survey or interview. In the rare event that distress continues or is experienced after the interview, we recommend that you speak to your supervisor or call lifeline on 131 114.

Confidentiality
Any identifying details will be omitted from your interview transcription. You will also be provided with a transcription of the interview to amend any information that you believe identifies yourself. Any data published or reported will remain de-identified. Group findings will be reported as part of the student researchers' theses for the qualification of a Master / Doctor of Philosophy in Psychology (Educational and Developmental). Findings may also be submitted for publication or used in conference presentations, but individual participants will not be identifiable in any such publications.

Storage of data

Storage of data will adhere to the University regulations. Paper documents will be scanned to electronic format and shredded. All electronic documents will be stored in a password protected Monash University server and will only be available to the researchers on this form. It will be deleted after 5 years.

Results

If you would like to receive a summary of the results of this study, please let the student researcher (Ciara) know (Ciara.hart@monash.edu).

Complaints

Should you have any concerns or complaints about the conduct of the project, you are welcome to contact the Executive Officer, Monash University Human Research Ethics Committee (MUHREC):

Executive Officer
Monash University Human Research Ethics Committee (MUHREC)
Room 111, Chancellery Building D,
26 Sports Walk, Clayton Campus
Research Office
Monash University VIC 3800

Tel: +61 3 9905 2052 Email: muhrec@monash.edu Fax: +61 3 9905 3831

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Dr Rochelle Hine

Co-Investigator
Faculty of Rural and Indigenous Health
Clayton Campus
Monash University
Rochelle.hine1@monash.edu

Ciara Hart

Student researcher
Faculty of Education
Clayton Campus
Monash University
0428 678 456
ciara.hart@monash.edu

Study 3 (Narrative Therapy)

MONASH University

EXPLANATORY STATEMENT

Project title: Narrative therapists' perspectives and experiences of practice with parents who have a mental illness
Project ID: 27250

You are invited to take part in this study. Please read this Explanatory Statement in full before deciding whether or not to participate in this research. If you would like further information regarding any aspect of this project, you are encouraged to contact the researchers listed below.

What does the research involve?
This study aims to investigate narrative therapists' views and experiences of practicing narrative therapy with parents who have a mental illness. Participation will involve an interview about your views and experiences of narrative therapy with parents. This interview will be conducted either over the phone or on Zoom and will take approximately 40-60 minutes. The interview will be recorded with your consent and you will receive a copy of the written transcript. You will be able to make amendments to the transcript if you wish.

Why were you chosen for this research?

You are invited to participate in this study because you practice narrative therapy.

Consenting to participate in the project and withdrawing from the research

If you agree to participate in this research, please follow the below link to provide your consent and demographic information in an online survey:

https://monash.az1.qualtrics.com/jfe/form/SV_8iSSMYlUaDw0xh4

You are free to withdraw from the research at any stage until you have approved your interview transcript. Your approval will be assumed if you do not respond with any amendments within two weeks of being sent the transcript (unless you ask for more time). Your decision to take part (or not to take part), or to withdraw, will not affect any existing or future relationship what you may have with Monash University. If you chose to withdraw from the study, any information that you have supplied will be deleted.

Possible benefits and risks to participants
We cannot guarantee that you will receive any benefits from this research, however, it may encourage professional reflection on the research topic. An understanding of this topic may inform future training and professional development opportunities as well as practice resources.

It is not expected that participation in the study will cause you any discomfort. If this does occur please inform the researcher who will modify, pause or stop the survey or interview. In the rare event that distress continues or is experienced after the interview, we recommend that you speak to your supervisor or call lifeline on 131 114.

Confidentiality
Any identifying details will be omitted from your interview transcription. You will also be provided with a transcription of the interview to amend any information that you believe identifies yourself. Any data published or reported will remain de-identified. Group findings will be reported as part of the student researchers' theses for the qualification of a Master / Doctor of Philosophy in Psychology (Educational and Developmental). Findings may also be submitted for publication or used in conference presentations, but individual participants will not be identifiable in any such publications.

Storage of data

Storage of data will adhere to the University regulations. Paper documents will be scanned to electronic format and shredded. All electronic documents will be stored in a password protected Monash University server and will only be available to the researchers on this form. It will be deleted after 5 years.

Results

If you would like to receive a summary of the results of this study, please let the student researcher know (Ciara.hart@monash.edu.au).

Complaints

Should you have any concerns or complaints about the conduct of the project, you are welcome to contact the Executive Officer, Monash University Human Research Ethics Committee (MUHREC):

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Monash University Human Research Ethics Committee (MUHREC)
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Co-Investigator
Faculty of Education
Clayton Campus
Monash University
Rochelle.hine@monash.edu

Ciara Hart
Student researcher
Faculty of Education
Clayton Campus
Monash University
ciara.hart@monash.edu

Appendix D: Interview Schedules

Study 1 (Schema Therapy)

6. **What have your experiences been like of using schema therapy with parents with a mental illness?**

   Example probes: If anything, what have you found positive about using schema therapy with parents?

7. **Do you think that the schema therapy model is relevant to the experiences of clients who are parents? Why/Why not?**

   Example probes: Which aspects of the model, if any, do you think are relevant to parenting experiences?

8. **Do you think schema therapy techniques meet the needs of clients who are parents? Why/Why not?**

   Example probes: Which techniques of schema therapy, if any, do you think are suited to the needs of your clients who are parents? Why are they suited?

9. **If at all, how do you think the therapy could be adapted to better suit practice with parents?**
10. **What resources, if any, do you think would be helpful for practicing schema therapy with parents?**

Study 2 (Acceptance and Commitment Therapy)

1. **What have your experiences been like of using acceptance and commitment therapy with parents with a mental illness?**

   Example probes: If anything, what have you found positive about using acceptance and commitment therapy with parents?

2. **Do you think that the acceptance and commitment therapy model is relevant to the experiences of clients who are parents? Why/Why not?**

   Example probes: Which aspects of the model, if any, do you think are relevant to parenting experiences?

3. **Do you think s acceptance and commitment therapy techniques meet the needs of clients who are parents? Why/Why not?**

   Example probes: Which techniques of acceptance and commitment therapy, if any, do you think are suited to the needs of your clients who are parents? Why are they suited?

4. **If at all, how do you think the therapy could be adapted to better suit practice with parents?**
5. **What resources, if any, do you think would be helpful for practicing acceptance and commitment therapy with parents?**

Study 3 (Narrative Therapy)

1. **What have your experiences been like of using narrative therapy with parents with a mental illness?**

   Example probes: If anything, what have you found positive about using narrative therapy with parents?

2. **Do you think that the narrative therapy model is relevant to the experiences of clients who are parents? Why/Why not?**

   Example probes: Which aspects of the model, if any, do you think are relevant to parenting experiences?

3. **Do you think narrative therapy techniques meet the needs of clients who are parents? Why/Why not?**

   Example probes: Which techniques of narrative therapy, if any, do you think are suited to the needs of your clients who are parents? Why are they suited?

4. **If at all, how do you think the therapy could be adapted to better suit practice with parents?**
5. **What resources, if any, do you think would be helpful for practicing narrative therapy with parents?**