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“Nice to know that I wasn’t forgotten”: Parents’ experiences of involvement in youth psychotherapy

Marylyn Omach Nakirija

marylyn.nakirija.23@ucl.ac.uk

University College London

Nick Midgley

Anna Freud

Antonella Cirasola

Anna Freud

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Introduction

Adolescence is a key phase in the development of mental health difficulties, with many adults reporting their initial experience of depression in their teenage years (Morales-Muñoz et al., 2023). Various psychological therapies for youth depression have demonstrated effectiveness (Cuijpers et al., 2023), but there is a debate about the role parents should play in such therapy. It is possible for parents, at times, to be less actively involved in youth psychotherapy (Gvion, 2025). However, as developmental researchers have increasingly recognised the on-going, pivotal role of parents in adolescents' lives, greater emphasis has been placed on involving parents in youth psychotherapy to promote therapeutic change, either through joint sessions or parallel therapeutic work with parents (Haine-Schlagel & Walsh, 2015; Riley & Avdi, 2026).

There are varying degrees of parental involvement in psychotherapy, with caregivers potentially playing direct or indirect roles depending on the nature of the therapy. A direct role is not only about being part of the therapy itself; it may also include parents referring their child to Child and Adolescent Mental Health Services (CAMHS), physically taking their child to therapy to ensure attendance, and managing their child's symptoms in the family home (*anonymised*, Year). Indirect roles may refer to parents providing financial and logistical support for adolescents to access therapy, and parental attitudes towards mental health (Acri & Hoagwood, 2015). Studies have found parents often value involvement in their teenage child's therapy and having a greater understanding of their adolescent's treatment as it promotes inclusivity in their child's therapeutic journey and enables parents to support their child through learning and utilising therapeutic strategies within the home both during and following the end of therapy (Creswell et al., 2021; Feder & Diamond, 2016).

However, it is not uncommon for parents to have differing goals or expectations for their child's therapy compared to those of the adolescent seeking mental health treatment (*anonymised*, Year). Services may have different approaches to involving parents and carers, with adolescent services in particular sometimes reluctant to actively engage parents because of concern that this will compromise the therapeutic relationship with the adolescent. Research suggests, regardless of the service's approach, some parents may decide to have a less active involvement in youth psychotherapy for various reasons including; holding negative attitudes towards mental health services or because of the financial strain of taking adolescents to therapy sessions (Reardon et al., 2017). These varied parental attitudes highlight the complexity of the nature of parental involvement.

Having a consideration for adolescents' perspectives on the degree of parental involvement in youth psychotherapy further highlights the complexity. Traditionally, adolescence is seen as a life stage where the need for autonomy and separation is regarded as a core developmental focus (Erikson, 1980), so adolescents may want to minimise or control parental involvement in youth psychotherapy (Hassett et al., 2018). Yet Creswell and colleagues (2021), in a qualitative study of young people who had been in therapy, found that most adolescents who experienced substantial improvement reported they valued parental involvement in their recovery. Specifically, they felt parents could practically support them outside of sessions because they had been informed about therapeutic strategies. This small study highlights, from adolescents' perspectives, the potential value of engaging parents in youth psychotherapy.

However, there also is research in which adolescents report on parental involvement less favourably. Gondek et al. (2017) conducted a systematic review of qualitative studies which explored facilitators and barriers to person-centred care in CAMHS. The findings from the study highlighted how some adolescents found parental involvement to be intrusive as they felt unable to speak openly in parental presence, which acted as a barrier to person-centred care. Thus, there seems to be an ongoing debate regarding the extent therapists should involve parents in youth psychotherapy due to the role of adolescents' preferences and developmental stage (*anonymised*, Year).

Despite these debates, there is some evidence demonstrating a relationship between parental involvement and positive treatment outcomes. Pine and colleagues (2024) conducted a meta-analysis of randomised controlled trials (RCT) to examine whether paternal involvement in treatment adds additional benefits beyond individual psychological interventions for adolescents. The findings suggested that interventions involving parents in treatment have a significantly greater impact on adolescent psychopathology when compared to interventions that targeted adolescents alone. Additionally, parental involvement has been found to promote adolescents' treatment adherence due to parental support which highlights the value of adolescents' therapists developing an alliance with parents (*anonymised*, Year).

However, Forsberg and colleagues (2014) study obtained some mixed findings about the relationship between parental involvement and treatment outcomes. The study was based on adolescents with anorexia nervosa who engaged in Family-Based Treatment. The results showed parent alliance scores with the therapist were significantly higher than adolescent-therapists' alliance scores early in treatment, though this did not predict adolescents' recovery at the end of treatment.

While there is little, if any, literature which has examined parents' experiences of involvement with their adolescent's therapy, some research has examined the experience of being the parent of an adolescent in treatment (Norcross & Lambert, 2019; Roest et al., 2023). *Anonymised* (Year) analysed 48 interviews with parents of adolescents receiving treatment for depression, using thematic analysis. The study identified four themes: 'lack of awareness', 'emotional turmoil', 'helplessness', and 'parenting in overdrive'. The parents in the study often reported feeling unprepared for the onset of their children's symptoms and described carrying a considerable emotional burden. Many parents also reported uncertainty about how to best support their child. The study highlighted the strain and stress that can be experienced by parents of adolescents with depression, and the need for therapists to also provide support to parents. However, the study did not explore parents' experience of their involvement in youth psychotherapy and how they felt this impacted their child.

The Current Study

Although parental involvement is widely recognised as potentially important in youth psychotherapy, there remains limited research examining how parents themselves experience and understand their involvement in their teenage child's treatment. In particular, little is known about parents' perceptions of the quality and extent of their involvement in psychotherapy for adolescent depression. The current study addresses this gap by exploring parents' experiences and perceptions of their involvement in their children's time-limited treatment for adolescent depression, with the aim of informing clinical practice and contributing to a more nuanced understanding of parental involvement in youth psychotherapy.

Method

Setting

The current study presents a secondary qualitative data analysis from the *anonymised* (*anonymised*, Year) study, the qualitative, longitudinal arm of the *anonymised* (*anonymised*, Year) study. *Anonymised* was a large-scale UK RCT evaluating the effectiveness of three manualised, short-term psychological treatments for adolescents ($N = 465$) aged 11– 18 years diagnosed with depression. Adolescents were randomly allocated to Brief Psychosocial Intervention (BPI), Cognitive Behavioural Therapy (CBT) or Short-Term Psychodynamic Psychotherapy (STPP). All treatments were manualised and demonstrated to be delivered with fidelity to their respective treatment approach (*anonymised*, Year). Details of the trial design and main findings are reported elsewhere (*anonymised*, Year; *anonymised*, Year).

Each psychological treatment manual had a different approach to parental involvement. Brief Psychosocial Intervention (**BPI)** is a goal-oriented treatment focused on psychoeducation about depression, problem solving, and promoting increased positive activities (*anonymised*, Year). It consisted of up to 12 sessions with adolescent and four family sessions over a 20-week period, each session 30-60 minutes. Cognitive Behavioural Therapy (**CBT**) focuses on identifying connections between thoughts, feelings and behaviours maintaining depressive symptoms and aims to modify cognitive biases, through a process of collaborative empiricism and development of shared goals between the therapist and client (*anonymised*, Year). In this study, treatment involved up to 20 sessions with the adolescent, and parents could be invited to attend selected sessions on a case-by-case basis. Short-Term Psychoanalytic Psychotherapy (**STPP**) aims to help the young person give meaning to their emotional experiences, attachment patterns, and developmental tasks (*anonymised*, Year). In this study STPP included 28 sessions with adolescent, with parents offered up to seven separate sessions with a different clinician ('parent worker') from the adolescent's therapist. As such, the STPP approach was different to BPI and CBT, as parent usually had some interaction with two different therapists – one working with their adolescent child (whose sessions they did not join), and a second working directly with them (without the adolescent being present).

Ethics

The *anonymised* and *anonymised* projects were granted ethical approval by local NHS provider trusts and the Cambridgeshire 2 Research Ethics Committee (REC reference: *anonymised*). Written informed consent was obtained for all participants.

Data Collection

Post-Therapy Interviews

Semi-structured interviews were conducted with parents of adolescents in the *anonymised* study using the Experience of Therapy Interview, Parent Version (*anonymised*, Year). Participants were interviewed before treatment (Time 1; baseline), and after treatment ended (Time 2; 36 weeks post-randomisation). The interview schedule, covered: parents' understanding of the difficulties that brought adolescent to CAMHS; impact of adolescents' difficulties on the life of their child, the parents' own lives and the family; expectations of (at T1), and experiences of (at T2) treatment at CAMHS; and in the T2 interviews, perceptions of change (or lack of) in adolescents difficulties overtime and the experience of taking part in research.

Participants

Of the 76 adolescents who took part in the *anonymised* study, 53 had parents who completed the Experience of Therapy interview (*anonymised*, Year) at Time 2. Of these, two adolescents never began therapy, so their parents' interviews were excluded. The final sample consisted of interviews from one or both parents of 51 adolescents. Demographic information was limited to adolescent participants as parental demographic data were not collected. All parents in the sample are referred to in relation to their child's pseudonym.

Table 1 presents the available demographic information for the adolescents whose parents participated in this study. The adolescents included slightly more females than males, with an average age of 15.23 at the start of treatment. Although ethnicity data were missing for some participants, available information indicated that over half of the young people reported their ethnicity as 'White' (57%) followed by 'Mixed' (20%) and 'Black/Black British' (8%). Treatment allocation was broadly balanced across the three treatment arms, with only slightly more parents of adolescents in STPP, and most young people were noted as 'treatment completers' (i.e., had not stopped attending therapy earlier than planned).

[Place **Table 1** here]

Data Analysis

The current study adopts a qualitative design to explore parents' experiences of their involvement in youth psychotherapy. Interviews were transcribed verbatim and analysed according to Braun and Clarke's (2021) six-phase process of a Reflexive Thematic Analysis (RTA). The RTA process involved familiarisation of the dataset through repeated reading of interview transcripts, after which initial codes were generated in a flexible manner. Codes were collated into preliminary themes which were examined, refined and evaluated for coherence and relevance.

Trustworthiness

Trustworthiness of findings were addressed using Lincoln and Guba's (1985) criteria. Credibility was supported through close engagement with the methodology and contextual features of the dataset in relation to the study aims. Confirmability was enhanced through transparency in the analytic process, including the use of reflexive research logs. Dependability was supported through regular supervision with the third author who provided critical appraisal of analytic interpretations. The relatively large sample size allowed for patterns of experiences to be identified, supporting the potential transferability of findings to similar contexts.

Reflexivity was integral to the analytic process. The first author brought clinical experience working in CAMHS and supporting parents of adolescents, which facilitated sensitivity to the emotional and contextual dimensions of parents' accounts. At the same time, this experience was recognised as potentially shaping analytic assumptions regarding parental roles and motivations. A reflexive and inquisitive stance was therefore maintained throughout analysis, including ongoing review of the emerging analytic themes with third author to ensure interpretations remained grounded in the data. The second and third authors additionally conducted an audit of the analysis to enhance the accuracy and rigour of the analytic process.

Results

Parents across all three treatment arms described varied experiences of involvement in their child's therapy, ranging from collaborative and supportive engagement to more limited or challenging involvement. Generally, these experiences were not specific to any treatment modality; analysis therefore focused on parents' understandings of involvement rather than differences between models. However, in the interviews with the parents of those young people who had been in the STPP arm, it was not always clear whether they were referring to their child's therapist, or to the 'parent worker' who worked directly with them. In order to allow the reader to judge this, treatment type is indicated alongside each extract. The analysis generated two overarching themes and five related subthemes (see Figure 1).

[Place **Figure 1** here]

Theme 1: Parental Involvement Shaped by Trust and Relational Experience with their Child's Therapist

Parents' accounts indicated that their sense of involvement in their child's therapy was closely shaped by the quality of their relationship with the therapist, particularly the development of trust. Experiences ranged along a continuum from feeling welcomed and collaboratively involved to feeling excluded, mistrustful, or disengaged. Across interviews, relational trust appeared to function as a central mechanism influencing parents' engagement with the therapeutic process and their support for their child's participation.

Feeling welcomed, valued and included: "nice to know that I wasn't forgotten"

Just over half of parents described positive experiences of involvement characterised by feeling welcomed into their child's therapeutic journey. For example, Eden's parent (STPP) spoke about how being involved had supported them to recognise the importance of looking after themselves as a parent:

"…realising that I'm a person and I need things for myself…"

When therapists actively acknowledged parents and created opportunities for contact, this fostered a sense of being remembered and valued within the therapeutic process. For example, Jay's parent (STPP) shared how "…it's nice to have a conversation…somebody that seems interested". Notably, most parents felt that their own involvement contributed to better treatment outcomes by increasing their own support for their children's participation in therapy. For example, Hayden's parent (STPP) described not only developing a sense of relationship with the 'parent worker' therapist but also how this made them eager for their child to attend sessions:

"…it was a good relationship and I enjoyed working with [therapist]…she was very good…at just trying to help us bring us around to see things…without making us feel dreadful…work it through in a calm way and…gave us some good strategies"

Several parents appreciated proactive communication, such as telephone check-ins, which conveyed care for the wider family context. Casey's parent (STPP) described feeling reassured by the therapist's willingness to make time for them during a difficult period:

"…nice to know that I wasn't forgotten… I was having a particularly bad day… [therapist] went 'how are you doing'…was on the phone three quarters of an hour."

Parents also emphasised the importance of being given space to share their perspectives and contribute to discussions about their child's progress. Opportunities to participate in review meetings and conversations with therapists helped them feel heard and involved – as described by Ashton's parent (CBT):

"…inform the therapist of…issues…with [my daughter]…and just to give [therapist] a bit of insight…"

These experiences contributed to a sense of partnership in care and appeared to strengthen parents' commitment to supporting their child's engagement in therapy. For many, feeling included and emotionally supported enhanced their confidence in the therapeutic process and reinforced their own role within it.

Developing — and struggling to develop — trust: "…at the beginning I wasn't sure…"

Trust emerged as central to parents' experiences of involvement and typically developed over time through ongoing interactions with the therapist. Positive first impressions, clear communication, and therapists' perceived professionalism supported the development of confidence in both the therapist and the therapeutic process. For some parents, an initial sense of reassurance provided hope and direction, as described by Ashton's parent (CBT):

"…happy [my daughter] was getting the help…cause that's... what I've been fighting for…"

In some cases, trust developed gradually even when initial impressions were uncertain. Ashley's parent (BPI) reflected on how early reservations shifted as they became more familiar with the therapist:

"…at the beginning I wasn't sure… [therapist] can be really judgemental… but… obviously really good at her job… it was helpful then I felt fine…"

Parents frequently linked trust to therapists' relational qualities, including warmth, patience, and a non-judgemental stance. Sensitive communication about difficult topics was particularly valued. Morgan's parent (BPI) described appreciating the therapist's ability to discuss concerns without evoking shame:

"…[therapist] reassured me to know that…something can be done…cos before I used to think there was no hope…"

As trust developed, parents described increased confidence in therapists' expertise and decision-making. This enabled them to support therapeutic recommendations, even when this involved stepping back from direct involvement. For example, Aubrey's parent (BPI) accepted the therapist's suggestion for individual sessions for their adolescent:

"…the first time we went together and it was a disaster… the therapist said perhaps it'd be better [my daughter] did this by herself."

However, not all parents experienced trust as easily established. Some described difficulties developing trust when they perceived therapists as unprofessional, dismissive, or insufficiently communicative. Sam's parent (STPP) reported concerns after hearing that their child felt upset during sessions:

"I wasn't happy with [therapist]… she was upsetting [my daughter] when she shouldn't have."

Others expressed frustration about limited communication and a lack of feedback about their child's progress, which contributed to feelings of exclusion. Kyle's parent (BPI) described wanting greater transparency:

"I didn't have any feedback…just…hoping…[to see therapist]…"

Perceived power imbalances also undermined trust. Some parents felt judged or hesitant to question professional decisions. Chris' parent (CBT) described withholding concerns despite doubting the relevance of aspects of treatment:

"I'm not a trained psychologist but I know my child… I just thought… this is not relevant… but I'm not gonna question a professional."

In such cases, difficulties establishing trust limited parents' sense of partnership and reduced their engagement with the therapeutic process.

Disengagement and resistance: "I don't wanna become reliant on that!"

When trust was limited or relational safety felt compromised, some parents described disengaging from the therapeutic process. Disengagement ranged from emotional distancing and scepticism about therapy to active decisions to limit involvement.

For some, disengagement reflected frustration with therapists' communication or perceived lack of usefulness. Max's parent (STPP), for example, felt the therapist offered little insight, as the therapist did not

share “anything I didn’t already know myself”. Others maintained a more neutral stance outwardly while privately doubting the value of therapy, as illustrated by Avery’s parent (CBT):

“I wasn’t positive about it… I didn’t tell [my daughter]… she needed to be… open minded.”

Structural and organisational factors also shaped disengagement. Inconsistent staffing and frequent therapist changes were experienced as undermining relational continuity and trust. Aubrey’s parent (BPI) described their experience of disengagement:

“…I’ve no relationship, I mean I couldn’t pick [therapist] out in a line up actually…”

Formal communication perceived as impersonal or blaming further strained relationships. One parent described feeling criticised by the therapist due to the wording of a letter:

“…in the letter ‘failed to attend’… I didn’t ‘fail to attend’, I was unable to attend.” (Quinn’s parent, STPP)

A small number of parents described actively choosing not to develop a relationship with their child’s therapist. For some, this reflected preference for therapy to remain a private space for their child or their own personal beliefs. Cam’s parent (STPP) explained:

“I don’t wanna become reliant on that! I’m a Christian… I pray for my daughter.”

Others felt their child needed an independent space separate from parental involvement – as reflected by Avery’s parent (CBT):

“I’m half the problem… I was quite happy for [my daughter] to have something… just be for her.”

Across these accounts, disengagement appeared closely linked to difficulties establishing a trusting and collaborative relationship with the therapist. Where trust and relational safety were limited, parents were less likely to feel meaningfully involved in their child’s therapeutic journey.

Theme 2: Holding on While Letting Go: Parental Involvement as a Developmental Process

The final theme captured parents' descriptions of the nature of their involvement in their child's treatment. The two subthemes illustrated varied experiences of (a) the type of involvement by parents and (b) how their child's preferences influenced decisions about whether to be involved in the psychotherapy.

Direct vs indirect involvement*:* "[we all had a good] understanding"

Most parents who were directly involved in their child's treatment described their role as primarily supportive, often because they felt their child was overwhelmed by the therapeutic process. For example, Jordan's parent (BPI) explained their child "didn't want to go in on her own so she wanted me there." Several parents also noted that direct involvement created opportunities to collaborate with the therapist, which helped foster a more positive and constructive relationship with them. For instance, Bailey's parent (CBT) spoke about how their child's therapist involved them in shared decision making and praised how the therapist ensured everyone was on the same page as the treatment plan was "a mutual agreement… [we all had a good] understanding". Some parents also reinforced learnt therapeutic strategies outside of their child's therapy sessions through being directly involved in their child's treatment as they received "…suggestions of what to do…" (Pat's parent, CBT) from their child's therapist, which they felt may have supported with improving treatment outcomes.

Considering the parents who were indirectly involved in their child's treatment, nine parents mentioned how they would only drop-off their child to therapy sessions and would typically be in the waiting room while their child was with the therapist. For instance, Jordan's parent (BPI) reported they would usually "sit outside and read a book". Some parents were also indirectly involved in their child's treatment through having to "persuade" (Casey's parent, STPP) their child to attend therapy sessions when they resisted as their child found the therapist unhelpful. For example, Sam's parent (STPP) described how they attempted to clarify what their child's therapist may have been trying to say following a misunderstanding as they asked their child "have you just misinterpreted and got it all wrong?". These parents respected the value of their child's therapeutic space and facilitated treatment engagement, which parents perceived as having a positive impact on their child.

For parents who felt they had a good relationship with their child's therapist, they believed this was beneficial because they felt they could voice issues their child would share about the treatment to the therapist when their child felt unable to. For example, one child disclosed to their parent discomfort towards their therapist and did not want to return to therapy, and the parent, who felt she had a good relationship with their child's therapist, arranged a telephone conversation in an attempt to explore alternative options:

"I did phone up…they were gonna change [the therapist]…" (Jordan's parent, BPI)

Respecting adolescents' preferences: "the older the teenager is, the less involvement you get"

For some parents, the nature of their involvement in their child's therapy was at times influenced by the adolescents' preferences. On the one hand, some parents reported they were happy their child wanted parental involvement. For instance, Jordan's parent (BPI) shared how their child wanted emotional support during the treatment:

"[My son] felt uncomfortable one day and wanted me in there."

Similarly, Jesse's parent (CBT) described how their child sought parental support to discontinue treatment due to perceiving it as unhelpful. As this parent reported limited involvement in their child's therapeutic process, this may provide an insight into how reduced parental engagement could influence how parents respond to their child's wishes regarding treatment continuation:

"…[My daughter] was adamant she weren't gonna carry on anymore…I said 'well then you need to tell them' and we did…"

On the other hand, there were some parents who shared their experience of how their child did not want parental involvement. For instance, Ashley's parent (BPI) reported how their child preferred to manage their own treatment:

"[My daughter] didn't want us to be involved…she just wanted to see [therapist] on her own."

There were some parents who also expressed an awareness of how their child's age influenced the extent of parental involvement. For example, Ashley's parent (BPI) described noticing their child's growth towards independence but found it difficult to not be involved in their child's treatment:

"…the older the teenager is, the less involvement you get…they're still your child and you still want to look after them..."

Discussion

The current study explored parents' experiences of involvement in youth psychotherapy for adolescent depression, focusing on what shaped the quality and extent of their involvement and how parents understood its relevance to treatment. Using Reflective Thematic Analysis, findings highlight parental involvement as variable, relational, and developmentally negotiated. Parents' engagement was shaped by (a) relational dynamics with therapists, including feeling recognised and able to trust; (b) the interaction between service-therapist factors and parents' own responses (including withdrawal or resistance); and (c) adolescents' developmental needs and

preferences, which saw parents 'holding on while letting go'. Overall, the results suggest that parental involvement is not be understood as a simple matter of attendance, but as an ongoing process of alliance-building and boundary negotiation within the context of adolescent autonomy.

Parental Involvement Shaped by Trust and Relational Experience with their Child's Therapist

Across accounts, parents' sense of involvement was strongly shaped by the quality of their relationship with their child's therapist. Feeling welcomed, listened to, and acknowledged supported parents' trust and engagement, consistent with literature emphasising the importance of alliance beyond the adolescent-therapist dyad (*anonymised*, Year; Haine-Schlagel & Walsh, 2015). The phrase 'nice to know that I wasn't forgotten' captures how seemingly modest acts of contact – telephone check-ins, review meetings, opportunities to speak – could communicate recognition and provide emotional containment for parents who are often managing significant distress and uncertainty (*anonymised*, Year). While the STPP model built in an explicit space where the parents' own needs could be addressed, it was clear that this sense of being kept in mind could be achieved in all three arms of the study, whether it was the young person's therapist or the 'parent worker' who took on this role.

These findings align with Bordin's (1979) conceptualisation of alliance as involving emotional bonds and collaboration, suggesting that in youth psychotherapy a meaningful alliance may include a parent-therapist alliance where parents experience themselves as legitimate partners in the process. Parents' accounts indicate that relational attunement is not merely supportive; it may function as a mechanism that strengthens parents' capacity to sustain practical and emotional support for adolescents' therapy participation. In this sense, involvement is partly mediated through parents' confidence in the therapist and in the treatment pathway, which parents often linked to encouraging attendance and maintaining commitment during difficult periods.

Trust emerged as dynamic and co-constructed, developing overtime through professionalism, non-judgemental communication, clarity about process, and a sense that the therapist could hold sensitive material without shaming parents. This fits relational perspectives that view alliance as negotiated across treatment rather than established once (Norcross & Lambert, 2019). Fonagy and Campbell's (2017) concept of epistemic trust further sharpens this interpretation: parents' willingness to accept the therapist's guidance as credible appeared contingent on feeling relationally safe and respected. Clear communication and review points seemed to support this process by reducing uncertainty, reinforcing shared goals, and helping parents understand how (and why) their involvement might be useful (Riley & Avdi, 2024). Where this trust developed, parents described being

better able to extend therapeutic work into the home, including supporting strategies and maintaining a stabilising environment.

The subtheme ‘disengagement and resistance’ captured more challenging experiences of some parents lacking a sense of trust with the therapy process or their child’s therapist, illustrating that parental involvement can become constrained when relational safety is compromised. Parents described feeling marginalised or excluded from adolescent treatment through limited communication – aligning with Riley and Avdi’s (2026) findings of how parents felt their engagement in their child’s therapy was hindered by clinicians’ lack of flexibility with scheduling joint sessions with their children. Perceived unresponsiveness, or not being offered meaningful avenues to contribute were experiences which echo concerns that privileging the adolescent-therapist relationship can inadvertently diminish parental engagement (Burney et al., 2024). In these accounts, trust was harder to establish and parents often experienced power imbalances, hesitating to question therapeutic decisions despite feeling they held important knowledge about their child. This dynamic is clinically significant, as it suggests that parents’ limited involvement may sometimes reflect silencing within professional hierarchies, rather than lack of care or motivation.

Parents’ descriptions of harsh or dismissive interpersonal styles were especially consequential, shaping whether parents felt able to collaborate or whether they withdrew. These findings resonate with literature describing alliance ruptures and barriers in work with parents (Joffe & Dwarika, 2025), while adding nuance by showing how parents make sense of these experiences and how quickly they can erode engagement. Importantly, disengagement also appeared as an active response – sometimes rooted in scepticism about therapy, prior negative service experiences, perceived inconsistency in provision, or value-based frameworks such as faith. This supports research linking parental frustration with services to reduced engagement (Reardon et al., 2017; Riley & Avdi, 2026), but extends it by highlighting that withdrawal may serve protective functions (e.g., avoiding reliance, protecting the adolescent’s space, or managing feeling judged). Clinically, these findings emphasise the need for therapists to adopt a collaborative stance that explicitly acknowledges parents’ emotional experience, clarifies boundaries, and reduces power asymmetries.

Service-level factors also mattered. Reports of therapist turnover and inconsistent provision undermined continuity and relational safety, suggesting that parental involvement is shaped not only by therapist skill but also by organisational contexts that can disrupt trust and engagement. This has implications for services aiming to reduce dropout and promote sustained engagement in care.

Holding on While Letting Go: Parental Involvement as a Developmental Process

The final theme clarifies that parental involvement is not only relational but also developmental. Parents described different forms of involvement ranging from direct participation in sessions to indirect roles such as facilitating attendance, providing logistical support, and helping translate or reinforce therapeutic strategies at home. Direct involvement often supported psychoeducation and shared decision-making, enabling parents to generalise learning beyond sessions (Cardy et al., 2020; Ruberman, 2009). Indirect involvement, however, was not necessarily disengagement; many parents saw it as a deliberate stance to protect adolescents' privacy and therapeutic space while still sustaining treatment through encouragement and practical support. This aligns with evidence that parental support can be central to adherence, especially when adolescents' motivation fluctuates (Forsberg et al., 2014).

Parents' accounts also highlighted the clinical tension created by adolescents' autonomy needs. As adolescents aged, parents reported less involvement, often accompanied by an emotional struggle: wanting to protect and help while respecting independence. This mirrors developmental understandings of adolescence as a period where autonomy needs intensify, making involvement more complex and contingent (Ruberman, 2009). The theme 'holding on while letting go' therefore captures not only parental behaviour but also the emotional labour of adjusting roles in response to adolescents' preferences and developmental stage. These findings underscore the importance of therapists actively negotiating boundaries of involvement, revisiting these discussions overtime, and framing involvement as flexible rather than all-or-nothing (Gvion, 2025).

Clinical Implications and Future Directions

The findings suggest several practical implications. First, parental involvement is fundamentally relational, consistent acts of inclusion (e.g., check-ins, keeping parents in mind, clear updates about process, structured review points) which may strengthen trust and help parents feel supported. Second, therapists may benefit from explicitly negotiating the purpose, limits and timing of parental involvement early in treatment and revisiting this as adolescents' needs change – particularly to manage tensions between confidentiality and parental desire for information. Third, limited parental involvement should not be assumed to reflect resistance: it may indicate rupture, value-based preferences or developmental sensitivity. Identifying the meaning of non-involvement may prevent misattunement and support re-engagement.

At a service level, continuity and clarity appear important conditions for parental trust. The study was not aiming to compare the difference between having a single therapist working with both young person and parents' vs having two separate therapists involved, but the findings suggested that in both models' relational

trust could be established – or broken. More importantly, where therapist turnover and inconsistent contact are common, services may need protocols that preserve relational safety (e.g., transparent transitions, handover meetings, minimal disruption to parent contact). Future research would benefit from primary qualitative designs explicitly focused on the parent-therapist relationship, with more diverse samples to explore cultural and intersectional influences on involvement. Guidelines, including National Institute for Health and Care Excellence (NICE), may also benefit from more explicit recognition that parental involvement should be tailored to adolescents' age, presentation, and preferences rather than treated as a uniform standard (Pine et al., 2024).

Strengths and Limitations

This qualitative study offers in-depth insights into parents' experiences of involvement in youth psychotherapy, addressing gaps in a literature that has often prioritised therapists' or adolescents' perspectives. The sample size enabled rich exploration of varied parental experiences, supporting nuanced analysis of relational patterns not easily captured through quantitative methods.

However, several limitations should be acknowledged. The use of secondary data constrained the scope of inquiry, as interviews were not designed specifically to explore parental involvement. Demographic data were collected for adolescents rather than parents, limiting representativeness and exploration of how parental characteristics may have shaped experiences. Additionally, as participants were recruited through services in North London, the findings may not reflect the wider regional and socio-cultural diversity of families accessing services across the UK, potentially limiting the transferability of the findings. Future research should include families from a wider range of geographical contexts to better capture variation in parental involvement.

Conclusion

Parental involvement in youth psychotherapy for depression emerges as a relational and developmentally negotiated process rather than a fixed level of participation. Parents' experiences of recognition, trust, and collaboration shaped how involved they felt and how able they were to support adolescents' therapy engagement. Conversely, experiences of exclusion, power imbalance, and service inconsistency constrained involvement and sometimes prompted withdrawal. Attending to parents' perspectives – and actively negotiating involvement in ways that protect adolescent autonomy while supporting parents' role – may enable more collaborative, responsive, and sustainable youth psychotherapy.

References

Acri, M. C., & Hoagwood, K. E. (2015). Addressing parental mental health within interventions for children: A review. *Research on Social Work Practice, 25*(5), 578-586. 10.1177/1049731514546027

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, research & practice, 16*(3), 252. https://doi.org/10.1037/h0085885

Braun, V., & Clarke, V. (2021). One size fits all? What counts as quality practice in (reflexive) thematic analysis?. *Qualitative research in psychology*, *18*(3), 328-352. https://doi.org/10.1080/14780887.2020.1769238

Burney, V., McCann, C. M., & Arnold-Saritepe, A. (2024). Parent engagement in child-focused interventions: A systematised review of qualitative allied health literature. In *Child & Youth Care Forum* (Vol. 53, No. 6, pp. 1451-1486). New York: Springer US. https://doi.org/10.1007/s10566-024-09797-6

Cardy, J. L., Waite, P., Cocks, F., & Creswell, C. (2020). A systematic review of parental involvement in cognitive behavioural therapy for adolescent anxiety disorders. *Clinical child and family psychology review, 23*, 483-509. https://doi.org/10.1007/s10567-020-00324-2

Anonymised (Year). The alliance with young people: Where have we been, where are we going?. *Psychotherapy, 60(1)*, 110. https://doi.org/10.1037/pst0000461 [Blinded for review]

Anonymised (Year). *Short-term psychoanalytic psychotherapy for adolescents with depression: A treatment manual*. Karnac Books. [Blinded for review]

Creswell, C., Leigh, E., Larkin, M., Stephens, G., Violato, M., Brooks, E., ... & Clark, D. M. (2021). Cognitive therapy compared with CBT for social anxiety disorder in adolescents: a feasibility study. *Health Technology Assessment (Winchester, England), 25*(20), 1. 10.3310/hta25200

Cuijpers, P., Karyotaki, E., Ciharova, M., Miguel, C., Noma, H., Stikkelbroek, Y., ... & Furukawa, T. A. (2023). The effects of psychological treatments of depression in children and adolescents on response, reliable change, and deterioration: a systematic review and meta-analysis. *European child & adolescent psychiatry*, *32*(1), 177-192. 10.1007/s00787-021-01884-6

Erikson, E. H. (1980). *Identity and the life cycle*. W W Norton & Co.

Feder, M. M., & Diamond, G. M. (2016). Parent-therapist alliance and parent attachment-promoting behaviour in attachment-based family therapy for suicidal and depressed adolescents. *Journal of Family Therapy*, *38*(1), 82-101. 10.1111/1467-6427.12078

Fonagy, P., & Campbell, C. J. P. H. (2017). Mentalizing, attachment and epistemic trust: how psychotherapy can promote resilience. *Psychiatria Hungarica*, *32*(3), 283-287. https://discovery.ucl.ac.uk/id/eprint/1574378

Forsberg, S., LoTempio, E., Bryson, S., Fitzpatrick, K. K., Le Grange, D., & Lock, J. (2014). Parent–therapist alliance in family-based treatment for adolescents with anorexia nervosa. *European Eating Disorders Review, 22*(1), 53-58. 10.1002/erv.2242

Gondek, D., Edbrooke-Childs, J., Velikonja, T., Chapman, L., Saunders, F., Hayes, D., & Wolpert, M. (2017). Facilitators and barriers to person-centred care in child and young people mental health services: A systematic review. *Clinical psychology & psychotherapy*, *24*(4), 870-886. 10.1002/cpp.2052

Anonymised (Year). Improving mood with psychoanalytic and cognitive therapies (IMPACT): a pragmatic effectiveness superiority trial to investigate whether specialised psychological treatment reduces the risk for relapse in adolescents with moderate to severe unipolar depression: study protocol for a randomised controlled trial. *Trials, 12*(1), 1-12. https://doi.org/10.1186/1745-6215-12-175 [Blinded for review]

Anonymised (Year). Cognitive behavioural therapy and short-term psychoanalytical psychotherapy versus a brief psychosocial intervention in adolescents with unipolar major depressive disorder (IMPACT): A multicentre, pragmatic, observerblind, randomised controlled superiority trial. *The Lancet Psychiatry, 4*(2), 109–119. https://doi.org/ 10.1016/S2215-0366(16)30378-9 [Blinded for review]

Gvion, Y. (2025). Between Privacy and Secrecy: Reconsidering Parental Involvement in Psychodynamic Psychotherapy with Adolescents. *Journal of Infant, Child, and Adolescent Psychotherapy*, 1–9. https://doi.org/10.1080/15289168.2025.2606162

Haine-Schlagel, R., & Walsh, N. E. (2015). A review of parent participation engagement in child and family mental health treatment. *Clinical child and family psychology review*, *18*(2), 133-150. 10.1007/s10567-015-0182-x

Hassett, A., Green, C., & Zundel, T. (2018). Parental involvement: a grounded theory of the role of parents in adolescent help seeking for mental health problems. *Sage open, 8*(4), 2158244018807786. https://doi.org/10.1177/2158244018807786

Anonymised (Year). *Cognitive behaviour therapy for depression in young people: Manual for therapists*. https://dev.psychiatry.cam .ac.uk/files/2016/06/CBT-Manual.pdf [Blinded for review]

Joffe, S., & Dwarika, V. M. (2025). Therapists' perceptions of alliance barriers in the parent–therapist relationship when treating children who have experienced trauma. *Australian Journal of Psychology*, *77*(1), 2528346. https://doi.org/10.1080/00049530.2025.2528346

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

Anonymised (Year). Lessons about adolescent unipolar depression from the Improving Mood with Psychoanalytic and Cognitive Therapies Trial. *Journal of the American Academy of Child and Adolescent Psychiatry*. 10.1016/j.jaac.2023.03.017 [Blinded for review]

Anonymised (Year). Expectations of therapy interview (young person and parent versions). *Unpublished manuscript.* Anna Freud Centre, London. [Blinded for review]

Anonymised (Year). The meaningful assessment of therapy outcomes: Incorporating a qualitative study into a randomized controlled trial evaluating the treatment of adolescent depression. *Psychotherapy, 51*(1), 128–137. https://doi.org/10.1037/a0034179 [Blinded for review]

Anonymised (Year). Therapists' techniques in the treatment of adolescent depression. *Journal of Psychotherapy Integration, 28*(4), 413–428. [Blinded for review]

Morales-Muñoz, I., Mallikarjun, P. K., Chandan, J. S., Thayakaran, R., Upthegrove, R., & Marwaha, S. (2023). Impact of anxiety and depression across childhood and adolescence on adverse outcomes in young adulthood: a UK birth cohort study. *The British Journal of Psychiatry*, *222*(5), 212-220. 10.1192/bjp.2023.23

Norcross, J. C., & Lambert, M. J. (2019). *Psychotherapy relationships that work: Volume 1: Evidence-based therapist contributions*. Oxford University Press. https://doi.org/10.1093/med-psych/9780190843953.001.0001

Anonymised (Year). The therapeutic relationship and change processes in child psychotherapy: a qualitative, longitudinal study of the views of children, parents and therapists. *Research in Psychotherapy: Psychopathology, Process, and Outcome, 25*(1). 10.4081/ripppo.2022.556 [Blinded for review]

Pine, A. E., Baumann, M. G., Modugno, G., & Compas, B. E. (2024). Parental involvement in adolescent psychological interventions: a meta-analysis. *Clinical Child and Family Psychology Review*, *27*(3), 1-20.

Reardon, T., Harvey, K., Baranowska, M., O'brien, D., Smith, L., & Creswell, C. (2017). What do parents perceive are the barriers and facilitators to accessing psychological treatment for mental health problems in children and adolescents? A systematic review of qualitative and quantitative studies. *European child & adolescent psychiatry*, *26*, 623-647. 10.1007/s00787-016-0930-6

Riley, E. G., & Avdi, E. (2024). Parent work offered by child psychoanalytic psychotherapists: a literature review. *Journal of Child Psychotherapy, 50*(3), 370–391. https://doi.org/10.1080/0075417X.2024.2402783

Riley, E. G., & Avdi, E. (2026). The experience of parent work in short-term psychoanalytic psychotherapy. *Journal of Child Psychotherapy*, 1-19. 10.1080/0075417X.2026.2621386

Roest, J. J., Welmers-Van de Poll, M. J., Van der Helm, G. P., Stams, G. J. J., & Hoeve, M. (2023). A meta-analysis on differences and associations between alliance ratings in child and adolescent psychotherapy. *Journal of Clinical Child & Adolescent Psychology*, *52*(1), 55-73. 10.1080/15374416.2022.2093210

Ruberman, L. (2009). Working with parents: implications for individual psychotherapeutic work with children and adolescents. *American journal of psychotherapy, 63*(4), 345-362. 10.1176/appi.psychotherapy.2009.63.4.345

Anonymised (Year). 'It's always difficult when it's family... whereas when you're talking to a therapist...': Parents' views of cognitive-behaviour therapy for depressed adolescents. *Clinical Child Psychology and Psychiatry, 26*(4), 1018-1034. https://doi.org/10.1177/13591045211013846 [Blinded for review]

Anonymised (Year). The experience of being the parent of an adolescent with a diagnosis of depression. *Journal of Child and Family Studies, 25*, 618-630. https://doi.org/10.1007/s10826-015-0237-0 [Blinded for review]

Anonymised (Year). Clinical and psychosocial predictors of suicide attempts and nonsuicidal selfinjury in the Adolescent Depression Antidepressants and Psychotherapy Trial (ADAPT). *American Journal of Psychiatry, 168*(5), 495–501. https://doi.org/10.1176/appi.ajp.2010.10050718 [Blinded for review]

Tables and Figures

Table 1

Demographic Information about Adolescents

Variable	n (%)	M (SD)
Gender		
Girls	32 (63%)	
Boys	19 (37%)	
Age (years)		15.23 (1.65)
Ethnicity	N (%)	
White	29 (57%)	
Black/Black British	4 (8%)	
Asian/Asian British	1 (2%)	
Mixed	10 (20%)	
Other	2 (4%)	
Missing [a]	5 (10%)	
Treatment type		
BPI	16 (31%)	
CBT	16 (31%)	
STPP	19 (37%)	
Treatment status		
Completer	35 (69%)	
Non-completer	16 (31%)	

Note. Total sample size was $N = 51$. Percentages rounded to nearest whole number and may not sum to 100%.

[a] Information on ethnic background were missing for certain participants. Percentages based on available data.

Figure 1

Themes and Subthemes

