The Benefits of Sharing House-Tree-Fire-Water-Person Drawings with Parents when their Anxious Child is in Therapy

by

Judith Bredekamp

Submitted in accordance with the requirements for the degree of

DOCTOR OF PHILOSOPHY

in the Faculty of Education at the

UNIVERSITY OF PRETORIA

Supervisor: Prof. Linda Theron

October 2024

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Declaration

I declare that the thesis, which I hereby submit for the degree Philosophiae Doctor in Educational Psychology at the University of Pretoria, is my own work and has not previously been submitted by me for a degree at this or any other tertiary institution



.....

Judith Bredekamp

October 2024

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The author, whose name appears on the title page of this thesis, has obtained, for the research described in this work, the applicable research ethics approval. The author declares that she has observed the ethical standards required in terms of the University of Pretoria's *Code of ethics for researchers and the Policy guidelines for responsible research.*

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Dedication

I dedicate this research to all the parents and children who made this study possible.

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Acknowledgements

To have achieved this milestone in my life, I would like to express my sincere gratitude to the following people:

- My Heavenly Father, who provided me the strength, courage and perseverance to complete this study;
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- My parents, for waiting (sometimes patiently) for me to finish and for their unconditional love and support
- Last, but not the least, my family and friends, for the walks, suppers and always believing in me

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Abstract

While the literature is clear that children's mental health resilience can be bolstered by effective parenting, child psychotherapy, and enabling psychologist-parent alliances, it is less clear how psychologists might facilitate all these processes simultaneously. In response, I investigated the benefits of sharing the House-Tree-Fire-Water-Person (HTFWP) drawing with parents when their children, aged 10 to 12, diagnosed with generalized anxiety disorder (GAD), were in sandplay therapy. I drew on the Multisystemic Theory of Resilience that explains resilience as the child's capacity to thrive in the face/aftermath of significant stress as being dependent on resources within themselves and their social and physical ecology. I employed a qualitative approach with an exploratory, instrumental, multiple case study design. My sample consisted of seven purposefully selected cases, involving nine primary (parents) and seven secondary informants (child-clients). I used reflexive thematic analysis (RTA) to identify patterns and themes in the data. The findings of my study demonstrated the benefits for the parent, psychologist and child. The parent(s) acquired heightened insight into their child's anxiety and felt supported and effective in their caregiving role. The psychologist benefitted from the facilitation of an alliance with the parent and the drawings provided feedback regarding therapy progress. For the child, there was increased potential for therapy gains to be sustained and understanding and connection was fostered. Supporting children's mental health resilience requires input into multiple systems (the child and their parents). The contribution my study makes helps establish evidence-based practices that not only enhance the parent-psychologist alliance but also optimizes the therapeutic process for children experiencing anxiety. In addition, the findings of my study are distilled into insights for other mental health professionals wanting to use the HTFWP drawing to bolster the resilience of children diagnosed with GAD.

Keywords: anxiety in children, House-Tree-Fire-Water-Person drawings, parent-psychologist alliance, resilience to anxiety, sandplay therapy

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List of Abbreviations

ACE	Adverse childhood experience
CBT	Cognitive Behavioural Therapy
EMDR	Eye movement desensitization and reprocessing
GAD	Generalized anxiety disorder
HTFWP	House, tree, fire, water, person drawing
HPCSA	Health Professions Council of South Africa
ISST	International Society for Sandplay Therapy
PSYSSA	Psychological Society of South Africa
RTA	Reflective thematic analysis
SA-ACAPAP	South African Association of Child and Adolescent Psychiatry and Allied Professions

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Chapter 1

Introducing My Study

1.1 Introduction and Rationale

"Un bon croquis vaut mieux qu'un long discours" Napoleon Bonaparte

(Translation: A good sketch is better than a long speech)

My personal professional experience as an Educational Psychologist for the past 17 years motivated my PhD study. As an Educational Psychologist I assess children who are experiencing barriers to learning, behavioural challenges and emotional concerns. These factors often affect their academic achievement and well-being in the educational setting or amongst their family. In addition to psycho-educational assessments, I also provide psychotherapy as part of my professional practice. As I understand that each client is different with different needs and ways of being, I have various tools in my therapeutic toolbox (for example, narrative therapy, cognitive behavioural therapy and eye movement desensitization and reprocessing (EMDR) therapy). My preferred modality when working with children in therapy is sandplay therapy.

Dora Kalff (2020) is the founder of sandplay therapy (Ahn et al., 2020; Akimoto et al., 2021; Foo et al., 2020; Ghaljaei et al., 2023; Iivonen et al., 2021; Kostyunina & Valeeva, 2016; Maurer, 2017; Park, 2020; Xiong et al., 2022). Being a student of Jung, Kalff synthesized Jungian analytical psychology, Lowenfeld's World Technique and eastern contemplative philosophies (Carey, 2006; Enns & Kasai, 2003, Liu et al., 2021; Punnett & Canfield, 2020; Roesler, 2019; Steinhardt, 1998; Tan et al., 2021; Wiersma et al., 2022; Zappacosta, 2012; Zhou, 2009). Due to the influence of Jungian psychology, sandplay therapy is sometimes referred to as Jungian Sandplay Therapy (Foo et al., 2020; Green & Connolly, 2009; Steinhardt,

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1998; Vaz, 2000). The International Body for sandplay therapists is called the International Society for Sandplay Therapy (ISST). In 2023 ISST-certified South Africans launched a member society called the South African Sandplay Therapy Society (SASTS), of which I am a founding member. Although sandplay therapy is practiced in South Africa, there is little research on the effectiveness of sandplay therapy, both in the South African and African context (Ferreira et al., 2014; Forsyth, 2011; Homeyer & Stone, 2023; Humphris, 2019; Jang et al., 2019; Olaniyi et al., 2021; Rousseau et al., 2009; van Westrhenen et al., 2019).

Sandplay therapy promotes self-awareness, emotional healing and self-regulation (Ahn et al., 2020; Ammann, 2022; Anboohi, 2020; Fang et al., 2022; Ferreira et al., 2014; Forsyth, 2011; Kostyunina & Valeeva, 2016; Leinberger, 2022). It provides an avenue for children to address trauma and emotional distress, aggression, low self-esteem, externalising behavioural problems and negative interpersonal relationships (Han et al., 2017; Kowen, 2020; Park, 2020). Ammann (2022) and Zappacosta (2012) concur that sandplay therapy is beneficial for working through difficult childhood experiences and challenges with addiction.

This modality involves the use of two sandtrays, one wet so that the sand can be more easily shaped and moulded and the other dry, which allows for a different tactile experience. There are also miniatures available (representing different aspects of the world) to create a visual representation of the client's inner world (Ferreira et al., 2014; Forsyth, 2011; Karpaviciute et al., 2022; Liu et al., 2021; Liu et al., 2023; Maree et al., 2012; Roesler, 2019; Zappacosta, 2012). Within the sandtray, clients create a three-dimensional world, exploring the symbolic representation of unconscious thoughts and emotions (Akimoto et al., 2021; Albert, 2015; Bartosh & Bartosh, 2019; Cao et al., 2019; Da Matta & Ramos, 2021; Foo et al., 2020; Gupta et

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al., 2023; Humphris, 2019; Jang et al., 2019; Xiong et al., 2022). The sandplay therapist offers a safe therapeutic space, enabling clients to express and process their experiences non-verbally (Ghaljaei et al., 2023; Liu et al., 2023; Vosough Gerayeli, 2019; Wiersma et al., 2022; Zhou, 2009). The non-verbal aspect of sandplay therapy is an important therapeutic feature in a country like South Africa with 12 official languages (Ferreira et al., 2014). Symbols and themes that emerge during the sandplay process, serve as reflections of the client's psyche, guiding the therapeutic journey toward healing and self-discovery (Cao et al., 2019; Da Matta & Ramos, 2021; Fang et al., 2022; Foo et al., 2020; Gupta et al., 2023; Homeyer & Stone, 2023; Suri, 2012; Tan et al., 2021; Vosough Gerayeli, 2019; Wiersma et al., 2022).

While sandplay therapy resonated with me as a preferred modality for working with children, it also presented me with challenges, especially in terms of engaging parents effectively. In my professional experience, not involving parents sufficiently often led to misunderstandings about the therapy process, which at times fostered a sense of doubt about the effectiveness of sandplay therapy. This doubt was potentially detrimental, as it occasionally resulted in parents deciding to withdraw their children from therapy prematurely, before the children could achieve the desired outcomes or fully process their experiences.

Not engaging with parents also led to disconnection between the child-in-the-therapeutic context and the child-in-their-family, -school or -broader community context. However, having regular feedback sessions with parents helped lessen these unhelpful outcomes. This experience is affirmed in the literature on the importance of psychologists having a working alliance with the parents of their child-clients (de Greef et al., 2017; Diamond et al., 2000; Fox, 2012; Gvion & Bar, 2014;

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Kazdin & Whitley, 2006; Kazdin et al., 2005; Marker et al., 2013; Núñez et al., 2022; Schmidt et al., 2014; Zemmelman, 2018; Zorzella, et al., 2017). Numerous authors concur that providing parents with feedback is important as it bolsters the child's therapeutic outcomes, fosters therapeutic engagement and acceptance of treatment by the parents (Kazdin et al., 2005; Nevas & Farber, 2001; Núñez et al., 2022; Zemmelman, 2018). Parent feedback sessions offer valuable insights that help parents understand their child's needs and they are then able to extend support outside of the therapy room (Zemmelman, 2018). Feedback sessions also serve to strengthen a psychologist's relationship with parents.

As I engaged with the parents of children who were receiving sandplay therapy, I found that having something concrete and tangible (for example, sandtray scenes completed by the child) facilitated discussions during feedback sessions making them more experiential for parents. This approach allowed them to actively participate in their child's therapy process and they no longer felt like outsiders or intruders in the therapy space. However, I also found that showing the parents the sandplay scenes created by their children was potentially overwhelming for the parents and raised concerns for me about the violation of the child's privacy. Given this experience, but still knowing the importance of feedback sessions for parents, I struggled to determine which tangible items, aside from the sandplay scenes, would best support feedback related to sandplay therapy.

The COVID-19 pandemic escalated my struggle to find something tangible to anchor feedback to parents. As noted by several authors, from March 2020, South Africa and the world were challenged by the COVID-19 pandemic (Cusinato et al., 2020; De Man et al., 2022; di Fazio et al., 2022; Garcia-Adasme et al., 2021; Goodman et al., 2022; Harrison et al., 2022; Marzilli et al., 2021; Munir, 2021;

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Nyashanu et al., 2020; Porter et al., 2021; Revet et al., 2021; Subramaney et al., 2020; Taylor et al., 2020; Unwin et al., 2022; van der Berg et al., 2020). As noted by several researchers, this pandemic led to an increase in prevalence of mental health challenges such as increased suicidal crises and major depressive episodes (Abuhammad et al., 2022; Asmundson & Taylor, 2020; Cusinato et al., 2020; di Fazio et al., 2022; Harrison et al., 2022; Lakkunarajah et al., 2022; Zhang et al., 2021). Researchers agree that amongst children, COVID-19-related mental health challenges included an increase in anxiety (Bloom et al., 2022; Garcia-Adasme et al., 2021; Harrison et al., 2022; Janssen et al., 2020; Lakkunarajah et al., 2022; Marzilli et al., 2021; Ran et al., 2020; Karki et al., 2020; Van den Heuvel et al., 2022; Yoshikawa et al., 2020; Zhang et al., 2021).

In response to escalating COVID-19 pandemic alert levels, South Africa implemented a rigorous stay-at-home order known as *lockdown.* Lockdown limited movement of South Africans who could only travel for emergency purposes or to essential services like health care practitioners (de Man et al., 2022). While this policy was introduced to limit contact and control the spread of the COVID-19 virus, it significantly impacted mental health, primarily by exacerbating anxiety. Lockdown introduced multiple stressors: isolation, limited social interaction, increased feelings of loneliness, depression and heighted anxiety (Bloom et al., 2022; de Miranda et al., 2020; di Fazio et al., 2022). It raised uncertainties around the impact of the pandemic and there were concerns for personal and family health leading to significant emotional distress (Brooks et al., 2022; Cusinato et al., 2020; Garcia-Adasme et al., 2021; Goodman et al., 2022; Lakkunarajah et al., 2022; Marzilli et al., 2021). Lockdown resulted in disruptions to the daily routines of families that previously provided a sense of control and stability; these adverse circumstances increased

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anxiety levels (Bloom et al., 2022; de Miranda et al., 2020; di Fazio et al., 2022). Financial insecurity increased as economic difficulties, due to job losses or reduced income, also contributed to anxiety in families (Asmundson & Taylor, 2020; de Miranda et al., 2020; di Fazio et al., 2022; Garcia-Adasme et al., 2021; Goodman et al., 2022; Harrison et al., 2022). Furthermore, exposure to often distressing media coverage about the impact of the pandemic worsened these anxieties (Cusinato et al., 2020; Garcia-Adasme et al., 2021; Harrison et al., 2022). Compounding these issues, access to mental health services was curtailed during lockdown, making it more difficult to get the help to manage anxieties and other mental health concerns (de Miranda et al., 2020; Harrison et al., 2022). Thus, while lockdown was crucial for physical public health, it inadvertently created conditions that significantly fostered an increase in anxiety among the population.

During the COVID-19 period, South Africa, aligning with global increases, saw a rise in anxiety-related referrals (Bloom et al., 2022; de Man et al., 2022; Harrison et al., 2022). A study by Harrison et al. (2022) found that after implementing COVID-19 measures like lockdown, the combined prevalence of anxiety disorders, including generalized anxiety disorder (GAD) among children and adolescents who had not reported prior mental health challenges was 32%. A South African-based study by De Man et al. (2022), found the prevalence rates of anxiety during lockdown to be 46% amongst the study participants. These high prevalence rates could be due to limited accessibility to mental health care support in South Africa. A survey conducted in 2014, indicated a 1.4 mental health professional for every 100 000 people whereas globally this ratio is 9.0 for very 100 000 (Sankoh et al., 2018). While not presenting statistical data, another South African-based study by Subramaney et

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al. (2020) explored the high prevalence of GAD during COVID-19 measures, including the effects of lockdown.

When lockdown levels allowed, I conducted my psychology practice in person. During this time I encountered an even more urgent need for therapeutic intervention for children and escalating referrals of children challenged by lockdown-related anxiety. Although anxiety is a normative response to stressful situations it transitions to a disorder when it persists, becomes disproportionate and affects daily functioning (Beesdo, 2009; Creswell et al., 2020; Doyle, 2022; Driscoll, 2020; Strawn et al., 2020). Disordered anxiety is noted to have long-term consequences, such as a decline in academic or cognitive impairment (Beesdo, 2009; Brown, 2019; Doyle, 2022; Harrison et al., 2021; Kurdi et al., 2018; Rivera, 2019; Pollard et al., 2023; Reardon et al., 2020; Schiele & Domschke, 2018; Schwartz et al., 2019; Strawn et al., 2020). There are added complications with potential comorbidities like depression and substance abuse (Baker et al., 2021; Etkin et al., 2022; Harrison et al., 2021; Lunn et al., 2023; Nel et al., 2018; Oduntan et al., 2022; Pollard et al., 2023; Reiser et al., 2014; Schiele & Domschke, 2018; Schwartz et al., 2019; Spence, 2018; Strawn et al., 2020. There are possibilities of adverse effects on physical health such as disturbed sleep, cardiovascular and gastrointestinal problems (Doyle, 2022; Oduntan et al., 2022; Rivera, 2019; Pollard et al., 2023; Reardon et al., 2020; Schiele & Domschke, 2018). There is also the possibility of impaired social interactions with family members and friends (Bailey et al., 2020; Doyle, 2022; Johnson et al., 2021; Rivera, 2019; Spence, 2018).

Particularly during times of stress and uncertainty, such as the COVID-19 pandemic, children depend heavily on their parents for comfort, guidance, and support (Bram, 2021; Chandler, 2018). Patient, understanding and supportive

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parents, ease a child's anxiety. Based on my reading (de Greef et al., 2017; Diamond et al., 2000; Feinstein et al., 2009; Kazdin & Whitley, 2006; Nevas & Farber, 2001) and my observations as a psychologist, I was aware that including parents in a child's therapy process fostered parental empathy, patience, and support for their children. In addition, including parents in a child's therapy process would foster my rapport with parents. However, as explained earlier, I was unsure of how to effectively encourage rapport with the parents in order that they, in turn, would support their child. From pre-COVID-19 experience, I knew that showing parents their child's sandplay scene was not the best solution for me as showing parents their child's sandplay scenes were often overwhelming for parents to bear and at times interefered with my rapport with their child. My ongoing practitioner uncertainty prompted my PhD study.

The rationale for my study was based on the following two questions that emerged from my interaction with the child client and their parents: Firstly, how does one effectively communicate progress seen in the sandplay process to keep parents engaged with me as the child's psychologist and with their child's therapeutic process? Secondly, how does one engage with parents to better support a child-client? Answering these questions became the rationale for my study.

When trying to answer the first question, I sought a method of communicating with parents that mirrored the symbolic and metaphoric language inherent in sandplay therapy (Akimoto et al., 2021; Albert, 2015; Bartosh & Bartosh, 2019; Campbell, 2007; Cao et al., 2019; Da Matta & Ramos, 2021; Foo et al., 2020; Gupta et al., 2023; Homeyer & Stone, 2023; Humphris, 2019; Jang et al., 2019; Xiong et al., 2022). This idea is underpinned by the sentiment expressed in the quotation attributed to Napoleon Bonaparte at the beginning of this chapter. His assertion that

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“a good sketch is better than a long speech” suggests that drawings (and sandplay scenes), rich in symbolism and metaphor, often convey profound meaning, which surpasses mere words. Additionally, symbolization facilitates the comprehension of that which cannot yet be articulated (Aite, 2002). Using visual metaphors, such as depictions of a house or fire, goes beyond literal representation to convey associations such as relationships or inner worlds (Peterson et al., 2015). A drawing may also be more appropriate than sandplay scenes as it provides a pared down version that is less overwhelming for parents.

A possible solution to my search for a method of communicating with parents that used the same language as sandplay therapy came about when I applied a drawing technique learned during my training as a sandplay therapist. When training as a sandplay therapist, one’s casework is under the supervision of a teaching member certified by the International Society for Sandplay Therapy (ISST). One of my sandplay therapy teachers (i.e., Anke Seitz), introduced me to the House-Tree-Fire-Water-Person drawing (HTFWP) during one of our supervision sessions.

The HTFWP drawing is a projective technique used in child and adolescent psychotherapy, predominantly as a diagnostic tool (Groschwitz, 2016; Kreuter-Hafer et al., 2016; Lutz, 2007; Wienand, 2016, 2020). It is a technique that prompts children to draw a house, tree, fire, water and a person in order to understand their inner world. In my study the inner world of the child, which I wanted to understand, related to their anxiety.

I started using the HTFWP drawing intermittently throughout the child’s therapy process. The use of this drawing resonated with me as a tool to be used for interpreting projective drawings. Another such tool was the *Goodenough Draw-a Person*, discussed by Springer et al. (2020), which was integral to my professional

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training as an Educational Psychologist, and which I continued to use in my practice. The drawings symbolically expressed the thoughts and emotions of the child and influenced my perception and understanding of the child in therapy. During the child's sandplay therapy process, I observed that the themes emerging in the child's sandplay scenes often echoed what I was seeing in the HTFWP drawing series. The HTFWP drawing series appeared to offer a metaphorical insight into the child's inner world, similar to Slade's (2008, p. 227) description of 'hot spots' – emotionally charged moments that enhance understanding of the child's inner experiences. Borrowing from Slade's terminology, my 'hot spots' refer to themes in the HTFWP drawing series and instances in the sandplay scenes that helped me understand the child-client's emotional experiences. Slade (2008) used this hot-spot concept in the understanding of parent-child dynamics, drawing on attachment research specifically pertaining to the challenges faced by parents attempting to understand the internal experiences of their children. Based on my intuition, I hypothesized that incorporating these HTFWP drawings as reflections of the child's inner experiences would assist parents in gaining deeper insights into their children during therapy feedback sessions. I believed that as hot spots, these HTFWP drawings held the potential to help parents gain a deeper understanding of their child's inner world and their struggles with mental health challenges like anxiety.

Drawing parallels between sandplay therapy and the HTFWP drawing series I, like Amod et al., (2013), recognised that they both explored affect, perceptions, character, needs and an understanding of challenges without the need for verbalization. Moreover, both sandplay and the HTFWP drawing series involve hands-on psychological work, which implies not just talking about one's challenges, but using tangible materials like clay, paint or sandplay miniatures to try to express

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and process one's emotional challenges. Based on observations from my ongoing sandplay practice and the literature pertaining to the use of drawings in therapy (Baghdadi et al., 2020; Kissos et al., 2020; Lev-Wiesel et al., 2021; Sheikh et al., 2019), I theorized that using a series of HTFWP drawings could facilitate communication with parents about their child's progress in therapy and enhance their understanding of their child's anxiety challenges. However, despite a thorough search of the available literature, I could not find any publication supporting my view.

As I continued to explore the best way to facilitate feedback and the potential of the HTFWP drawing to facilitate feedback, I explored ways of gaining greater value from the HTFWP drawings by using them, not just to facilitate feedback, but also to foster more effective parenting. My rationale echoed Zemmelman (2018), who believed that when progress is made in therapy in isolation from the system to which the child belongs (for example, family or school), this progress can be undone as the conditions within the system would not have changed. Likewise, multisystemic accounts of children's resilience show that children's positive outcomes are dependent on the systems children are connected to, such as parents and families (Masten et al., 2021; Masten et al., 2023; Ungar, 2021; Ungar & Theron, 2020). I wanted to build/build on the parents' concern for, and empathy with their child with the intention of bolstering their parenting skills. My hope was that this growth would lead to more effective parenting which would minimise future challenges for the children currently in therapy, as research has shown that effective parenting bolsters children's resilience (Masten & Palmer, 2019; Masten et al., 2021; Ungar, 2011; Ungar & Theron, 2020).

Therefore, any means of communication I used with parents had to be one that fostered unity rather than division, strengthening the bond between child and

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parent, and empowering and supporting parents to be more effective in their parenting. It occurred to me that the HTFWP drawing series might have other benefits too. In particular, building an alliance between myself and parents which, according to Bram (2021) and Accurso and Garland (2015), could enhance positive parenting skills. I was eager to explore how the HTFWP drawing series might support the parent-psychologist alliance (especially considering the similarities this drawing shared with sandplay therapy), a strategy that appears not to have been previously investigated in any formal or systemic way.

In summary, based on my professional experience and the literature on the parent-psychologist alliance, it was evident to me that building a relationship with parents was an important task (Accurso & Garland, 2015; Bonanno, et al., 2007**;** Bonanno et al., 2024; Bram, 2021; Bratton et al., 2005; de Greef et al., 2017; Diamond et al., 2000; Feinstein et al., 2009; Fox, 2012; Gvion & Bar, 2014; Hawley & Garland, 2008; Kazdin & Whitley, 2006; Kottler, 2016; Nevas & Farber, 2001; Ruberman, 2009; Zemmelman, 2018). While the available literature broadly described how this alliance could be utilized, I felt frustration regarding the lack of guidance on creating it (Bram, 2021; de Greef et al., 2017; Núñez et al., 2022; Zilcha-Mano, 2017). Responding to this lack of information, I wanted to explore the potential benefits of the child-client's HTFWP drawing series to create a unique and insightful way to engage parents in understanding and supporting their child's therapeutic journey. In other words, I designed my research to explore the potential benefits of the HTFWP drawing series as a communicative bridge between myself, as treating psychologist, and parents, to effectively convey the child's emotional and psychological state and the progress made in therapy.

1.2 Problem Statement

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Building a relationship with parents when their child is in psychotherapy is an important task for psychologists, and there are several convincing reasons to establish this connection (Accurso & Garland, 2015; Bram, 2021; Campbell & Simmonds, 2011; de Greef et al., 2017; Diamond et al., 2000; Fox, 2012; Grosberg, 2019; Kazdin & Whitley, 2006; Kazdin et al., 2006; Kottler, 2016; Nevas & Farber, 2001; Ruberman, 2009). Amid the ongoing repercussions of the COVID-19 pandemic, there were also reports on the increase in the prevalence of anxiety among children (Garcia-Adasme et al., 2021; Munir, 2021; Zhang et al., 2021). Moreover, in South Africa, where psychological services are often limited, the rising prevalence of child anxiety highlights the urgency for optimizing child psychotherapy (Bloom et al., 2022; de Man et al., 2022; Harrison et al., 2022; Subramaney et al., 2020; van der Berg et al., 2020). The stigma associated with mental health treatment further complicates these challenges, emphasizing the need for therapeutic environments that not only facilitate progress but also foster comfort and understanding for both children and parents (Porter et al., 2021).

Through a relationship with parents, psychologists can significantly impact various aspects of parenting and familial dynamics. Research has shown that such relationships can significantly enhance various aspects of parenting and familial dynamics, thereby improving therapeutic outcomes for children undergoing child psychotherapy (Accurso & Garland, 2015; Bram, 2021). Moreover, the emotional support offered to parents can be important to their ability to navigate the challenges of raising a child (de Greef et al., 2017; Fox, 2012). Additionally, a robust bond between psychologists and parents can contribute to parental resilience and empowerment (Bonanno et al., 2024; Diamond et al., 2000). Furthermore, nurturing these relationships can improve the parent-child dynamic, reduce feelings of

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isolation and enhance the overall well-being of the family unit (Campbell & Simmonds, 2011; Fox, 2012). Importantly, these connections also provide psychologists with valuable insights for refining treatment plans and ultimately lead to improved therapeutic outcomes, underscoring the significance of investing in these relationships for both professional fulfilment and the betterment of children's lives (Chandler, 2018; Kazdin & Whitley; 2006).

However, despite the recognition of the importance of the parent-psychologist alliance in child psychotherapy, there is little detailed guidance on how to create this alliance, pointing to a gap in the literature (Diamond, 2000; Feinstein et al., 2009). This gap in the literature highlights the need for research to better understand and delineate the process(es) involved in building effective alliances with parents within the child's therapy context.

Another underexplored area in child psychotherapy is the potential of drawings like the HTFWP drawing series (Groschwitz, 2016; Kreuter-Hafer et al., 2016; Lutz, 2007; Usländer & Reitz, 2015; Wienand, 2016, 2020). Typically used as a diagnostic tool the HTFWP drawing series could be beneficial to forming and strengthening the parent-psychologist alliance by visually communicating a child's progress and emotional state to their parents (Groschwitz, 2016; Kreuter-Hafer et al., 2016; Lutz, 2007; Wienand, 2016, 2020). This could be particularly effective in a context such as South Africa, where making the most of available mental health resources is crucial due to the constraints in the mental healthcare system (de Man et al., 2022; Subramaney et al., 2020; van der Berg et al., 2020).

Therefore, this PhD study aims to address these knowledge gaps by exploring the potential benefits of incorporating the HTFWP drawing series into feedback sessions with parents. My research seeks to establish evidence-based practices that

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not only enhance the parent-psychologist alliance but also optimize the therapeutic process for children experiencing anxiety. By developing a detailed framework for using the HTFWP drawing series in child psychotherapy, I hope to provide new avenues for psychologists to effectively engage with parents, thereby improving outcomes for children facing mental health challenges amidst ongoing global stressors.

1.3 Purpose of My Research

To address the aforementioned problem, I conducted an instrumental multiple-case study. The purpose of my instrumental multiple-case study was to explore the benefits, if any, to the therapeutic process of sharing the child-client's series of HTFWP drawings with their parent(s) during parent-feedback sessions when their child was in sandplay therapy for GAD. This exploration sought to uncover potential advantages not only for the child, parents, and psychologist involved in the child's therapy process, but also for the relationships between these stakeholders. I focused on GAD as it is largely under-diagnosed and untreated globally and in South Africa, yet has substantial adverse outcomes on the lives of children (DeMartini et al., 2019; Nel et al., 2018, Theuring et al., 2023). These adverse outcomes negatively affect mood and behaviour, lead to substance abuse, impair academic performance, and lead to a deterioration in physical health, with consequences that can extend into adulthood (Pollard et al., 2023).

Furthermore, in the event that I determined that sharing the child-client created HTFWP drawing series was beneficial, I also aimed to identify and record pointers for psychologists regarding the integration of this drawing series into parent feedback sessions. Through this, my objective was to offer practical recommendations for psychologists to effectively utilize the HTFWP drawing series

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within the context of treating GAD in children. By providing concrete, actionable guidance on using the HTFWP drawings, my research seeks to foster the parent-psychologist alliance, promoting better outcomes for children challenged by anxiety.

1.4 Research Questions

My study was guided by a single primary research question:

- How does sharing the series of the child-client's HTFWP drawings in parent feedback sessions benefit the therapeutic process – if at all – when a child is in psychotherapy for GAD?

Based on my findings the following secondary question would be addressed:

- What pointers can psychologists follow to effectively incorporate the child-client's HTFWP drawing series into parent feedback sessions to optimize the therapeutic process for children undergoing psychotherapy for GAD?

1.5 Working Assumptions

The importance of acknowledging and critically reflecting on assumptions in qualitative research is emphasised as assumptions can shape the knowledge produced and influence the research process (Braun & Clarke, 2013). In my attempt to "own my perspectives" as encouraged by Braun and Clarke (2022, p. 7), I reflected on the assumptions underpinning my study. At the beginning of my study, I assumed that parents would actively seek help to better understand and co-manage their child's anxiety, particularly given the surge in anxiety referrals attributed to the COVID-19 pandemic. In addition, drawing upon my professional experience as an Educational Psychologist, I assumed that children would readily engage in drawing activities when prompted. My assumption that children would readily engage in drawing activities was further supported by research studies demonstrating successful engagement of children in such activities (Angell & Angell, 2013, Hall & Theron, 2016; Malindi & Hay, 2023; Malindi & Machenjedze, 2012). Moreover,

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drawing from my interactions with children in therapeutic settings, I assumed that children would willingly allow me to share their drawings with their parents as I previously experienced it a common trend for children to want to share their creations with their parents.

Drawing upon my clinical experience of using the HTFWP drawings in my practice, I anticipated that sharing the child-client's HTFWP drawing series with their parents during the feedback sessions would enhance the parent-psychologist alliance. This assumption, however, was not grounded in existing literature specific to HTFWP drawings for this purpose; instead, it resonated with general findings that emphasise the significance of a strong parent-psychologist alliance (de Greef et al., 2017; Diamond, 2000; Feinstein et al., 2009; Kazdin & Whitley, 2006; Nevas & Farber, 2001; Zemmelman, 2018). Furthermore, I expected that sharing the HTFWP drawing series would provide parents with valuable insights into their child's anxiety, potentially leading to adjustments in parenting strategies. While specific research on this drawing was limited, studies on the therapeutic usefulness of sharing child-client's drawings with parents supported my assumption regarding insights and improved parenting (Broecher, 2012; Maloney, 1981; Molinari, 2013).

Moreover, I assumed that fostering this alliance through sharing the HTFWP drawing series would lead to more effective parenting, thereby enhancing resilience in children and families (Maholmes, 2014; Young & Nabuco, 2017). In other words, I expected this drawing-facilitated alliance to increase parental support of the child's therapeutic process (Feinstein et al., 2009; Kazdin & Whitley, 2006; Zemmelman, 2018). I also expected this drawing-facilitated alliance to enhance parents' insight into their child's anxiety (Broecher, 2012; Diamond, 2000; Maloney, 1981; Molinari,

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2013). Ultimately, I expected the drawing-facilitated alliance to improve parenting practices and bolstering the child's resilience (Masten et al., 2021).

1.6 My Positioning as a Researcher

The intention of researcher reflexivity is to guide critical self-exploration, as a way of ensuring ethical conduct (Braun & Clarke, 2013; Creswell & Creswell, 2023; Kalu & Bwayla, 2017; Merriam & Tisdell, 2016; van der Vaart et al., 2018). As a researcher, practicing researcher reflexivity as described by Levitt et al. (2018), I needed to examine my beliefs, biases, and perspectives as they could potentially influence my research. My practice of reflexivity as a researcher encompassed acknowledging my working assumptions, personal and professional experiences, beliefs about my research topic, motivations for exploration, and theoretical foundations (Holmes, 2020). These are areas that I covered when introducing my study. In addition, aligning with the following authors (Merriam & Tisdell, 2016; Swaminathan & Mulvihill, 2018), I realised that factors such as gender, socio-economics, cultural aspects, age, ethnicity, language and biography, influenced my researcher reflexivity. Levitt et al. (2018) stressed the context-dependent nature of researcher reflexivity, underscoring continuous awareness. Researcher reflexivity was therefore multifaceted and required my ongoing consideration, as it potentially impacted my research process, my interactions with informants, and data interpretation (Durdella, 2019; Swaminathan & Mulvihill, 2018).

In qualitative research, researcher reflexivity mitigates biases, assumptions, and preconceptions affecting data collection, analysis, and interpretation. Describing how my background shaped my approach to my study enhanced transparency and credibility (Holmes, 2020; Levitt et al., 2018). As transparency regarding my background, interests, and experiences fosters research trustworthiness (Billups,

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2020; Flick, 2018; Korstjens & Moser, 2018; it is important to articulate these clearly as encouraged by Holmes (2020).

In this context of articulating my background, I am a 57-year old 'coloured' woman (a racist classification based on skin colour from the Apartheid era). I have been married for 32 years and am a mother of two adult children (my daughter is 30 and my son is 27 years of age). I am also an Educational Psychologist with 17 years' experience. I run a private practice from my home. Prior to becoming an Educational Psychologist, I taught for 13 years. My time as an educator was predominantly spent in the primary school environment within the intermediate phase (Grade 4 to Grade 6).

Of all possible factors influencing my researcher reflexivity, the COVID-19 period and my role as a mother during this time, had the most significant impact on my study. In 2020, my daughter started her internship as a doctor in a state hospital in a different province from our home. Initially, our family was filled with excitement for her new endeavour. However, this excitement turned to worry when the first case of the COVID-19 pandemic was reported in South Africa. By March of that year our country was in lockdown and my daughter found herself on the frontlines as a junior doctor. Due to the lockdown measures, our only connection was telephonic or via video calls. Many of the video calls found her in full personal protective equipment (PPE), including a mask as she worked long hours at the hospital. Her duties included rotations in the COVID-19 ward adding to the anxiety our family experienced, knowing she faced the harsh realities of the pandemic daily.

In addition, my son was completing his final year at university, now compelled to study from home, due to lockdown measures to contain the COVID-19 pandemic. His final year as an engineering student is typically when their big project is

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completed. Being able to spontaneously visit a lecturer's office for support, was now no longer possible. As a parent, despite my children being adults, I inevitably brought my personal experiences of anxiety regarding their well-being and our family's experiences during the lockdown measures into my study.

With these lived experiences of being anxious for my children, I brought a depth of understanding of parent-child dynamics, particularly related to the anxious times of the COVID-19 pandemic lockdown measures. My experiences allowed sensitivity to the lockdown experiences of the parents in my study and to their feelings of no or little control over their children's well-being. While this sensitivity had value (for example, providing insights into how parents coped with the challenges of their own and their children's anxiety during the pandemic), it could have presented a limitation. This limitation related to my own children being much older, and the nuances of raising younger children could have limited my understanding of my parent informants' experiences.

However, this limitation was mitigated by my professional positioning. In my professional capacity as an Educational Psychologist, I have worked with children of all ages for 17 years. My professional experience allowed me to recognise the psychological and developmental needs of children. I had also spent 13 years prior as an educator in the primary school setting. I predominantly taught Grade 4 learners who typically reach the age of 10 in that grade. I was therefore familiar with primary school children, particularly those in the intermediate phase (Grade 4 to Grade 6).

This experience as an educator provided me with valuable insights into the educational environment and the challenges faced by children in this age group, including the possibility for increased anxiety. It allowed me to anticipate potential difficulties that primary school-aged children and their parents might encounter due

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to the pandemic lockdown measures, such as heightened anxiety due to social isolation and disrupted routines. In addition, it equipped me with an understanding of how school closures, remote learning and other pandemic-related disruptions could impact children in the primary school phase – potentially exacerbating their anxiety and stress.

Moreover, my years of experience also shed light on how many parents, understandably felt overwhelmed by their newfound roles as primary educator during the pandemic lockdown. This understanding of both the educational landscape and the perspectives of parents enabled me to approach my research with an understanding of the challenges faced by children and families during this unprecedented time. My choice of topic, specifically working with parents whose children are anxious, and focusing on the age range between 10 and 12 years, was significantly informed by my personal and professional background (Kalu & Bwayla, 2017).

My professional background also influenced how I conceptualized this study as I predominantly use sandplay therapy as a modality when doing therapy with children and experience has also shown the benefit of drawings for children who struggle to verbalise their emotions. As researchers are considered the primary instrument in qualitative studies (Billups, 2020; Gallin, 2022), I was able to utilise this therapy experience to bridge the gap between myself and my informants (both child-clients and their parents), in that I could navigate the evolving relationship dynamics with my informants while upholding ethical standards (Billups, 2020). My familiarity with sandplay therapy and the benefits of drawing for children who struggle to verbalise their emotions, provided insight into the potential therapeutic benefits of the HTFWP drawing series to a child's sandplay process. I also have experience in

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facilitating a safe and supportive environment for parents and children to share their experiences, encouraging open communication and trust-building. However, these experiences could also influence my interpretation of data, necessitating a vigilant and reflexive approach to any assumptions influenced by my background.

Finally, the context of my research (my practice, which is also where I live) speaks to my vigilance around injustice. Under the apartheid government of South Africa, the area in which I now live was not open to people of colour before 1994 and the beach on the border of this area (see chapter 4, Figure 6) was where we protested as university students because that beach was reserved for ‘white’ South Africans only. In 1994, the Apartheid regime that enforced the division of race was done away with and replaced by a democracy that ensures the equality of all the people of South Africa. However, despite living in this area for 25 years, I still feel a sense of discomfort and unease when confronted with the historical injustices that once governed access to public spaces like the beach and housing. While this area is now open to all cultures, socio-economic imbalances persist, perpetuating divisions. By being wholly inclusive in terms of race, colour or creed – despite the ongoing discrepancies – I try to contribute to the societal healing still required in South Africa. Hence, I place labels like 'white' and ‘coloured’ in quotation marks, to signal a critical perspective and my reluctance on its usage. Based in this area of historical segregation, it was important for my research to include children from diverse backgrounds. As my practice is situated close to schools with a student body inclusive of different ethnic and socioeconomic backgrounds, it ensures accessibility for all children.

By embracing the complexities of my researcher reflexivity and leveraging my background and experiences, I endeavour to enrich my study. Aligning with the ideas

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of Porter et al. (2021), I was aware of the crucial need to optimize the therapeutic process in the South African context, and to this end, I aimed to develop and share pointers with fellow mental health professionals based on the findings of my study. My study seeks to enhance the therapeutic environment and provide practical solutions for other mental health practitioners that will enable better communication between the parent and the child's psychologist and in so doing provide a more supportive environment for the child.

1.7 Paradigmatic Lenses

Paradigmatic lenses serve as the foundational framework that connect data to theory. It offers a philosophical perspective that shapes our theoretical understanding of the world, thereby underpinning all research endeavours by providing a coherent structure through which observations are interpreted and theories are developed (McLachlan & Garcia, 2015). Four synergistic paradigmatic lenses or perspectives informed my study—Ontological, Epistemological, Methodological and Theoretical. As briefly explained below, each foundational perspective builds on the next, shaping my research process and outcomes.

Social constructionism (Creswell & Creswell, 2023; Grix, 2002; Merriam & Tisdell, 2016; Willig, 2021) was the ontological lens that guided my research. My social constructionist ontological position gave rise to my epistemological assumptions (Cohen et al., 2007). My study explored symbols in understanding how sharing the series of the child-client's HTFWP drawings in parent feedback sessions benefitted the therapeutic process, if at all, when a child is in psychotherapy for GAD. Therefore, I was guided by the epistemological lens of *Symbolic Interactionism*, incorporating insights from various scholars (Ali et al., 2022; Creswell & Creswell, 2023; Gallin, 2022; Quist-Adade, 2019; Salvini, 2019; Segre, 2019;

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Totkova, 2019; van der Vaart et al., 2018; Wang et al., 2019; Willis Hepp et al., 2019). I chose to use qualitative methodology as this aligned with my epistemological stance, enabling a nuanced exploration of the benefits of sharing of the child-client's HTFWP drawing series. Transitioning to the theoretical lens, my study drew on the framework of multisystemic resilience (Masten, 2024; Masten et al., 2021; Masten & Cicchetti, 2016; Masten et al., 2023; Masten & Motti Stefanidi, 2020; Theron & Ungar, 2023; Ungar, 2018, 2021; Ungar & Theron, 2020; Ungar et al., 2021); Bronfenbrenner's social-ecological model of human development (Bronfenbrenner, 1979; 1992); and the Supporting Alliance Model (Baweja et al., 2016; Correa, 2020; Ekornes, 2015; Franklin et al., 2021; Feinstein et al., 2009; Gasparro et al., 2023; Gatta et al., 2019, Marinucci et al., 2023; Müller & Donley, 2019, Rilveria, 2022; Wingerden et al., 2021).

Next, I explain each of the paradigmatic lenses identified above.

1.7.1 Ontological Lens

In the context of research, ontology refers to the researcher's assumptions about the nature of reality and how they conceptualise it and the relationship between the researcher and who or what is being researched (Creswell & Creswell, 2023; Levitt et al., 2018; van der Vaart et al., 2018; Willig, 2021). It involves understanding the researcher's beliefs about the nature of the social world, including whether reality is objective and external or constructed and subjective (Merriam & Tisdell, 2016; Potter & Robles, 2022). Ontological considerations are important in qualitative research as it influences various processes such as the choice the researcher makes with regard to research methods, data collection techniques, and the interpretation of findings. By being aware of their ontological assumptions, researchers can better understand how they perceive reality and how this perception

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shapes their research process including the collection, analysis and interpretation of data (Creswell & Creswell, 2023; Levitt et al., 2018; Merriam & Tisdell, 2016; Willig, 2021).

Rooted in social constructionism which posits that reality is constructed through human interaction (Creswell, 2007; Creswell & Creswell, 2023), this worldview emphasises the role of language, symbols, discourse, and social interactions in the co-construction of reality (Willig, 2021). Social constructionism challenges the idea of objective reality independent from human perception and interpretation and encourages researchers to examine how reality and knowledge are co-constructed within social contexts (Merriam & Grenier, 2019; Merriam & Tisdell, 2016; Willig, 2021). In my study, the specific social context where discourse was used in the understanding of symbols within social interactions to co-create reality and construct knowledge, were the feedback sessions where I shared the child-client's HTFWP drawings with their parents and we co-created our understanding of these drawings.

Social constructionism encourages researchers to examine how power dynamics, like those potentially found in a therapeutic context, influence the production of knowledge (Merriam & Grenier, 2019). For example, in my study, where I served as both the treating psychologist and researcher, my informants may have perceived me as holding authority and may have felt compelled to comply with my expectations and desires, potentially shaping the knowledge produced in my study. As explained next, this prompted me to prioritise understanding the perspectives of my informants rather than imposing my own interpretations and conclusions upon them.

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My ontological assumptions influenced my understanding of the construction of knowledge (Willig, 2021). Using a social constructionist lens, I came to recognise that the knowledge I aimed to produce was intricately tied to discursive, interactive processes as illustrated by the interaction between myself and informants during parent feedback sessions. This ontological perspective emphasised the fluid, dynamic nature of reality (Merriam & Grenier, 2019) and highlighted the subjectivity inherent in the construction of reality and knowledge production, urging me to critically reflect on my role in shaping research outcomes. In other words, my commitment to social constructionism led me to practice reflexivity as a researcher, continuously questioning my assumptions and examining how my position as a researcher influenced the knowledge I generated. For example, I was sensitive to how my personal beliefs and experiences may unconsciously influence data interpretation, shaping my study's conclusions (see Section 1.6). By explicating my ontology I added to the transparency of my study (Levitt et al., 2018).

1.7.2 Epistemological Lens

Epistemology, the study of knowledge and how it is acquired, is essential for qualitative research as it determines the underlying principles on how researchers believe the creation of knowledge can be understood and interpreted (Creswell, 2007; Quist-Adade, 2019; Willig, 2021). My epistemological stance influenced the manner in which I generated, analysed and interpreted knowledge (Creswell & Creswell, 2023; Willig, 2021). In my study, I adopted Symbolic Interactionism as my epistemological framework, drawing upon insights from various scholars (Ali et al., 2022; Creswell, 2007; Creswell & Creswell, 2023; Gallin, 2022; Quist-Adade, 2019; Salvini, 2019; Segre, 2019; Totkova, 2019; van der Vaart et al., 2018; Wang et al., 2019; Willis Hepp et al., 2019; Yazan, 2015).

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Symbolic Interactionism posits that individuals actively construct knowledge through their social interactions (Quist-Adade, 2019; Salvini, 2019; van der Vaart et al., 2018; Yazan, 2015), which aligns with my ontological perspective with its emphasis on discourse within a social context for the co-creation of reality (Creswell & Creswell, 2023; Merriam & Tisdell, 2016; Willig, 2021). Symbolic Interactionism also emphasises the interpretation of symbols within specific contexts (Ali et al., 2022; Creswell, 2007; Creswell & Creswell, 2023; Gallin, 2022; Quist-Adade, 2019; Salvini, 2019; Segre, 2019; Totkova, 2019; van der Vaart et al., 2018; Wang et al., 2019; Willis Hepp et al., 2019). This perspective underscores the relational and context-dependent nature of knowledge creation and dissemination (Ali et al., 2022; Creswell, 2007; Creswell & Creswell, 2023; Gallin, 2022; Quist-Adade, 2019; Salvini, 2019; Segre, 2019; Totkova, 2019; van der Vaart et al., 2018; Wang et al., 2019; Willis Hepp et al., 2019).

According to Symbolic Interactionism a shared understanding is created by individuals through their interpretation of symbols negotiated during social interaction (Creswell & Creswell, 2023). It posits that symbols play an important role in communication as it enables individuals to convey and interpret meanings and emotions (Wang et al., 2019). The symbols referred to in symbolic interaction serve as the building blocks for communication and help people understand themselves and others (Willis Hepp et al., 2019). The symbols can be visual cues (like colour and shape), drawings, images, and signs, verbal and non-verbal language and objects all conveying symbolic messages (Salvini, 2019; van der Vaart et al., 2018; Willis Hepp et al., 2019). Understanding the meaning of symbols plays an important role in shaping knowledge (Gallin, 2022). However, meaning is not inherent in

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symbols but rather negotiated within a social context (Quist-Adade, 2019). In other words, individuals ascribe meaning to the symbols as they interact with each other.

Symbolic Interactionism is a sociological and social psychological way of understanding how knowledge is created (Creswell & Creswell, 2023; Wang et al., 2019). It has its roots in the ideas of Mead (1964; 1977; 2009), a philosopher and sociologist whose work in interconnectedness and the creation of identity through social interaction laid the groundwork in the early 20th century. Blumer (1969) subsequently developed the ideas of Mead by emphasizing the importance of meaning-making in symbols through social interaction and coined the term “Symbolic Interactionism”. Mead (1964; 1977; 2009) and Blumer (1969) offered a nuanced way of understanding the creation of knowledge in social interaction. Symbolic Interactionism continues to develop into new areas and has subsequently been used in research on parenting styles (Totkova, 2019), creative and art-based research (van der Vaart et al., 2018), systems theory (Ali et al., 2022), user behaviour on social network sites (Wang et al., 2019), experiences of principals from Catholic primary schools (Gallin, 2022) and adoptive parenthood (Willis Hepp et al., 2019).

In my study, Symbolic Interactionism guided my exploration of the potential benefits of sharing a child-client’s HTFWP drawing series with their parents during feedback sessions. The drawings created by my primary informants, the words of my primary and secondary informants and my observations of non-verbal behaviours served as symbols, shaping interactions between parents and myself as the treating psychologist (Billups, 2020). The drawings had the five different symbols in them (house, tree, fire, water and person) as well as visual cues like colour and line density. The meaning of these symbols (drawing, words, and observations) were interpreted to get a shared understanding (see Section 3.3.2.3). Moreover, Symbolic

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Interactionism facilitated the comprehension of the real-world consequences of parental behaviours on a child's anxiety within their social context, essential for understanding broader implications and prompting parental behavioural adjustments (Totkova, 2019). Put differently, Symbolic Interactionism facilitated understanding of how parental interpretations of their child's drawings influenced their beliefs and behaviours, leading to adjustments in their parenting style.

Acknowledging drawings as symbols representing children's perspectives aligns with the emphasis of Symbolic Interactionism on subjective meanings, underscoring the role of drawings as communication tools (Creswell, 2007; Creswell & Creswell, 2023). In addition, the emphasis on the subjective construction of meaning, where the child explains their drawing and parent's share their interpretations rather than me providing a clinical interpretation, reflects the principles of Symbolic interactionism. Informed by Symbolic Interactionism, the interactive nature of parent feedback sessions where both parents and I attempt to understand the symbols created by the child-client result in the co-creation of knowledge regarding the benefits of sharing the child-client's HTFWP drawing series with their parents in feedback sessions. This framework (Symbolic Interactionism) also laid the groundwork for the step-by-step guidance that fellow mental health professionals in similar settings could follow for the use of this drawing when a child is in therapy for GAD. Thus, Symbolic Interactionism offered a comprehensive framework for understanding the dynamics of knowledge generation and dissemination in the context of my study. Furthermore, it emphasised the importance of qualitative methods in constructing and sharing knowledge (Ali et al., 2022; Gallin, 2022).

1.7.3 Methodological Lens

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Qualitative research in psychology is multifaceted, drawing from a diverse array of concepts and principles to explore human experiences, behaviours, social interaction and phenomena enriching the field of psychology with diverse perspectives and insights (Billups, 2020; Creswell & Creswell, 2023; Levitt et al., 2018; Lewin & Glenton, 2018; Morse, 2015; Price, 2015; Sabnis & Wolgemuth, 2024; Sommer et al., 2020; Weston et al., 2022; Willig, 2021). Social, cultural, and historical contexts play a vital role in qualitative research, shaping individuals' experiences and behaviours (Billups, 2020; Creswell & Creswell, 2023; Levitt et al., 2018; Merriam & Tisdell, 2016; Price, 2015; Sabnis & Wolgemuth, 2024; Willig, 2021). These contexts are crucial for providing nuanced insights into human behaviour and experiences, representing the unique viewpoints of participants (Billups, 2020; Creswell & Creswell, 2023; Merriam & Tisdell, 2016; Sabnis & Wolgemuth, 2024).

These principles made qualitative research apposite for my study which explored the benefits of sharing HTFWP drawings series (created during therapy by children in psychotherapy for GAD) with their parents during parent feedback sessions. In addition, this method was suitable for my study as it is grounded in the understanding that qualitative research is adept at exploring complex phenomena that resist straightforward measurement, such as the nuanced dynamics within therapeutic settings (Creswell, 2007; Flick, 2010; Yanow & Schwartz-Shea, 2015). My interest in the experiences of the children and parents during therapy and feedback sessions as well my interaction with them concurs with the focus of qualitative methodology on human experiences, social interaction, and real-life settings.

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Qualitative research typically employs an inductive approach, allowing theories and hypotheses to emerge from collected data (Billups, 2020; Creswell & Creswell, 2023; Merriam & Grenier, 2018; Merriam & Tisdell, 2016; Price, 2015). This methodological flexibility makes qualitative methods well-suited for exploratory research, enabling researchers to delve into a research problem in a flexible, open-ended manner, free from preconceived ideas or hypotheses (Creswell, 2007). Additionally, qualitative research allows for flexibility in research methods based on emerging insights and new understandings (Price, 2015; Sabnis & Wolgemuth, 2024; Willig, 2021). My study, an exploratory qualitative investigation, aligns with these principles. Rather than aiming to prove or test existing theories, my research aimed to generate new insights (Cohen et al., 2007; Creswell, 2007). In addition, my research not only described the potential benefits of the HTFWP drawing series but also delved into the underlying mechanisms contributing to these possible benefits. This inductive approach was particularly appropriate, given that my secondary research question focused on developing pointers for psychologists working with children exhibiting symptoms of GAD. Thus, my study explored the potential benefits of the HTFWP drawing series and offered practical applications and real-life implications for child psychotherapy in relation to GAD.

As noted by several authors, the researcher serves as the primary instrument in qualitative research for data collection and analysis, often collaborating with participants to incorporate their insights (Billups, 2020; Creswell & Creswell, 2023; Merriam & Grenier, 2018; Merriam & Tisdell, 2016). In my role as both the researcher and practitioner, I essentially served as the primary research instrument. I recognised that my personal characteristics, biases, and interpretations influenced my research process and outcomes and guided my engagement both during parent

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feedback sessions and therapy sessions with children (see Section 1.6) (Billups, 2020; Creswell & Creswell, 2023; Lamba et al, 2022; Levitt et al., 2018; Merriam & Tisdell, 2016; Price, 2015; Sabnis & Wolgemuth, 2024).

Qualitative research aims to provide rich detailed insights into complex phenomena – allowing researchers to explore nuances and intricacies – gaining insight, discovery, and interpretation (Creswell & Creswell, 2023; Levitt et al., 2018; Merriam, 1998; Merriam & Tisdell, 2016; Price, 2015; Sabnis & Wolgemuth, 2024; Willig, 2021). In my study, the complex phenomenon being explored is the benefit (if at all) of the HTFWP drawing series to the therapeutic process for children undergoing therapy for GAD. My study aligned with the emphasis on the nuanced, detailed insights of qualitative research offering discursive insights into the potential benefit of this drawing series to the child's therapeutic process when the child is in therapy for GAD. The qualitative research methods that I utilised in my study included semi-structured interviews, drawing facilitated parent feedback sessions (HTFWP-drawing elicitation conversations; see Section 4.7.1.3), observations, checklists and drawings, all geared toward answering my research questions (Creswell, 2007; Price, 2015; Yanow & Schwartz-Shea, 2015). I appreciated the flexibility allowed by qualitative methodology, as it allowed me to modify the sequence of interview questions in response to the parents' reactions to their child's HTFWP drawing series.

This methodological choice resonated with my epistemological and ontological perspectives. Qualitative research acknowledges the subjective nature of human experiences, emphasises the exploration of individuals' perspectives and meanings, and recognises that reality is constructed through social interactions (Billups, 2020; Creswell & Creswell, 2023; Merriam & Tisdell, 2016; Price 2015;

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Sabnis & Wolgemuth, 2024; Willig, 2021). This aligns with social constructionism, my ontological lens, which underscores the co-creation of reality within a social context (Merriam & Grenier, 2018; Willig, 2021). Similarly, my epistemological perspective was reflected in my methodology (Thornberg & Keane, 2022). The HTFWP drawing series and the HTFWP-drawing elicitation conversations designed to explore the benefits, if any, of the HTFWP drawing series, embodied my epistemological lens of Symbolic Interactionism, and emphasised the subjective nature of knowledge and the active role of social interaction in constructing meaning through symbol interpretation.

Ensuring methodological integrity and transparency is fundamental in qualitative research. Qualitative researchers strive to maintain rigorous standards when documenting their methods and findings, thereby enhancing the credibility and trustworthiness of their research (Lamba et al., 2022; Levitt et al., 2018). Moreover, adhering to ethical guidelines is essential to safeguard the rights and well-being of participants and to uphold the integrity of the research process (Levitt et al., 2018; Sabnis & Wolgemuth, 2024). Recognizing the importance of emphasising methodological rigor in qualitative research, I extensively address these aspects in Chapter 4, detailing my research methods, and in Chapter 5, presenting my findings.

1.7.4 Theoretical Lenses

One of the goals of therapy with children is to foster their resilience (Ferreira et al., 2014; Gallerani & Dybicz, 2011; Masten et al., 2021). Hence, my study was framed by a multisystemic understanding of resilience theory, previously called socio-ecological or systemic resilience theory and used interchangeably (Masten, 2020, 2021b, 2024; Masten et al., 2021; Masten et al., 2023; Ungar, 2018, 2019, 2021; Ungar & Theron, 2020). For my study, I chose to focus on multisystemic

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resilience due to its prominence in recent literature (Masten, 2024; Masten et al., 2021; Masten & Cicchetti, 2016; Masten et al., 2023; Ungar, 2018, 2021; Ungar & Theron, 2020).

Initial approaches to resilience theory understood resilience to be the capacity of a child to adjust well to risks that threaten that child's development, functioning, or survival (Masten, 2014; Ungar, 2011). In other words, resilience was understood to be a personal capacity. Increasingly, resilience studies that are grounded in the multisystemic approach report that a child's capacity to thrive is less about the individual characteristics of the child and more dependent on their context (Masten et al., 2021; Ungar & Theron, 2020). Put differently, the child's capacity for resilience is distributed across systems, including their own biological and psychological resources, their social networks (for example, their family or school community) and their built and natural environment (Theron et al., 2021). Aligned with this, is an emphasis on the importance of resilience-enabling interventions (such as therapy) targeting malleable factors and/or processes within the child's context, rather than just targeting children themselves (Luthar & Eisenberg, 2017; Matsopoulos & Luthar, 2020; Ungar, 2011).

One of these malleable factors/processes is parenting, as effective parenting can nurture child resilience (Masten et al., 2021). Through effective parenting, multiple resilience-enabling factors (for example, warm attachment; a sense of belonging, self-regulation, a positive view of self and family) can be boosted (Masten et al., 2021). Therefore, facilitating more effective parenting and enhancing the parent-child relationship, child and/or family resilience will most likely be improved. A parent-psychologist alliance enhances effective parenting and the parent-child relationship (Accurso & Garland, 2015; Bram, 2021; de Greef et al., 2017; Gvion &

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Bar, 2014; Kazdin & Whitley, 2006; Núñez et al., 2022; Schmidt et al., 2014). My exploration of the potential benefits of the HTFWP drawing series included the hope that sharing the drawings would support facilitation of this alliance.

Numerous South African studies of child and youth resilience have also used a systems approach and accentuated the importance of parenting to child and youth resilience (see systematic review by van Breda & Theron, 2018). This precedent further motivates the usefulness of a resilience framework. As explained in the section outlining my assumptions (see Section 1.5), I hoped to use the HTFWP drawing to meaningfully involve parents in their child's psychotherapeutic process and advance their parenting skills.

The framework of multisystemic resilience is further supported by Bronfenbrenner's social-ecological model of human development (Ungar, 2019). Bronfenbrenner (1979, 1992) conceptualises the environment as a set of nested structures for which he gave the abstract terms of microsystem, mesosystem, exosystem and macrosystem. The microsystem consists of three levels, one of which speaks of the physical space. In my study, the physical space consists of the immediate setting that contains the child in, for example, the therapy room or the child's home. Bronfenbrenner (1979, 1992) indicates the second level of the microsystem as the prominent people in the life of the child and the reciprocal relationship they have with the child. In my study, these prominent people are the parent and the psychologist. The final level of the microsystem refers to the dyadic interaction between the child and their parent and the child and their psychologist. The mesosystem is the interaction between the psychologist and the parents. The focus of my study is the various levels of the microsystem (child, parent and

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psychologist) and the reciprocal influence within the dyad (parent-child) as well as the mesosystem of interaction between psychologist and parent.

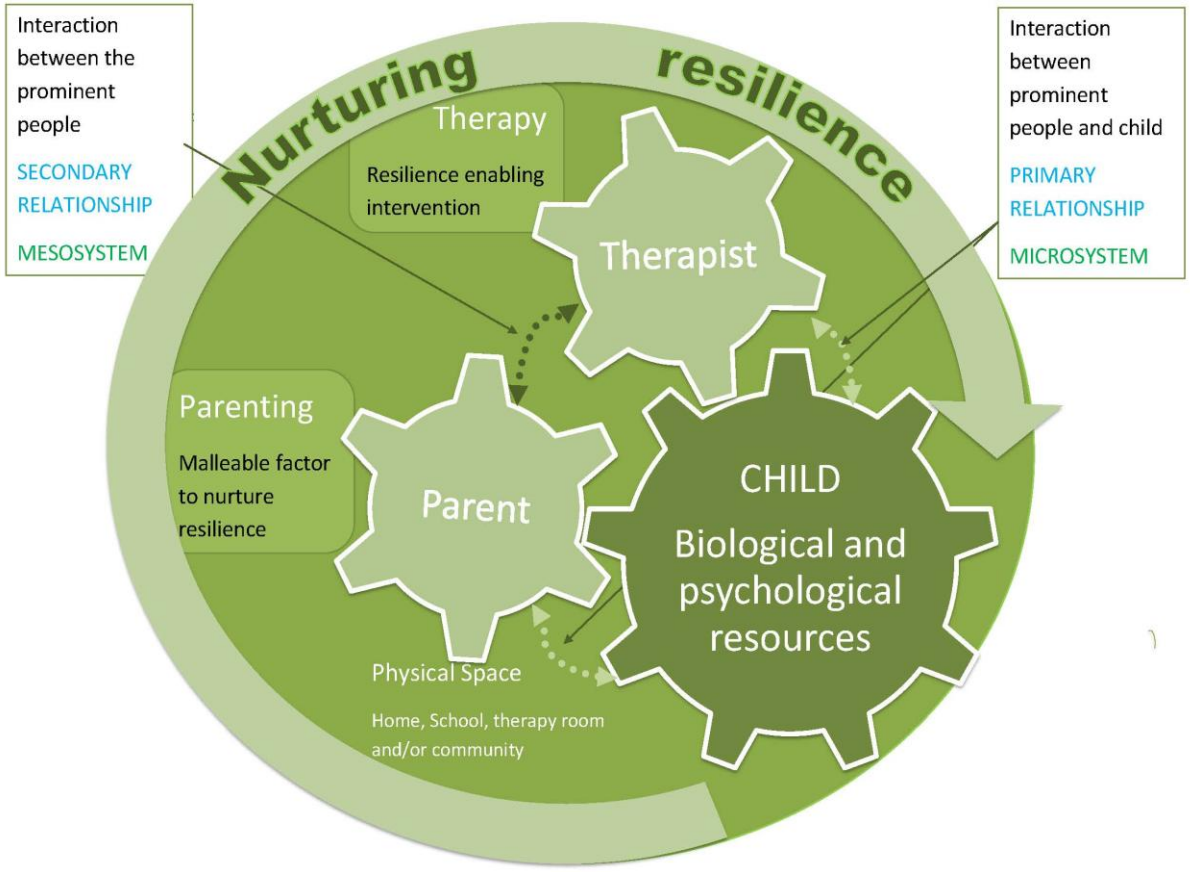
In many ways, the multisystemic approach to resilience fits with Bronfenbrenner's social-ecological model of human development that traditionally guides the practice of Educational Psychology (Matsopoulos & Luthar, 2020). They both support the premise that the process of the positive development of the child is a reciprocal one between the child and the systems they are in. This premise is further supported in the Supporting Alliance Model, which argues that a child's primary relationships with their parents/teachers/psychologist, implied secondary relationships like those of parent-psychologist, parent-teacher, teacher-psychologist, add value to a child's development (Baweja et al., 2024; Correa, 2020; Ekornes, 2015; Feinstein et al., 2009; Franklin et al., 2012; Gasparro et al., 2023; Gatta et al., 2019; Marinucci et al., 2023; Müller & Donley, 2019; Rilveria, 2022; Wingerden et al., 2021). When applying the Supporting Alliance Model to my study, the focus is on the effective collaboration of all those involved in the child's therapy process (child, parent and psychologist). The Supporting Alliance Model, therefore, argues that the therapeutic alliance between child and psychologist is most effective in the context of a supporting alliance between parent and psychologist (Correa, 2020; Ekornes, 2015; Feinstein et al., 2009; Gasparro et al., 2023; Gatta et al., 2019; Marinucci et al., 2023; Rilveria, 2022; Wingerden et al., 2021). Therefore, like the multisystemic approach to resilience and Bronfenbrenner's model, the Supporting Alliance Model emphasises that the systems to which the child is connected and the relationships between these systems are co-responsible for the child's positive development (Baweja et al., 2024; Correa, 2020; Ekornes, 2015; Feinstein et al., 2009; Franklin et al., 2012; Gasparro et al., 2023; Gatta et al., 2019; Marinucci et al., 2023; Müller &

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Donley, 2019; Rilveria, 2022; Wingerden et al., 2021). It is therefore incumbent on a psychologist to find meaningful ways of creating this parent-psychologist alliance. Figure 1 shows the integration of these three theories.

Figure 1

Diagram of my conceptual framework informing my theoretical lenses



1.8 Key Theoretical Concepts

The following are the key concepts for my research: therapeutic process, HTFWP-drawing elicitation conversations, parents, parental co-management of anxiety, parent-psychologist alliance, therapy, sandplay therapist and child-client.

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1.8.1 Therapeutic Process

In my study, the therapeutic process of child psychotherapy was operationalized as a collaborative process involving ongoing interactions between the child-client, parent/caregiver, and psychologist to address psychological, emotional, and behavioural issues. It utilized techniques such as sandplay therapy (Ahn et al., 2020; Akimoto et al., 2021; Ammann, 2022) and creative techniques such as drawing (Baghdadi et al., 2020; Kissos et al., 2020; Lev-Wiesel et al., 2021; Sheikh et al., 2019). Central to this process was building a trusting relationship, enabling the child to develop coping skills and manage emotions effectively. It aimed to enhance the child's emotional well-being and promote positive growth through the collaborative efforts between the child, parent, and psychologist. In my study, the therapeutic process was operationalised as eight sandplay therapy sessions with the child and three HTFWP-drawing elicitation conversations with the parents. Each session with the child lasted 40 minutes, and sessions with the parents ranged from 40 to 50 minutes.

1.8.2 HTFWP drawing and HTFWP-Drawing Elicitation Conversations

The House-Tree-Fire-Water-Person (HTFWP) drawing is a projective technique developed by Ursula Eschenbach (Usländer & Reitz, 2015). It is primarily used with children and adolescents for diagnostic purposes (Groschwitz, 2016; Kreuter-Hafer et al., 2016; Lutz, 2007; Wienand, 2016, 2020). In my study, it was created by the child-client and used to facilitate conversation in HTFWP-drawing elicitation conversations with parents (see Chapter 3, Section 3.3.2) .

I adapted traditional elicitation methods (such as photo elicitation) (Billups, 2020; Roulston & Halpin, 2022) for my study and termed it HTFWP-drawing elicitation conversations. HTFWP-drawing elicitation conversations involved showing parents HTFWP drawings created by their child during therapy to spark discussions.

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These sessions, occurring at various therapy stages, aimed to uncover parents' thoughts and emotions about the drawings. Using open-ended questions, I encouraged free association to explore aspects like colour and emotional content. Throughout, I guided parents in expressing their responses and shared the child's insights, fostering mutual understanding of the child's experiences.

1.8.3 Parents

The concept of parents refers to adult caregivers who meet the physiological, health and developmental needs of their child (Bhana et al., 2016; Bornstein, 2019; Casale et al., 2015; Davidson et al., 2021; Freeze et al., 2014; McCurdy et al., 2022; Roman et al., 2016; Rothenberg et al., 2021; Rothenberg et al., 2020d; Sahithya & Raman, 2021). This group includes biological parents as well as a variety of other caregivers: mothers and/or fathers, single and married parents, divorced parents, adoptive parents, adolescents and grandparents who for various reasons have to take on the role of parent (Bornstein, 2019). Worldwide one needs to acknowledge that parenting is not restricted solely to biological parents and that unique family structures and and cultural practices contribute to child-rearing (Casale et al., 2015; Freeze et al., 2014; Sharer et al., 2015; Shenderovich et al., 2021). The concept of parents was operationalised in my study as a caregiver who has the legal right to initiate therapy for the child in question and agrees to attend three feedback sessions.

1.8.4 Parental Co-Management of Anxiety

Particularly within the research on resilience in children and parent-child interactions with anxious children, the concept of parenting has been considered a protective and promotive influence on the healthy development of children (Lansford, 2019; Masten & Palmer, 2019). Another of the key protective and promotive factors for children emphasised in resilience research is self-efficacy (Masten et al., 2021).

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There therefore needs to be balance between support of a child's agency in the self-efficacious management of their anxiety and their parent's co-management of their anxiety (Shields et al., 2001). The concept of co-management relates to the following parenting factors: parental responsiveness, autonomy, support and control (Masten & Palmer, 2019).

Parental responsiveness is the ability of parents to recognise their children's distress and the degree to which these parents are helpful, warm and available in these situations of distress (Masten & Palmer, 2019; Shields et al., 2001). Research shows that emotional regulation (i.e., the capacity to understand and manage emotions) in children is strongly correlated to high parental responsiveness as higher responsiveness is associated with secure attachment (Grolnick et al., 2019). Supporting a child's autonomy can be defined as the extent to which parents foster a child's initiation of activities, the child's self-efficacy, the child's belief that their own actions can make an impact on the environment and the opportunities for a child's self-expression (Gottfried, 2019; Shields et al., 2001). Control can be defined as the degree to which a child's behaviour is supervised either through the use of authoritarian discipline or the use of direct forbidding or orders (Grolnick et al., 2019; Shields et al., 2001). In controlling environments, the child's input into decision-making and problem-solving are discouraged and they are pressured toward specific outcomes (Grolnick et al., 2019). In this study the concept of parental co-management is therefore operationalised as parenting that is high in responsiveness, high in autonomy and support with moderate control as at these levels these factors are supportive of bolstering children's resilience and co-managing anxiety.

1.8.5 Parent-Psychologist Alliance

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The concept of alliance refers to the quality and nature of collaborative interaction between parent(s) and therapist towards the goals of therapy and the affective relationship that emerges as a result of this interaction (Kazdin et al., 2005). This affective relationship with its collaborative nature towards achieving good therapeutic outcomes for the child in therapy, between parent and therapist, is how this concept is actualised in my study.

1.8.6 Therapy

In the field of psychology, therapy generally refers to different modalities (based on the theoretical framework of the therapist) used by mental health professionals to help children, adolescents and adults who are experiencing difficulties with their emotions (American Academy of Child and Adolescent Psychiatry [AACAP], 2017). Specifically, with regard to children, it is the healing process that allows them to express their feelings in a non-judgemental secure environment (Axline, 1969). More specifically, in my study, the concept of therapy takes the form of sandplay. Sandplay therapy "is a non-verbal play therapy that intentionally creates a space for the unconscious to manifest" (Turner, 2017, p. 2). The objects from the external world, as expressed by Winnicott (1971), are the miniatures and sandtrays in sandplay that the child-client uses to create a world that is then an expression of their internal reality giving their inner world a tangible form (Seitz, 2020). As in my general practice, just so in this study, sandplay was conducted in 40-minute sessions.

1.8.7 Sandplay Therapist

A sandplay therapist is a trained professional who utilizes sandplay therapy as a therapeutic approach when working with clients, particularly children and adolescents (Zappacosta, 2012). In South Africa, sandplay therapists are typically trained in psychology and are mental health professionals registered in their

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professional capacity with a statutory body. They have undergone specific training in sandplay therapy techniques after their registration at the Health Professions Council of South Africa (HPCSA). Their training is stipulated by the International Society for Sandplay Therapy (ISST) and upon completion they are certified as sandplay therapists (Constitution of the South African Sandplay Therapy Society, 2022).

Overall, a sandplay therapist facilitates the exploration of the client's inner world through the use of sandplay materials, allowing for the expression and processing of unconscious thoughts and emotions in a symbolic and creative way (Amman, 2022; Kalff, 2022). I am the sandplay therapist in my study. I have been registered as an Educational Psychologist with the HPCSA since 2007, and have been an ISST certified sandplay therapist since 2018.

1.8.8 Child-Client

The child-client is defined as a 0 – 18 year old child who is being treated by a professional health care provider, like a psychologist, for an internalised or externalised mental health disorder (Feinstein et al., 2009). In my study, this concept was operationalised as a primary school child, between the ages of 10 and 12, who was referred to me for behaviours related to generalised anxiety disorder by a mental health professional practising at the school. These child-clients were a client of the referring colleague.

1.9 Overview of Research Methodology

An overview of my research methodology, which followed a case study design, follows. It is discussed in detail in Chapter 4.

1.9.1 Study Setting and Case Selection

My instrumental multiple case study took place at my private psychology practice located in Table View, Cape Town, a suburb in the larger Blouberg area, characterized by diverse socio-economic conditions. My informants consisted of

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primary (parents) and secondary (child-clients) informants selected through purposive sampling techniques. This method ensured the inclusion of cases relevant to my research objectives. The inclusion criteria specified parents whose children were dealing with GAD; the children ranged in age from 10 to 12 years and attended one of two schools in Blouberg. Gatekeepers at these schools, i.e., mental health professionals, facilitated access to eligible informants and identified families interested in participating. Ultimately, my study included 9 primary informants (7 mothers and 2 fathers) and 7 secondary informants (4 boys and 3 girls), forming a total of 7 cases.

1.9.2 Data Generation: Strategies and Documentation

The data collection procedures for my study involved multiple methods to gather comprehensive insights into the experiences of both primary informants (parents) and secondary informants (children with GAD). For primary informants, data collection began with the completion of a demographic questionnaire and the Child Behaviour Checklist (CBCL/6-18). This provided background information on the family context and the severity of the child's anxiety symptoms.

I conducted initial semi-structured interviews to explore parents' understanding of their child's anxiety, their responses to it, and their expectations of therapy. These interviews provided flexibility in responses and allowed me to probe for deeper insights. I also carried out three HTFWP-drawing elicitation conversations at different stages of therapy, where parents responded to HTFWP drawings made by their child. These discussions were guided by open-ended questions about the drawings, encouraging free association and the exploration of emotions, symbols, and meanings. At the end of the therapy process, I conducted final semi-structured

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interviews, similar to the initial ones, to assess any changes in the parents' understanding and responses to their child's anxiety.

For the child-clients, who were secondary informants, I asked them to create HTFWP drawings three times during the therapy sessions. The children were prompted to draw specific elements—house, tree, fire, water, person—and then asked to explain their drawings. This approach provided valuable insights into their experiences and emotions. Throughout the data collection process, I employed open-ended questions and probing techniques to encourage both primary and secondary informants to reflect and elaborate on their experiences.

1.9.3 Data Analysis

I conducted a Reflexive Thematic Analysis (RTA) (Braun & Clarke, 2021a; 2021b; 2022; Braun et al., 2022) of qualitative data obtained from semi-structured interviews and HTFWP-drawing elicitation conversations. This approach allowed me to identify one overarching theme and three subthemes. These themes are detailed in Chapter 5.

1.9.4 Trustworthiness

Trustworthiness is important in qualitative research as it helps establish the rigour and quality of the research (Creswell & Creswell, 2023). Trustworthiness considers the degree to which the findings of a study are credible, transferable, dependable, confirmable and authentic (Yin, 2018). In ensuring the trustworthiness of my study, I adhered meticulously to the criteria of credibility, transferability, dependability, confirmability, and authenticity outlined by influential scholars such as Lincoln and Guba (1985), Creswell (2007; 2012) and Levitt et al. (2018).

1.9.5 Ethical Considerations

Ethical considerations dominated my study, guided by ethics clearance from the Departments of Education and Health Sciences at the University of Pretoria

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(number: EDU168/21), the professional codes of conduct of the Health Professions Council of South Africa (HPCSA), and legislation such as the Protection of Personal Information Act (POPIA 2013). These measures ensured respect for ethical principles of my profession and the protection of the informants' rights, confidentiality and informed consent throughout the research process (Weston et al., 2022).

1.10 Overview of Thesis

In this thesis I offer details of my exploration of sharing the child-client's series of HTFWP-drawings with their parent(s) during parent-feedback sessions when this child was in therapy for GAD to determine the potential benefits of this drawing series to a child's therapeutic process. Each chapter details various facets of this exploration.

Chapter 1

In this chapter, I articulate the rationale behind my study, offering a comprehensive background of my research topic and its significance within the realm of child psychotherapy. I share the research questions that guided my purpose. I explain my position as a researcher and delineate my paradigmatic framework. I summarise the methods I used to conduct my study and confirm that I worked ethically and rigorously. Finally, I present an outline of the organizational structure of my thesis.

Chapter 2

In Chapter 2, I conduct a thorough review of the existing literature concerning parents' roles as champions of resilience within the context of children diagnosed with GAD. I identify gaps, controversies, and areas warranting further investigation.

Chapter 3

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In Chapter 3, I explore the literature regarding the enhancement of resilience, particularly in the context of GAD in children, through collaborative support systems, with a focus on the parent-psychologist alliance. I examine literature on formal interventions for anxiety, emphasizing sandplay therapy and the utilization of drawings, before specifically discussing the application of the HTFWP drawing.

Chapter 4

Chapter 4 provides a detailed account of the methodology that guided my study. As encouraged by Creswell and Creswell (2023), I offer a clear and comprehensive explanation of my research design, data collection and analysis techniques. I also detail the steps taken to ensure trustworthiness and comment on my ethical considerations.

Chapter 5

In Chapter 5, I present the findings of my study, beginning with a delineation of the identified themes. Through the voices and drawings of my informants, I breathe life into each theme, offering a vivid portrayal of their perspectives and experiences.

Chapter 6

In Chapter 6 I provide context for my findings by situating them within the relevant literature. This practice allows me to show where I have filled the gaps in literature and contributed to knowledge, thereby articulating the contribution my study has made to the field of child psychotherapy in the context of GAD.

Chapter 7

In chapter 7 I delineate the guidelines for the sharing of the child's series of HTFWP drawings with their parents during parent feedback sessions.

Chapter 8

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In this final chapter I reflect on the contributions and implications of my study. I also reflect on my experience as a researcher. I consider the limitations of my study and propose directions for future research.

1.11 Conclusion

Inspired by my experience as an Educational Psychologist addressing various challenges affecting children's well-being, I embarked on an exploration of the potential benefits of sharing the child-client's series of HTFWP drawings with their parents during feedback sessions when that child is in therapy for GAD. The purpose for my qualitative, instrumental multiple case study research was twofold. Firstly, I wanted to explore the potential benefits to the therapeutic process of sharing the child-client's series of HTFWP-drawings with their parent(s) during parent-feedback sessions when this child was in therapy for GAD. Secondly, if there were benefits, I wanted to identify and delineate guidelines for psychologists regarding the integration of the child-client's HTFWP drawing series into parent feedback sessions to enhance the therapeutic process for children in sandplay therapy for GAD. As my study is the first to explore the benefits, if any, of the HTFWP drawing series in the manner explained, my study holds potential to fill the gaps in the theory and practice of the parent-psychologist alliance and contribute to the uses of the HTFWP drawings as well contributing to the literature on including parents in a child's sandplay process. It also holds potential to contribute to the field of child psychotherapy. The following two chapters review the literature relevant to my topic.

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Chapter 2

Parents as Champions of Resilience

2.1 Introduction

This chapter focuses on the essential role parents play as champions of resilience, with a particular emphasis on generalized anxiety disorder (GAD) within the context of my study. Following the understanding that resilience can only be studied in the context of risk (Luthar, 2006; Masten, 2014; Ungar, 2019), I start Chapter 2 by explaining anxiety and GAD and how they place children at risk for adverse developmental outcomes. Moving forward, I delve into the risk factors associated with anxiety. Following the exploration of risk factors, I explore protective resources that contribute to resilience against anxiety. Both the risk and protective sections consider factors in the child themselves and the systems they are connected to, such as family and community.

2.2 Anxiety and Generalized Anxiety Disorder (GAD)

2.2.1 Anxiety

Anxiety is a defence mechanism that humans use as a way of protecting themselves from threat (Porges, 2022). As a defence mechanism, anxiety triggers physiological and psychological reactions when activated, forming part of the body's stress response (Porges, 2023). These reactions are commonly referred to as the "fight-or-flight" response (Aranberri-Ruiz et al., 2022; Bailey et al., 2020; Beesdo, 2009; Dadds & Barrett, 2001; Meers et al., 2020; Schiele & Domschke, 2018; Porges, 2021; Suveg & Zeman, 2004). The fight-or-flight response readies the body for action encompassing several key features (Porges, 2022).

In response to a threat (whether perceived or otherwise), physiological fight-or-flight reactions include somatic symptoms that have no physical cause (Dadds &

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Barrett, 2001). Individuals who are anxious can also experience a heightened awareness and increased alertness, which helps them recognise and react quickly to potential dangers (Aranberri-Ruiz et al., 2022; Bailey et al., 2020). When we are anxious our bodies respond by increasing our heart rate, changing our breathing, and causing us to sweat. This is because the body releases stress hormones like adrenaline and cortisol to prepare us for action, in response to the perceived threat (Aranberri-Ruiz et al., 2022; Porges, 2022, 2023; Troller-Renfree et al., 2019). Almost simultaneously, our focus and attention narrows towards the source of anxiety, helping us identify the danger quickly and make decisions essential for survival (Porges, 2021; Troller-Renfree et al., 2019). Feeling motivated to act, we instinctively take steps to reduce the threat by seeking safety or assistance (Porges, 2021). So, as children encounter new and demanding (i.e., potentially threatening) situations, for example, preparing for examinations or trying to master new tasks, their natural response would be anxiety (Brown, 2019).

Psychologically, anxiety can lead to feelings of fear or worry, heightened emotions, restlessness, irritability, sleep disturbances and negative thinking patterns (Porges, 2022, 2023). Anxiety is problematic when it becomes disproportionate or excessive, impacting daily functioning and quality of life as the aforementioned physiological and psychological reactions intensify (DeMartini et al., 2019; Harrison et al., 2021; Schwartz et al., 2019; Spence, 2018; Yang, 2023). In addition, it becomes problematic when it lingers for long periods or disrupts psychosocial functioning like interpersonal relationships, academic or work performance and social engagements (Beesdo, 2009; Doyle, 2022; Johnson et al., 2021; Rivera, 2019; Reardon et al., 2020; Schiele & Domschke, 2018; Spence, 2018; Strawn et al., 2020). In addition, it is problematic when it is overwhelming and persistent, and

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arises without clear triggering events (American Psychiatric Association [APA], 2022; Beesdo et al., 2009; Bloom et al., 2022; Brown, 2019; Dadds & Barrett, 2001; Doyle, 2022; Garcia- Adasme et al., 2021; Harrison et al., 2021; Schwartz et al., 2019; Spence, 2018; Yang, 2023). These negative effects threaten the child's mental health (Harrison et al., 2021). I discuss these negative effects in greater detail later in this chapter (see section 2.2.3).

According to Schwartz et al. (2019) anxiety is the most prevalent mental health challenge among children. Anxiety often arises in children and adolescents who are seen as particularly vulnerable to its development (Creswell et al., 2020; Ginsburg & Schlossberg, 2002; Harrison et al., 2021; Nasab & Alipour, 2015). Vulnerable populations include children with learning difficulties, children who live in poverty (Harrison et al., 2021; Kurdi et al., 2018), children experiencing family disruptions or natural disasters (Spence, 2018), and children who experience some form of physical illness (Dadds & Barrett, 2001; Doyle, 2022; Oduntan et al., 2022; Rivera, 2019; Pollard et al., 2023; Reardon et al., 2020; Schiele & Domschke, 2018).

Despite being a common occurrence among children, the significant impact of anxiety in children is often underestimated (Ginsburg & Schlossberg, 2002; Schwartz et al., 2019; Spence, 2018; Zhang et al., 2021). Strawn et al. (2020) calculate this prevalence at approximately 10% of youth receiving a diagnosis of an anxiety disorder before reaching the age of 18, while Brown (2019) states that 31.9% of adolescents between the ages of 13 and 18 are diagnosed with some form of anxiety disorder. The prevalence rates of anxiety disorders vary across populations with annual estimates showing rates of 22.2% in the USA and 14% in the EU. These statistics emphasise the wide-reaching impact of childhood anxiety (Schiele & Domschke, 2018). A study done in the Western Cape Province, South Africa (the

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province in which I conducted my study) with 621 adolescents aged 10 to 14 years, indicated a prevalence rate for anxiety as 20.9% (Mkhize et al., 2024). These findings regarding prevalence rates across three continents, emphasise the importance of early recognition and intervention to minimise its long-term effects on a child's overall well-being.

Research suggests that clinical levels of anxiety often persist over time (Beesdo et al., 2009). Longitudinal studies, like the one conducted by Theuring et al. (2023) in Berlin, Germany, on the mental health developments of 660 school-aged children during the COVID-19 pandemic, have shown that anxiety responses to such events can endure for a considerable period regardless of whether or not the children were infected with COVID. This study contributes to our understanding of the prolonged impact of the pandemic on children's mental health outcomes and our understanding of the persistence of anxiety symptoms.

2.2.2 Generalized Anxiety Disorder (GAD)

GAD is one of the 11 types of anxiety disorders categorized by the Diagnostic and Statistical Manual of Mental Disorders DSM-5-TR (APA, 2022). The other types include separation anxiety disorder, selective mutism, specific phobia, social anxiety disorder, panic disorder, agoraphobia, substance/medication-induced anxiety disorder, anxiety disorder due to another medical condition, other specified anxiety disorder, and unspecified anxiety disorder (APA, 2022; Beesdo, 2009; Dadds & Barrett, 2001; Schiele & Domschke, 2018; Schwartz et al., 2019). Each type of anxiety disorder has its own set of criteria. As explained in Chapter 1, my study is focused on GAD because of the high prevalence rates in South Africa, more so following COVID-19 (Subramaney et al., 2020).

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GAD, one of the more common anxieties in childhood, significantly impacts the lives of children and can progress into adulthood (Brown, 2019; Sonmez et al., 2020). GAD in children is characterized by uncontrollable, persistent worry (Bilsky & Friedman, 2022 Gouze et al., 2021; Hanna, 2020; Howard et al., 2017; Meers et al., 2020; Mohammadi et al., 2020; Sonmez et al., 2020; Theuring et al., 2023; Yang, 2023; Zygouris et al., 2022). Although these children seek constant reassurance, it does not alleviate their worries (Hanna, 2020; Meers et al., 2020; Theuring et al., 2023; Yang, 2023). Physical symptoms include restlessness, being easily fatigued, muscle tension, stomach aches or headaches that cannot be explained by physical causes, difficulty concentrating, and sleep disturbances, which can manifest in different ways, such as difficulty falling asleep or difficulty staying asleep and irritability (Bilsky & Friedman, 2022; Gouze et al., 2021; Hanna, 2020; Howard et al., 2017; Meers et al., 2020; Mohammadi et al., 2020; Theuring et al., 2023; Yang, 2023; Zygouris et al., 2022). The child with GAD often struggles with perfectionism, making mistakes and is overly self-critical (Hanna, 2020; Howard et al., 2017; Meers et al., 2020; Mohammadi et al., 2020; Theuring et al., 2023; Yang, 2023). In addition, they have a difficulty with uncertainty and making decisions (Meers et al., 2020). Their struggles with anxiety can lead to isolation and impair their social interaction (Meers et al., 2020; Yang, 2023; Zygouris et al., 2022). To be diagnosed with GAD, children must experience these excessive worries that negatively impact their daily lives over a six-month period (Zygouris et al., 2022).

Prevalence of GAD was evident in a study done in Jiangsu Province, China with middle school students aged 12 to 17 years (n= 22 380); 26.9% of whom exhibited anxiety symptoms (particularly GAD) with 20.6% having a combination of depression and anxiety symptoms (Zhang et al., 2021). Unfortunately, anxiety

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disorders like GAD are often un- or under-diagnosed and untreated, leading to compounded negative impacts on children's lives (Chambers, 2024; DeMartini et al., 2019; Parikh et al., 2022). For example, a study was conducted in the United Kingdom involving 222 children who had a mean age of 9.63; the study explored the reasons why parents do not seek professional support for their children (Reardon et al., 2020). These aforementioned authors found that more than 50% of parents of children with anxiety disorders did not seek professional support for their children as they (parents/caregivers) did not want their child/children to believe they had a problem. For these children, anxiety, particularly GAD, exerts substantial negative effects on their lives. A discussion of these effects now follows.

2.2.3 Negative Effects of Anxiety

Childhood anxiety problems are associated with various and typically enduring adverse outcomes. The long term consequences of anxiety include physical symptoms, risk for co-morbidity, academic difficulties, negatively impacted family functioning, and impaired social relationships (Bailey et al., 2020; Baker et al., 2021; Beesdo, 2009; Brown, 2019; Dadds & Barrett, 2001; Doyle, 2022; Etkin et al., 2022; Harrison et al., 2021; Johnson et al., 2021; Lunn et al., 2023; Nel et al., 2018; Oduntan et al., 2022; Pollard et al., 2023; Reardon et al., 2020; Reiser et al., 2014; Rivera, 2019; Schiele & Domschke, 2018; Schwartz et al., 2019; Spence, 2018; Strawn et al., 2020). Furthermore, behavioural challenges such as self-harm, as well as overall physical health and educational challenges, seem to persist into later childhood as well as teenage and early adult years (Pollard et al., 2023; Nel et al., 2018). Moving from micro- to mesosystems and relevant to my study, these aforementioned negative effects of anxiety will be discussed in greater detail.

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2.2.3.1 Physical Symptoms

Anxiety, including GAD, can manifest in physical symptoms that negatively impact children. Physiologically anxiety, regardless of age, often presents with symptoms such as psychomotor restlessness, rapid heartbeat, increased blood pressure, trembling, dizziness, rapid breathing, increased perspiration, insomnia, and headaches (APA, 2022; Garcia- Adasme et al., 2021). In children, anxiety may manifest as somatic complaints like abdominal pain or vague pain symptoms as well as changes in patterns of eating and sleeping (Doyle, 2022; Meers et al., 2020; Oduntan et al., 2022). Common physical complaints associated with anxiety include headaches, stomach aches, and fatigue (Theuring et al., 2023; Meers et al., 2020). These symptoms can be distressing and may lead to functional impairments, affecting daily activities and overall well-being (Driscoll et al., 2020). Physical symptoms of anxiety can also contribute to decreased engagement in activities and limitations in participation, further exacerbating the negative impact on the child's functioning and quality of life (Ginsburg & Schlossberg, 2002). For example, a study that explored important risk factors for GAD among 800 adolescents in Pakistan, aged 12 to 16, found that physical symptoms like headaches, sleep disturbances and stomach aches, led to decreased engagement in activities the adolescent typically enjoys (Lakhdir et al., 2021). Although Lakhdir et al. (2021) do not mention the types of activities in which the adolescent minimises engagement, activities that adolescents find enjoyable typically include social situations, school and recreational activities (Dadds & Barrett, 2001; de Miranda et al., 2020; Schwartz et al., 2019). Similarly, this finding was supported by Doyle (2022), who provided a general guide for primary care providers on the diagnosis and management of anxiety disorders in children.

2.2.3.2 Co-morbidity

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Anxiety disorders, including GAD, often co-occur with other mental health challenges, which can intensify the negative impacts on children. Anxiety is associated with an increased risk for depression, substance use disorders, and other psychiatric conditions such as post traumatic stress disorder, attachment disorder and phobias (Baker et al., 2021; Beesdo, 2009; Sonmez et al, 2020; DeMartini, 2019; Mohammadi et al., 2020). Studies indicate that individuals with anxiety, particularly GAD, often exhibit higher risks of developing depressive disorders, emphasising the interconnected nature of these mental health challenges (Harrewijn et al., 2021; Schiele & Domschke, 2018, Theuring et al., 2023). For example, in a systemic review and meta-analysis of the consequences of child anxiety problems, Pollard et al. (2023) found that of the eight analyses conducted, seven of the pre-adolescent anxiety problems were associated with mood outcomes, as in depression, when these children became adolescents. In addition, a study in Canada by Odunan et al. (2022), analysing 6023 journal entries from a data base, found that depression was a long-term consequence of anxiety.

Anxiety can also co-occur with other mental health challenges like behavioural challenges, for example, oppositional defiant disorder and neuro-developmental challenges such as attention deficit/hyperactivity disorder (Johnson et al., 2021; Suveg & Zeman, 2004). For example, in a study by Yamamoto et al. (2023), investigating resilience factors in 625 third and fourth grade Japanese children, it was found that co-morbid conditions associated with anxiety included depression, post-traumatic stress disorder, obsessive-compulsive disorders, and attention deficit/hyperactivity disorder. Furthermore, Hanna et al. (2020),McLaughlin et al. (2011) and Sonmez et al. (2020) stated that anxiety disorders in adolescents have been linked to an increased risk of suicidal behaviour. The presence of anxiety with

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other mental health challenges emphasises the need for cautious assessment, and adopting a holistic treatment strategy that addresses the primary and secondary (or comorbid) conditions (Dadds & Barrett, 2001; Doyle, 2022; Gouze et al., 2021; Strawn et al., 2020).

2.2.3.3 Academic Difficulties

The presence of anxiety disorders, including GAD, has been associated with academic difficulties and underachievement (Beesdo, 2009; Brown, 2019; Doyle, 2022; Kurdi et al., 2018; Pollard et al., 2023; Strawn et al., 2020; Yang, 2023; Zygouris et al., 2022). These difficulties may arise from difficulties controlling attention, motivation, decision-making and concentration due to anxiety and the resultant poor academic performance (Beesdo, 2009; Brown, 2019; Zygouris et al., 2022). Cognitive aspects include recurring intrusive thoughts or concerns and avoidance of certain situations due to excessive worry (APA, 2022; DeMartini et al., 2019; Ginsburg & Schlossberg, 2002; Meers et al., 2020). According to Zygouris et al. (2022), anxiety, particularly GAD, can interfere with memory, and problem-solving skills, making it challenging for children to perform well academically. For instance, a study by Yang et al. (2023) examining GAD among 1179 primary school children in China, attributed anxiety to further exacerbating academic difficulties, social impairment, and decreased mental well-being.

Not only does anxiety impact academic achievement, but it also interacts with low academic achievement to further affect a child's performance at school. For example, in a study by Kurdi et al. (2018) involving 424 primary school children in France, it was noted that when high anxiety and low academic achievement co-exist, they exacerbate each other, creating a cycle of negative outcomes like continued poor academic performance, low motivation and reduced engagement in school.

2.2.3.4 Impact on Family Functioning

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The presence of anxiety and GAD in children can have a significant impact on family functioning. It can lead to increased stress and conflict within the family unit (Bilsky & Friedman, 2022; Driscoll et al., 2020; Sonmez et al., 2020). This disruption can affect the parent-child relationship and strain familial dynamics due to the behavioural symptoms such as tantrums, irritability, and emotional outbursts that children with anxiety might exhibit (McLaughlin et al., 2011; Doyle, 2022). Bailey et al. (2020) highlight the possible overall reactivity in family members in reaction to the child's persistent anxiety. Parents may experience distress and are challenged in understanding and supporting their child's anxiety, leading to disruptions in family life (Beesdo et al., 2009; Bilsky & Friedman, 2022).

For example, the anxious behaviours in children leading to increased family conflict and negative parenting practices was found in a study conducted in Iran by Mohammadi et al. (2020) with 29 709 children (aged 6 to 18). Additionally, a study conducted in America by Driscoll et al. (2020), investigating the prevalence and impact of anxiety in 14 children (between the ages of 4 and 8) with Autism Spectrum Disorder, found that anxiety-related impairments in daily living skills and social interactions also contributed to increased caregiver burden in terms of time and attention. These examples highlight how the added responsibility, challenges in understanding their child's anxiety and possible feelings of helplessness in managing their child's anxiety, can result in poor parenting practices and familial conflict.

2.2.3.5 Impaired Social Relationships

Social dimensions encompass the impact on interpersonal functioning and social adaptation (Garcia-Adasme et al., 2021). The persistent need for reassurance due to a consistent state of unease in children experiencing GAD symptoms, can result in impaired relationships with teachers, caregivers and friends (Doyle, 2022).

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In addition, Beesdo (2009) highlighted that children who are anxious often struggle to initiate or maintain conversations, maintain friendships and struggle in group activities at school. Anxiety often results in social isolation and impaired social relationships (Meers et al., 2020; Yang, 2023; Zygouris et al., 2022). Children with anxiety disorders may experience social impairment like difficulties in peer relationships and friendships, social withdrawal, and avoidance of emotionally arousing situations (Hirshfeld-Becker et al., 2007; Spence, 2018; Suveg & Zeman, 2004). For instance, a review exploring a potential diagnostic biomarker for paediatric GAD, found that social problems and difficulties in peer interactions can further contribute to feelings of loneliness, isolation, and reduced quality of life for children with GAD or other anxiety disorders. This review included 41 studies conducted in the United States, Canada, Australia, New Zealand, Europe and Asia (Hanna et al., 2020). Additionally, the extensive study involving Iranian children with GAD previously mentioned (see Section 2.2.3.4), also suggests that anxiety is linked to social challenges, such as trouble initiating and sustaining social connections, withdrawing from social interactions, and experiencing social isolation (Mohammadi et al., 2020). These studies, conducted with different methodologies and in various contexts, highlight a common theme: anxiety negatively affects peer relationships. This could be because anxiety-related avoidance behaviours limit opportunities for the development of appropriate social behaviours and peer relationships (Driscoll et al., 2020).

2.3 Possible Origins of Anxiety

A wide range of risk factors, encompassing both micro- and macro-systemic processes, contribute to the development and prevalence of GAD in children. These risk factors include demographic, biological, psychological and environmental

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variables. Demographic variables include age and gender (Beesdo et al., 2009; DeMartini et al., 2019; Doyle, 2022; Garcia-Adasme et al., 2021; Ginsburg & Schlossberg, 2002; Kurdi et al., 2018; McLaughlin et al., 2011; Mohammadi et al., 2020; Nasab & Alipour, 2015; Zhang et al., 2021). Biological variables include the genetic predisposition influenced by a family history of mental health disorders (Bilsky & Friedman, 2022, Ginsberg & Schlossberg, 2002; Marzilli et al., 2021; McLaughlin et al., 2011; Suveg & Zeman, 2004). Psychological variables include temperament traits, difficulties with emotion regulation, low emotional self-efficacy, low self-esteem, perfectionism, and a tendency towards pessimism (Ginsberg & Schlossberg, 2002; Lunn et al., 2023; Luthar & Eisenberg, 2017; Masten & Motti-Stefanidi, 2020; McLaughlin et al., 2011; Suveg & Zeman, 2004; Ungar, 2019; Yoshikawa et al., 2020; Zygouris, 2022). Environmental variables include adverse childhood experiences (ACEs) such as parental separation/divorce, caregivers with mental health challenges that impact their care-giving role and family functioning, peer victimisation/bullying, discrimination, negative parenting styles and disasters like COVID-19 (Beesdo et al., 2009; Porter et al., 2021; Theuring et al., 2023; Yang, 2023; Yoshikawa et al., 2020). These risk factors can interact with each other and contribute to the development and maintenance of anxiety disorders in children (Ginsberg & Schlossberg, 2002). For instance, when the genetic basis of an anxious temperament interacts with environmental factors, such as parenting practices and exposure to stressors, it can further shape the development of anxiety disorders (Ginsberg & Schlossberg, 2002; McLaughlin et al., 2011).

2.3.1 Demographic Variables

Several research studies have explored the connection between demographic variables and anxiety disorders in children (Beesdo et al., 2009; DeMartini et al.,

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2019; Doyle, 2022; Garcia-Adasme et al., 2021; Ginsburg & Schlossberg, 2002; Kurdi et al., 2018; McLaughlin et al., 2011; Mohammadi et al., 2020; Nasab & Alipour, 2015; Zhang et al., 2021). Among these studies, there is a general understanding that the prevalence of GAD is more widespread among girls than boys (Beesdo et al., 2009; DeMartini et al., 2019; McLaughlin et al., 2011; Mohammadi et al., 2020; Zhang et al., 2021). Contrary to this finding, a specific study conducted in Spain by Garcia-Adasme et al. (2021), focussing on the anxiety effects of the lockdown during the COVID-19 pandemic on children over 7 years, found that boys exhibited higher levels of anxiety than girls (Garcia-Adasme et al., 2021). This dissimilar finding was not as a result of a gender imbalance as the gender difference in participants was not significant. This discrepancy may be attributed to the circumstances surrounding each child's confinement during the study. Additionally, the parents of the younger child participants in this research study responded on behalf of their children, which could have influenced this finding.

In addition to gender, age-related differences in the incidence, reporting and prevalence of anxiety disorders have been noted. As previously mentioned (see Section 2.2.1), childhood is considered a high risk period for the emergence of anxiety disorders (Ginsburg & Schlossberg, 2002; McLaughlin et al., 2011; Nasab & Alipour, 2015). Children between the ages of 6 and 11 years appear to be particularly vulnerable (Doyle, 2022). To illustrate, a study conducted in Canada involving Grade 3 to Grade 5 students (n = 424), found that eight-year-olds were especially susceptible (Kurdi et al., 2018).

2.3.2 Biological Variables

2.3.2.1 Genetic Predisposition

Numerous studies support the theory that children of parents with anxiety disorders are more likely to develop anxiety disorders themselves (Bilsky &

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Friedman, 2022, Ginsberg & Schlossberg, 2002; Marzilli et al., 2021; McLaughlin et al., 2011; Suveg & Zeman, 2004). While it is possible that these children are modelling their parents' anxious ways of being, anxiety disorder may have a moderate to high degree of heritability (Troller-Renfree et al., 2019). For example, an extensive review of the literature on the role of parental factors in childhood anxiety conducted by Ginsberg and Schlossberg (2002) reported that up to 60% of children of anxious parents meet the criteria for an anxiety disorder. Additionally, a comprehensive review of the literature on anxiety in children and adolescents reported an increased risk for children when both parents have an anxiety disorder (Beesdo et al., 2009). Mohammadi et al. (2020) also found associations between maternal history of psychiatric hospitalization or internalising symptoms and GAD in children (for details of that study see Section 2.2.3.4). Additionally, a study with 487 parents of children aged 2 to 16 in Italy explored the complex relationship between parents' distress due to COVID-19 and children's psychological challenges (Marzilli et al., 2021). These studies collectively demonstrate the influence of biological variables, such as the genetic predisposition and familial transmission, in the development of anxiety disorders in children of parents with anxiety disorders.

2.3.3 Psychological Variables

2.3.3.1 Heightened Anxiety-Related Temperament

Temperament, which refers to a child's innate personality traits, plays a crucial role in the development of anxiety disorders, including GAD, in children (Sahithya & Raman, 2021). Temperament includes factors such as sociability, emotional agitation/disturbance, neuroticism, behavioural inhibition (shyness, fearfulness and avoidant), energy, predictability of daily routines such as sleeping and eating patterns (referred to as rhythmicity) and distractibility (Beesdo et al., 2009; Sahithya & Raman, 2021; Troller-Renfree et al., 2019). Behavioural inhibition

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is a specific temperamental trait that has consistently been associated with an increased risk of anxiety disorders (Beesdo et al., 2009; Ginsberg & Schlossberg, 2002).

Behavioural inhibition is characterized by fearfulness and timidity in unfamiliar or novel situations (Troller-Renfree et al., 2019). Children with behavioural inhibition are more likely to avoid or withdraw from unfamiliar or challenging situations and have a heightened physiological reactivity to stress which makes them susceptible to the development of anxiety (Ginsberg & Schlossberg, 2002; Troller-Renfree et al., 2019). It has been suggested that behavioural inhibition may have a genetic component, as children with this temperament often have parents with anxiety disorders (Beesdo, 2009). However, in my view, the echoed anxiety in children could also be as a result of parents modelling anxious behaviour.

2.3.3.2 Emotion Regulation Difficulties

Emotion regulation is a psychological skill that influences anxiety disorders. Emotion regulation involves being able to understand and cope with emotions effectively, in a manner that is adaptive and socially acceptable (Suveg & Zeman, 2004; Zygouris et al., 2022). It refers to the ability to monitor, evaluate and moderate one's emotional experiences by being aware of and adjusting one's responses in situations especially when faced with stress or intense emotions (Kok, 2020; Marzilli et al., 2021; Suveg & Zeman, 2004). Being able to regulate one's emotions promotes psychological well-being.

Children need to be able to regulate their emotions as it helps them respond appropriately to difficult situations. Challenges in regulating emotions can impact how children manage stressful circumstances, increasing feelings of anxiety (Marzilli et al., 2021; Suveg & Zeman, 2004; Zygouris, 2022). Children also need parents who

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are able to regulate their own emotions, particularly during times of high stress (Marzilli et al., 2021).

Low emotional self-efficacy is also linked to anxiety in children as it relates to the belief in one's ability to regulate one's emotions (Suveg & Zeman, 2004). A characteristic of low emotional self-efficacy is a lack of confidence in managing one's own emotions (Brown, 2019). For example, in the United States, research conducted to study 26 children aged 8 to 12 diagnosed with an anxiety disorder compared to 26 of their counterparts with no anxiety disorder diagnosis, reported that low emotional self-efficacy further exacerbated anxiety in the former group by overwhelming children and making them feel incapable of effectively managing their emotions (Suveg & Zeman, 2004). Emotional self-efficacy also relates to one's ability to manage one's physiological response to stress which helps with emotional regulation (Bailey et al., 2020).

2.3.3.3 Negative Affectivity

Negative affectivity, which is a general tendency to experience undesirable emotions like sadness, anger and fear, has also been implicated in increasing the risk of anxiety disorders (Beesdo, 2009; Ginsberg & Schlossberg, 2002; Naragon-Gainey & DeMarree, 2017). This negative affectivity is also closely connected to the temperament trait of neuroticism (Naragon-Gainey & DeMarree, 2017). Furthermore, it is also closely associated with peer rejection and peer victimization as children who are bullied tend to exhibit negative affectivity leading to social withdrawal and difficulties in forming and maintaining relationships with peers (Beesdo, 2009; Rivera, 2019). For instances, the association between peer victimization and negative affectivity was reported in a study with 954 Grade 4 learners in the United States (Rivera, 2019).

2.3.3.4 Low Self-Esteem

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Self-esteem is how an individual assesses their worth or value, based on their abilities, qualities, and accomplishments shaped by personal experiences, interactions with others, and societal norms (Goodman et al., 2022; Lunn et al., 2023). Self-esteem is related to feelings of competence, autonomy and relatedness (Kurdi et al., 2018). Children who face challenges in school settings as a result of scholastic difficulties or physical difficulties resulting in limitations in activities are often at risk for low self-esteem (Johnson et al., 2021).

Low self-esteem is also associated with an increased vulnerability to anxiety disorders, including GAD. (DeMartini et al., 2019; Rivera, 2019). Negative self-perceptions, self-doubt, and excessive self-criticism associated with low self-esteem, fuel anxiety and worry, contributing to the development of GAD symptoms (Goodman et al., 2022; Hanna, 2020; Howard et al., 2017; Johnson et al., 2021; Meers et al., 2020; Mohammadi et al., 2020; Pastrana Riviera, 2019; Theuring, 2023). For example, children exhibiting low self-esteem may be at risk of anxiety as they develop negative beliefs about themselves and feel inadequate (Mohammadi et al., 2020). Moreover, children struggling with anxiety may adopt detrimental behaviours such as negative self-talk (dwelling on perceived flaws or shortcomings) and over-thinking, further intensifying their anxious symptoms (Meers et al., 2020; Mohammadi et al., 2020).

2.3.3.5 Perfectionism

Perfectionism characterized by setting excessively high standards, doubts about being able to achieve these standards, perceptions regarding parental expectations, self-criticism and worrying about making mistakes, contributes to the development of GAD (Flett & Hewitt, 2020; Lunn et al., 2023). For example, a meta-analysis of 121 studies from the Middle East, Asia, South America, and Europe

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provided insights into how perfectionistic tendencies, particularly the fear of making mistakes and harsh self-criticism, significantly contribute to the severity and onset of anxiety disorders (Lunn et al., 2023).

2.3.4 Environmental Risk Variables

Various environmental variables can cause or worsen anxiety. These include adverse childhood experiences (ACEs), parenting practices and, because of the timing of my study, the COVID-19 pandemic. Although my study is based in South Africa, these environmental variables apply universally.

2.3.4.1 Adverse Childhood Experiences (ACE)

Adverse childhood experiences (ACEs) have the potential for substantial negative impact on a child's development and their response to stress, as evident in multiple studies (Clayborne et al., 2021; Clemens et al., 2019; Craig et al., 2022; Cronholm et al., 2015; Doyle, 2022; Elmore & Crouch, 2020; McLaughlin et al., 2011; Mesman et al., 2021; Rivera, 2019; Reiser et al., 2014; Schiele & Domschke, 2018). The original ACE study by Felitti et al. (1998) investigated the relationship between seven categories of ACEs, namely, psychological and physical abuse, sexual abuse, exposure to substance abuse in the household, exposure to mental illness in the household, aggressive treatment of the maternal figure, and exposure to illegal behaviour in the household. This pioneering research found a clear association between ACEs and health risk behaviours, diseases, and mental health challenges in adulthood. A subsequent study with 264 university students (214 female, 50 male) aged 17 to 60, linked ACE-related anxiety to physical symptoms (Reiser et al., 2014). This study confirmed that cumulative ACEs significantly predicted “health anxiety” (i.e. worry regarding one’s health) (Reiser et al., 2014, p. 407).

Subsequent studies have expanded the original ACE categories, strengthening the relationship between childhood adversities and their long-term

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impact on psychological and physical outcomes (Clemens et al., 2019; Cronholm et al., 2015; Elmore & Crouch, 2020). Clemens et al. (2019) extended the ACE framework to encompass a wider range of household dysfunctions and child maltreatment, namely, emotional abuse, physical abuse, sexual abuse, emotional neglect, physical neglect, separation of parents, mental illness in the household, substance abuse by a household member, and violence against the mother. Cronholm et al. (2015, p. 1) introduced both traditional household-level adversities, known as “conventional ACEs”, and community-level adversities, termed “expanded ACEs”, which include witnessing community violence, experiencing racism, living in an unsafe neighbourhood, experiencing bullying, and having a history of living in foster care. Elmore and Crouch (2020) incorporated witnessing household violence, exposure to neighbourhood violence, racial/ethnic mistreatment, and economic hardship into their study. These expansions ensured a comprehensive understanding of the multifaceted nature of childhood adversities and emphasised the significant impacts these expanded ACE categories have on a child's development and well-being (Clemens et al., 2019; Cronholm et al., 2015; Elmore & Crouch, 2020). Collectively, these studies (Clemens et al., 2019; Cronholm et al., 2015; Elmore & Crouch, 2020) revealed that children exposed to multiple ACEs were at a higher risk of experiencing anxiety. For instance, the ACE of peer victimization does not only predict anxiety symptoms, but can also significantly contribute to exacerbating existing anxiety (Clemens et al., 2019; Johnson et al., 2021; Rivera, 2019; Pollard et al., 2023;).

The impact of ACEs on mental health has been supported in a study in Philadelphia, Pennsylvania (n= 1784 adults) in a socioeconomically and racially diverse population (Cronholm et al., 2015). Furthermore, an analysis of data (2016-

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2017 National Survey of Children's Health) (U.S. Department of Health and Human Services, 2019), consisting of a sample of 39,929 children across the United States, found that higher exposure to ACEs was significantly associated with increased odds of anxiety, particularly among older children. These additional categories are particularly relevant in the South African context, which grapples with the enduring effects of its political history, resulting in hardships that can contribute to mental health challenges. A cross-sectional national survey conducted in South Africa (n = 3402 adults) found that 23.6% of participants reported an ACE score of 4 or greater, with higher levels of ACE exposure significantly associated with increased likelihood of probable anxiety (Craig et al., 2022).

In addition to the aforementioned ACEs, factors such as parental divorce/separation, the loss of a parent, and inter-parental conflict have been included in the ACEs and linked to childhood anxiety in various studies (Beesdo, 2009; Clayborne et al., 2021; Clemens et al., 2019; Elmore & Crouch, 2020). These studies emphasise that the disruption of family dynamics and the associated emotional stress are fundamental factors enhancing the likelihood of anxiety symptoms. For example, a study conducted via a population-based survey in Europe among children aged 14 years and above, found that household dysfunction and child maltreatment was linked to anxiety among other negative consequences (Clemens et al., 2019).

Furthermore, based on a study of 34 653 American adults, McLaughlin et al. (2011) found that childhood adversities, including parental maladjustment such as inter-parental violence, were associated with an increased risk of mental health challenges in both childhood and later in life. Another study by Zhang et al. (2021), encompassing 23 025 adolescents aged 11 to 18, from seven junior high schools in

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China, reported that adolescents from harmonious families exhibited fewer anxiety symptoms than those from single-parent families or families marked by conflicting parental relationships. Similarly, a scoping review of 75 studies conducted in Europe on the impact of COVID-19 on vulnerable communities, including children, found that challenging family relationships were predictive of anxiety symptoms in children of all ages (di Fazio et al., 2022). The heightened anxiety in families characterised by difficult relationships or single parenting may be attributed to increased stress levels and a lack of support for children, especially when parents are preoccupied with other challenges, such as financial difficulties, as often observed in single-parent households. These stresses were exacerbated during the COVID-19 pandemic, as they overlapped with health-related anxieties, creating additional stressors within the family unit. Despite variations in target age groups and geographic populations, the studies by di Fazio et al. (2022), McLaughlin et al. (2011), and Zhang et al. (2021) consistently reported that family-related challenges are strongly associated with childhood anxiety, drawing attention to the important role of the family system in children's development and well-being across different ages and locations.

2.3.5 Ineffective Parenting and Anxiety

Insights from various authors emphasise the harmful impact of ineffective parenting practices on childhood anxiety in a wide variety of contexts (Bailey et al., 2020; Baker et al., 2021; Bilsky & Friedman, 2022; Clemens et al., 2019; Doyle, 2022; Gouze et al., 2021; Harrison et al.; 2021; Howard et al., 2017; Mohammadi et al., 2020). In the context of socio-economic adversity, placing a great deal of pressure on parents can lead to abusive parenting styles, exacerbating anxiety in children (Harrison et al., 2021). In addition, parents with GAD may struggle to effectively manage negative emotions, potentially contributing to anxiety onset in

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children or leading to maladaptive responses to their child's anxiety symptoms (Bilsky & Friedman, 2022; Mohammadi et al., 2020).

In relation to separation and divorce (one of the ACEs mentioned in the previous section), the inadvertent exposure of children to chronic worry and perceived danger in complex post-separation cases, typically contributes to emotional dysregulation and manifestation of anxiety (Bailey et al., 2020). This exposure and perceived danger often stems from parental conflict during divorce. Furthermore, parental separation can exacerbate anxiety by disrupting secure parent-child attachments (Clemens et al., 2019).

Parents play a critical role in the recognition and management of anxiety symptoms in children (Bilsky & Friedman, 2022; Doyle, 2022; Mohammadi et al., 2020). Parents inadvertently reinforce their child's anxiety by overprotecting them. In order to accommodate their child’s anxious fears, parents may allow avoidance of situations, which can further entrench the child’s anxiety (Doyle, 2022). Parental overprotection restricts children's exposure to challenges, typically hindering their ability to develop coping mechanisms and exacerbating fear and anxiety (Gouze et al., 2021; Howard et al., 2017).

A family system that supports a child’s well-being includes effective parenting. Effective parenting is intertwined with parenting style. There are different parenting styles, each with a distinct impact on childhood anxiety (Abed et al., 2023; Kelly et al., 2021). Parenting styles are characterized by a collection of enduring attitudes and behaviours that parents consistently exhibit in their interactions with their children, regardless of various situations and over time (von Suchodoletz et al., 2011). These distinct parenting styles encompass authoritative, authoritarian, permissive, and neglectful approaches. Baumrind's (1973) pioneering research

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noted that the degree of warmth and control exhibited by parents contributes significantly to the formation of each of these distinct parenting styles. Parental warmth involves being responsive to the child's needs, accepting the child, and showing positive approval, with the aim of promoting self-efficacy, self-reliance, and self-assertiveness in children. Parental monitoring/control, on the other hand, refers to the level of structure, expectations, and demandingness that parents place on their children through disciplinary and supervising measures (Masten & Palmer, 2019; Roman et al., 2016). The parenting styles related to risk for anxiety are: authoritarian, permissive, and neglectful parenting styles (Abed et al., 2023; Kelly et al., 2021; Rothenberg, 2021, 2023). As authoritarian, permissive, and neglectful parenting styles each have unique negative impacts on children's anxiety levels, I discuss each of these parenting styles next.

2.3.5.1 Authoritarian Parenting

Authoritarian parenting, characterized by strict rules and low warmth, has been linked to higher levels of anxiety in children (Kelly et al., 2021; Meers et al., 2020). The controlling nature of this parenting style creates a fear-based environment with a fear of failure and a constant need for approval, hindering the development of healthy coping mechanisms and healthy development (Butterfield et al., 2021). This type of control has been classified as coercive control and is characterized by arbitrary and domineering parental behaviour, negatively impacting the child (Pinquart & Gerke, 2019). Coercive control relies on threats and power assertion and can hinder the development of autonomy and expression of opinions in a healthy and outcome-oriented manner. Authoritarian parents may also use psychological control, which refers to using disappointment, guilt and shame to manipulate and control their children, which induces anxiety as this control pressures

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a child into thinking in a particular way (Bilsky & Friedman, 2022). For example, a study with adolescents (n = 544) and their mothers (n = 530) from six cultural groups, namely, Colombian, Neapolitan, Roman, African American, European American and Latin cultures, found that higher psychological control increased internalising symptoms such as anxiety in adolescents (Lunetti et al., 2021).

Research consistently indicates that authoritarian parenting is associated with elevated anxiety levels in children. Examples include Abed et al. (2023) who found a correlation between authoritarian parenting and anxiety symptoms in children in their study with 121 Saudi adults who gave their perspective of childhood anxiety in the survey. Similarly, Sahithya and Raman (2021) emphasised the negative impact of authoritarian parenting on anxiety outcomes in a study with 42 children aged 8 to 12 in India. Additionally, the research of Fox et al. (2021) involving 182 Grade 4 and Grade 5 learners from New York, emphasised the influence of authoritarian parenting on the emergence of negative cognitive patterns in children. These patterns manifest as beliefs in their inherent inadequacy and 'unlovability', as well as an expectation of rejection or abandonment by others. Such cognitive tendencies, or hopeless attributional style, are closely linked to a sense of heightened vulnerability and the accompanying experience of anxiety (Fox et al., 2021). Children with a hopeless attributional style believe that negative events are their fault and that they are incapable of changing the situation (Pastrana Rivera, 2019).

What the aforementioned study by Fox et al. (2021) also shows is the negative impact of limited parental warmth that often characterises authoritarian parents. The absence of parental warmth typically hinders the development of healthy coping mechanisms, making it difficult for children to regulate their emotions and effectively navigate stressful situations (Butterfield et al., 2021). This concept

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that lower levels of parental warmth can predict anxiety in children was demonstrated in a study involving a diverse group of participants. The study included 1315 children, 1275 mothers and 1032 fathers from nine different countries, including Africa (Kenya); China; Colombia; Italy; Jordan; Philippines; Sweden; Thailand; and the United States (Rothenberg et al., 2020a). When combined with strict control, lack of parental warmth creates an environment that perpetuates anxiety symptoms and reduces children's resilience in the face of challenges (Rothenberg et al., 2020a). Likewise, a study with 121 adults in Saudi Arabia found that authoritarian parenting lacking in warmth contributed to anxiety symptoms in children, as the communication style of their parents was fear inducing (Abed et al., 2023).

2.3.5.2 Permissive Parenting

Permissive parenting, characterized by low demands and high warmth, can also contribute to anxiety in children (Abed et al., 2023). The lack of structure and inconsistent discipline in permissive parenting can lead to a sense of insecurity and uncertainty, which can increase anxiety levels (Kelly et al., 2021). Without clear boundaries and expectations, children may struggle to regulate their emotions and face challenges effectively, contributing to heightened anxiety (Butterfield et al., 2021).

Various studies have found a positive correlation between permissive parenting and anxiety levels in children (Clayborne et al., 2021; Sahithya & Raman, 2021). For example, a study in India involving 42 children aged 8 to 12 years, found that permissiveness of fathers increased the chance of anxiety in children (Sahithya & Raman, 2021). Similarly, a review of 19 studies with varying sample sizes (50 to 13 292) drawn from eight countries (Belgium, Canada, Germany, Netherlands,

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New Zealand, Spain, and the United Kingdom), found a positive correlation between permissive parenting and anxiety in children (Clayborne et al., 2021). The lack of consistent boundaries and expectations in permissive parenting leaves children without the necessary framework to navigate the demands of life, potentially contributing to heightened anxiety symptoms.

2.3.5.3 Neglectful Parenting

Neglectful parenting, characterized by low warmth, low demands, with an absence of attention, support, and responsiveness, also has adverse effects on the development of anxiety symptoms in a child (Abed et al., 2023; Kelly et al., 2021; Rothenberg, 2022, 2023). Parents who use this parenting style have limited communication with their children. Limited communication and the absence of a safe space for children to express their feelings are associated with higher levels of anxiety symptoms in children (Butterfield et al., 2021). This type of environment impedes the building of trust and understanding, further increasing the possibility for the development of anxiety (Romero-Acosta et al., 2021; Sahithya & Raman, 2021; Vigdal & Brønnick, 2022). For example, various studies by Rothenberg et al. (2020a, 2020b, 2020c, 2020d, 2021, 2022) with 1338 children, 1283 mothers and 1170 fathers from nine countries reported that neglectful parenting results in the child presenting with internalising symptoms such as anxiety.

2.3.6 Disasters and Anxiety

Disasters, like extreme weather events, health pandemics, and acts of terrorism, pose widespread threats to the development and psychological wellbeing of children (Masten, 2021a). One recent example of such a disaster is the COVID-19 pandemic (Lakkunarajah et al., 2022). Extensive studies have highlighted the global mental health challenges brought about by the COVID-19 pandemic (de Man et al., 2022; Fouché et al., 2020; Luthar et al., 2020; Masten & Motti-Stefanidi, 2020;

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Nyashanu et al., 2020; Subramaney et al., 2020). Children were not exempt from these challenges (Lakkunarajah et al. et al., 2022).

The COVID-19 pandemic had far reaching impacts on various aspects of life, including health, well-being, social interactions, and the economy, thereby profoundly disrupting the support systems that children rely on, including their friendships, families, schools, and communities (Luthar et al., 2020; Masten & Motti-Stefanidi, 2020; Yoshikawa et al., 2020). One consequence was a significant rise in levels of anxiety among children. A study of 18 systematic reviews, comprising 366 research papers (some conducted in Africa), explored the impacts of COVID-19 on the mental health of children, and found that the pandemic and its associated mitigation measures resulted in heightened levels of anxiety among children globally (Harrison et al., 2022). Similar outcomes were observed in another systematic review consisting of 75 articles across different populations showing that 43.8% of children aged 7 years and above displayed symptoms of anxiety during periods of lockdown (di Fazio et al., 2022).

Children from disadvantaged backgrounds, who were already facing hardships such as poverty and limited healthcare access, bore a heavier burden from the effects of the pandemic (Masten & Motti-Stefanidi, 2020; Yoshikawa et al., 2020). Moreover, the loss of caregivers due to the COVID-19 pandemic had profound repercussions. This not only led to a rise in orphan rates per month during the initial phase of the pandemic, but also plunged many children into emotional distress, heightening their vulnerability to mental health challenges (Goodman et al., 2022; Unwin et al., 2022).

The mental health of children in South Africa has been significantly affected by the COVID-19 pandemic and subsequent lockdown measures. Increased

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instances of domestic violence, parental stressors, and the loss of loved ones (over 80 000 deaths by August 2021, according the National Institute for Communicable Diseases [NICD], (2021, August 26) led to heightened levels of stress and anxiety among South African children (Munir, 2021; Unwin et al., 2022; van der Berg et al., 2020). Lockdown measures, including school closures, specifically exacerbated anxiety in younger South African children for various reasons (Bloom et al., 2022). With the closure of schools, parents had to take on the added responsibility of home-schooling, placing more strain and feelings of overwhelm on parents and families (Munir, 2021).

Economic stresses brought by the pandemic made it difficult for parents to tend to their children's most basic needs (Goodman et al., 2022; Harrison et al., 2022; Unwin et al., 2022; van der Berg et al., 2020). In some families, co-parenting and custody arrangements added stress to the lives of families during lockdown (Subramaney et al., 2020). Lockdown resulted in limited access to healthcare (Janssen et al., 2020).

In South Africa, many children rely on school-based feeding initiatives as their primary source of a daily meal. With schools closed during lockdowns this essential support was missing. Children's uncertainty of when the next meal would be available understandably increased anxiety among children in these challenging circumstances (Munir, 2021; Subramaney et al., 2020; van der Berg et al., 2020).

Additionally, the increase in violence and sexual abuse during the pandemic further added to anxiety among children, as seen in the rise in calls received by Childline South Africa (Munir, 2021). A comparison of 'help requests' received by Childline South Africa shows a 36.8% increase in requests between August 2019 and August 2020, (United Nations International Children's Emergency Fund

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(UNICEF), 2020). Overall, reports of abuse increased 61.6% during the COVID-19 pandemic, particularly emotional abuse (Fouché et al., 2020).

South African based studies varied in their research methods. Bloom et al. (2022) conducted interviews with parents, children, and adolescents aged 4 to 18 in South Africa. Van der Berg et al. (2020) were part of the National Income Dynamics Study –Coronavirus Rapid Mobile Survey, which included questions related to children. Nyashanu et al. (2020) telephonically interviewed adults living in informal settlements while Munir (2021) interviewed children either independently or in the presence of their caregiver/parent. While their methods varied, these studies all concluded that the COVID-19 pandemic, with its multi-systemic risk implications, had a profound impact on the mental health of children, including more children reporting anxiety.

2.3.6.1 The Impact of the Pandemic on Parenting and Child Anxiety

The impact of the pandemic on parenting was noticeable in changes in parental behaviours and emotions. Studies have indicated that parents reported higher levels of negative emotion during the pandemic, indicating increased distress (Bloom et al., 2022; Janssen et al., 2020). For example, a systematic review of 84 articles from 29 countries highlighted that mothers, in particular, faced worsened mental health conditions, with increased rates of depression and anxiety compared to the pre-pandemic period (Fadda et al., 2023). Similarly in a study in the Netherlands, involving 557 parents with young children, it was noted that these parents faced significant challenges during the pandemic due to the transition to parenthood and the postpartum period (van den Heuvel et al., 2022). Despite variations in contexts and methodologies, the findings of both the review and Netherlands-based study aligned. To me, this suggests a degree of consistency in

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the findings regarding the impact of the pandemic on a parent's mental health, with a specific focus on increased anxiety and distress. This impact on a parent's mental health can potentially affect children by increasing their anxiety as well (Bilsky & Friedman, 2022, Ginsberg & Schlossberg, 2002; Marzilli et al., 2021; McLaughlin et al., 2011; Suveg & Zeman, 2004).

The COVID-19 pandemic significantly affected how parents care for their children, particularly in relation to lockdown measures (see Section 2.3.5). Lockdown measures led to social isolation, school closures, limited play opportunities, and substantial changes to lifestyle and routine, leading to challenges for parents and children alike (Bloom et al., 2022; Subramaney et al., 2020; van der Berg et al., 2020). Additionally, financial strain caused by the pandemic worsened existing stressors, negatively impacting parents and their parenting (Munir, 2021). The pandemic in South Africa caused disruptions in social support systems making it harder for parents to seek assistance when necessary, as indicated by a review of 48 studies (Munir, 2021). Given the link between parenting and child anxiety (see Section 2.3.5), it is understandable that the negative impacts of the COVID-19 pandemic on parents' capacity to parent warmly and responsively led to increased stress and anxiety among children.

2.4 Protective Factors and Processes

Resilience, which is demonstrated through positive or better-than-expected outcomes and adaptive behaviours among children exposed to significant stress, serves as evidence of children's ability to respond adaptively to stress exposure (Masten, 2014, 2021a; Wu & Ou, 2021). While children display varying levels of adaptive responses to risk exposure, the presence of protective factors and processes helps explain these differences in response adequacy. Typically, children

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who are exposed to high levels of risk, respond adaptively when they can draw on resources within themselves (for example biological or psychological strengths), their families (for example, caring parents or other supportive relatives), their communities (for example, enabling schools or effective mental health supports), and their physical environment (for example, spaces and places to play safely) (Masten et al., 2021; Pillay et al., 2023; Theron & van Breda, 2021; Ungar & Theron, 2020). In Sections 2.4.1, 2.4.2 and 2.4.3, I focus on the protective factors from personal to environmental systems that are strongly associated with children's resilience to anxiety.

2.4.1 Personal Resources and Resilience

Self-efficacy, a child's belief in their ability to cope with stressors, is a crucial individual protective resource (Masten, 2014; Masten & Motti-Stefanidi, 2020). When children feel capable of managing stress, they are more likely to feel empowered to confront challenges and overcome adversity. Ungar (2011) emphasised the importance of promoting self-efficacy as part of interventions aimed at fostering resilience in children and youth, which would be particularly important in the face of anxiety.

Research suggests that children with self-efficacy are more likely to perceive challenges as opportunities for growth rather than insurmountable obstacles, enabling them to navigate adversity more effectively and maintain positive outcomes (Southwick et al., 2014). For example, a study of 1031 German adults, investigating the effects of daily stress on mental health, found that self-efficacy acted as a buffer on the effects of daily stressors (Schönfeld et al., 2016). Similar benefits linking self-efficacy and resilience to anxiety were reported in a systematic review and meta-analysis that synthesized findings from 19 studies between parenting practices and

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anxiety in children (Clayborne et al., 2021). Furthermore, the benefits of self-efficacy to resilience against anxiety was found in studies with 127 primary school children in New York (Fox et al., 2021) and 100 orphaned children aged 7 to 17 in Ghana (Salifu Yendork & Somhlaba, 2015). Self-efficacy can therefore be considered a protective resource against anxiety across different settings.

Another key factor that supports individuals in dealing with challenges is adaptive coping skills (Bonanno & Mancini, 2008). Children who can regulate their emotions, can effectively solve problems, and employ positive coping strategies are better prepared to handle stress and difficulties (Luthar et al., 2020; Ran et al., 2020; Schiele & Domschke, 2018). Adaptive coping skills include practices like employing problem-focused strategies to tackle situations through actions, mindfulness techniques, positive self-talk, and cognitive reframing (Bonanno & Mancini, 2008; Harrison et al., 2021; Kalisch et al., 2017). These coping mechanisms can enhance resilience and buffer symptoms of anxiety (di Fazio et al., 2022; Schiele & Domschke, 2018; Southwick et al., 2014). For instance, a study in America with 210 Grade 3 to Grade 5 children, which specifically explored how children's self-efficacy and coping skills relate to their ability to manage their anxiety, suggested that children with greater self-efficacy are likely to develop more adaptive coping skills (Suveg & Zeman, 2004). Adaptive coping skills can be enhanced through quality education, strong caregiver support and access to community resources (Harrison et al., 2022).

Adaptive coping skills matter for the resilience of South African children too. A critical review of 61 resilience studies with South African children from 2008 to 2016 reported on personal resilience enablers, which included coping skills and self-efficacy that assisted children in adapting to stressors and challenges (van Breda &

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Theron, 2018). Strengthening children's coping mechanisms could help them manage anxiety symptoms, but, despite an extensive search I was not able to find South African studies that have investigated how to do this with regard to GAD. Pertinent to my study is strengthening adaptive coping skills through supportive relationships, like strong caregiver support, which will be further elaborated on.

2.4.2 Supportive Relationships

One of the most important protective resources, especially for children, is supportive relationships (Luthar, 2006; Yoon et al., 2021). Supportive relationships, particularly the parent-child relationship, play a fundamental role in fostering resilience. With regard to anxiety, supportive relationships provide a sense of security, competence, control, and stability, acting as a protective shield against anxiety (Abed et al., 2023; Aigba et al., 2020; Masten & Motti-Stefanidi, 2020; Vigdal & Brønnick, 2022). Positive parent-child communication reinforces the supportive relationships between parents and children, characterized by connectedness, trust, flexibility, respect, and active support for children (Abed et al., 2023).

Supportive relationships also enhance empathy, validation, and encouragement, providing emotional support that helps children feel understood and cared for (Clayborne et al., 2021; Vigdal & Brønnick, 2022). Secure attachment with parents, a key component of supportive relationships, promotes a sense of safety and security, fostering trust in others and the world around them (Abed et al., 2023; Gouze et al., 2021). Children who feel safe and connected in supportive relationships are less likely to develop anxiety symptoms (Bailey et al., 2020).

For parents to be effective in their supportive roles they need to practice self-compassion (Bag et al., 2022; Belfi et al., 2024; Egan et al., 2022; Haldorai et al., 2023; Kotera & Sheffield, 2020; Kotera et al., 2021; Pérez-Aranda et al., 2021; Ruiz-

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Fernández et al., 2021; Siegel, 2004; Yu et al., 2023). When parents treat themselves with gentleness, kindness and understanding during times of distress, they are better able to regulate their own emotions and respond empathetically and sensitively to their children (Belfi et al., 2024; Kotera & Sheffield, 2020; Siegel, 2004). Self-compassion relies on improved self-awareness and the recognition of the normative nature of parenting mistakes (Egan et al., 2022; Kotera & Sheffield, 2020). Self-compassion allows parents to see stressful situations as transient and helps them feel hopeful in being able to manage these stresses (Haldorai et al., 2023). The practice of self-compassion lessens feelings of inadequacy, self-criticism and self-judgement (Kotera & Sheffield, 2020). It helps to mitigate the development of mental health challenges and strengthen effective parenting (Bag et al., 2022; Belfi et al., 2024; Egan et al., 2022; Haldorai et al., 2023; Kotera & Sheffield, 2020; Kotera et al., 2021; Pérez-Aranda et al., 2021; Ruiz-Fernández et al., 2021; Siegel, 2004; Yu et al., 2023).

Globally, research has shown that besides strong parent-child relationships; peer relationships, relationships with teachers and even relationships with pets are significant protective factors and processes against anxiety (Doyle, 2022; Kurdi et al., 2018; Porter et al., 2021; Yamamoto et al., 2023). These relationships play a fundamental role in providing practical advice, promoting a sense of belonging in children, mitigating feelings of loneliness, and thereby buffering against anxiety (Vigdal & Brønnick, 2022; Yamamoto et al., 2023).

In terms of formal social supports, mental health services support resilience to anxiety in that they help children develop coping skills and problem solving strategies as well as provide positive relationships with supportive adults (de Man et al., 2022). These services can provide evidence-based treatment to help mitigate the effects of

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anxiety, offer support to families to help them better understand anxiety, and develop strategies to manage it (Theron, 2019). Mental health services can provide a supportive and non-judgemental environment for children to help children feel heard and validated. Studies have supported the importance of the quality of experience provided by mental health services and found that quality of service-use experience, rather than the quantity of service use, as paramount in building resilience among youth at risk (Ungar et al., 2013). However, formal social supports are infrequently reported in South African resilience studies (Van Breda & Theron, 2018). This could be because these services are often not appropriately available or accessible in vulnerable communities and the stigma of visiting the facilities that do exist is a barrier to access (de Man et al., 2022; Fouché et al., 2020; Theron, 2019).

2.4.3 Authoritative Parenting and Resilience to Anxiety

Research suggests that effective parenting involves high levels of warmth and an appropriate balance of confrontive or behavioural control, which contributes to optimal social and emotional development in children and was linked to reduced child anxiety across diverse cultures (Baumrind, 1973; Rothenberg et al., 2020a; Sahithya & Raman, 2021). This particular parenting style is known as authoritative parenting. It is basically characterised by warm parenting and moderate control, but also attachment, a sense of belonging, self regulation and a positive view of self and family, which can nurture child resilience (Masten et al., 2021).

2.4.3.1 Warm Parenting

Parenting characterised by warmth, involves creating a nurturing and supportive environment for children marked by acceptance and responsiveness (Abed et al., 2023; Rakhshani et al., 2022; Sahithya & Raman, 2021; Wei & Kendall, 2014). Research studies have consistently shown that warm parenting behaviours significantly impact the development and well-being of children (Butterfield et al.,

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2021; Rothenberg et al., 2020a, 2020b, 2020c, 2020d, 2021, 2022, 2023; Vigdal & Brønnick, 2022). For example, the study by Rothenberg et al. (2020a), previously mentioned (see section 2.3.4.2) found that higher levels of parental warmth were associated with lower levels of anxiety. Yet another study with 1338 children, 1283 mothers, 1170 fathers from the same nine countries as the previous study (i.e. China; Colombia; Italy; Jordan; Kenya; Philippines; Sweden; Thailand; United States), found similar outcomes (Rothenberg et al., 2021). Overall, the studies by Rothenberg et al. (2020a, 2020b, 2020c, 2020d, 2021, 2022, 2023) and Butterfield et al. (2021) collectively demonstrate the enduring influence of warm parenting on anxiety outcomes throughout different developmental stages (i.e., warmer parenting is associated with lower anxiety in children).

Similar results have been found in South Africa. For example, a study in Cape Town comparing the way 40 adolescent boys with conduct disorder and 40 adolescent boys without conduct disorder were raised, found that high levels of parental warmth and support were more likely to result in lower levels of anxiety and better behavioural outcomes in adolescents (Freeze et al., 2014). A similar positive impact of warm parenting on anxiety levels was observed in a study of 1046 adolescents living with HIV in the Eastern Cape (Shenderovich et al., 2021). Theron et al. (2022) explored how warm parenting towards adolescents is associated with better mental health outcomes, in terms of depression and conduct problems. While anxiety was not specifically discussed by these researchers, I theorise that warm parenting will be similarly insulating against the effects anxiety because both depression and anxiety are internalising mental health challenges.

2.4.3.2 Parental Control and Monitoring

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Authoritative parenting uses confrontive/behavioural control (Pinquart & Gerke, 2019). This type of control is firm but not overly strict, negotiated and reasoned. It encourages children to express their opinions in a behaviour-outcome-oriented manner, is consistent, and applies effective disciplinary practices (Baumrind, 1973; Butterfield et al., 2021; Pinquart & Gerke, 2019). Confrontive control is moderate and considers the developmental needs and abilities of children, and has a positive correlation with the cultivation of independence and confidence (Pinquart & Gerke, 2019). When employed effectively, it can anticipate the emergence of characteristics in children that help them thrive (for example, achievement orientation, perseverance, optimism, happiness, independence and positive self-esteem), and ultimately aid in the management and prevention of anxiety (Pinquart & Gerke, 2019; Rothenberg et al., 2021). The benefit of consistent and effective disciplinary practices which promotes confrontive control is illustrated in a systematic review including 19 articles representing samples from eight countries (Belgium, Canada, Germany, Netherlands, New Zealand, Spain, the United Kingdom and the United States), which found that these disciplinary practices support better adjustment and mental health in children (Clayborne et al., 2021). Even though the context was different (Minneapolis public primary schools), a previous study with families (n =205) found the same protective effect (Masten & Tellegen, 2012).

Monitoring, which also relates to control, refers to the degree to which parents are aware of their children's activities, whereabouts and social interactions (Clayborne et al., 2021). A study of 177 perinatal HIV adolescents and their caregivers from Kwazulu-Natal, South Africa, found that moderate monitoring can have a positive impact on the mental health of adolescents (Bhana et al., 2016). Similarly, a study of 891 adolescents from two different disadvantaged communities

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found that moderate monitoring in combination with warmth had a high potential to protect adolescent mental health (Theron et al., 2022).

2.4.3.3 Benefits of Authoritative Parenting

Authoritative parenting, characterized by responsiveness, warmth, democratic participation, good nature and structured boundaries, with clear expectations, fosters healthy development in children (di Giunta et al., 2022; Sahithya & Raman, 2021). The seminal works of Baumrind (1973) and the findings of more recent studies (Abed et al., 2023; Masten et al., 2021), note the benefits of authoritative parenting to emotional, cognitive, and behavioural domains. Authoritative parenting significantly contributes to resilience and emotional regulation, enabling children to adapt to challenges (Baumrind, 1973; Young et al., 2013). Literature on authoritative parenting has highlighted that children of authoritative parents exhibit better emotional regulation and fewer symptoms of anxiety as these children perceive high levels of parental responsiveness (Abed et al., 2023; Bhana et al., 2016; Butterfield et al., 2021; Casale et al., 2015; Clayborne et al., 2021; Creveling-Benefield & Varela, 2019; Davidson et al., 2021; di Giunta et al., 2022; Freeze et al., 2014; Kelly et al., 2021; Masten & Tellegen, 2012; Ojo et al., 2021; Pinquart & Gerke, 2019; Rakhshani et al., 2022; Richards et al., 2012; Romero-Acosta et al., 2021; Rothenberg et al. 2023; Rothenberg et al., 2019; Rothenberg et al., 2020b; Rothenberg et al., 2020c; Rothenberg et al., 2020d; Rothenberg et al., 2021; Sahithya & Raman, 2021; Shenderovich et al., 2021).

Furthermore, the positive reinforcement strategies used by authoritative parents promote consistent, positive, manageable behaviours in children, and enhanced self-esteem, which are protective factors against anxiety (Creveling-Benefield & Varela, 2019; di Giunta et al., 2022; Rakhshani et al., 2022). The direct

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impact of authoritative parenting on reducing anxiety is supported by studies that demonstrate a clear correlation between the high levels of parental responsiveness inherent in this style and lower anxiety symptoms in children (Rakhshani et al., 2022; Sahithya & Raman, 2021). For instance, a study in Iran of 100 adolescent girls (aged 12 to 16 years), found that those with authoritative parents reported higher levels of perceived parental responsiveness, associated with lower anxiety symptoms (Rakhshani et al., 2022). Similarly, a study with 42 children diagnosed with anxiety and a matched control group, found that authoritative parents provide emotional support, encourage independence, and maintain appropriate control levels, all of which reduce anxiety in children (Sahithya & Raman, 2021). The consistent support and reasonable control provided by authoritative parents equip children with effective coping mechanisms, reducing their vulnerability to anxiety and stress (Masten et al., 2021; Sahithya & Raman, 2021).

A core benefit of authoritative parenting is the promotion of autonomy and independence (Abed et al., 2023; Baumrind, 1973). Through positive reinforcement and logical explanations, authoritative parents guide the behaviour of their children without resorting to punitive measures (Creveling-Benefield & Varela, 2019). This in turn promotes autonomy as children from these families practice critical thinking (Abed et al., 2023). This approach enhances decision-making skills and fosters a sense of personal responsibility, empowering children to act independently and confidently (Baumrind, 1973; Bhana et al., 2016). In turn, this structured yet supportive environment characteristic of authoritative parenting also correlates with higher academic achievement, academic motivation and a love for learning (Abed et al., 2023). Children from these households often excel academically due to the

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optimal balance of parental support and the encouragement of independent problem-solving (Adlem, 2017; Baumrind, 1973).

Authoritative parenting promotes emotional regulation in children as children in these families are allowed to express their emotions (Abed et al., 2023; Kelly et al., 2021). The nurturing yet firm approach of authoritative parents fosters a secure attachment and a positive view of the world, essential for emotional stability (Masten et al., 2021; Rothenberg et al., 2021; Rothenberg et al., 2022; Theron et al., 2022). This environment allows children to manage their emotions effectively, contributing to lower anxiety levels and greater emotional well-being (Sahithya & Raman, 2021; Abed et al., 2023).

As effective communication and learning appropriate interaction with others is fundamental in authoritative households, children in these households typically have strong interpersonal skills and are more socially competent (Abed et al., 2023; Baumrind, 1973). Authoritative parents engage in open dialogue that fosters mutual respect and understanding, helping children develop strong communication skills and the ability to navigate social relationships effectively (Adlem, 2017; Baumrind, 1973). In addition, these children often have higher levels of self-confidence and self-esteem (Abed et al., 2023). Additionally, authoritative parenting helps develop a child's empathy for others (Smetana et al., 2019).

2.5 Conclusion

In conclusion, GAD poses various risks to children's well-being, including difficulties in emotional regulation, impaired social functioning, and academic challenges (Brown, 2019; Doyle, 2022; Harrison et al., 2021). To effectively address these risks, it is essential to adopt the multi-systemic understanding of resilience, recognizing the interplay between individual and contextual factors that contribute to

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children's resilience (Luthar, 2006; Masten, 2014; Ungar, 2019), also to GAD. When both the internal strengths of the child and the external support systems are acknowledged, more powerful (in my opinion) interventions can be designed to promote positive outcomes and enhance the well-being of children with GAD.

In Chapter 2, I reviewed the protective resources relevant to my study. This review excluded one formal source of social support for children with anxiety: therapy. Within the therapeutic process, another avenue of support emerges, namely, the parent-psychologist alliance. The parent-psychologist alliance plays a critical role in promoting resilience and positive treatment outcomes for children with anxiety (de Greef et al., 2017; Núñez et al., 2022; Zemmelman, 2018; Zorzella, et al., 2017). Despite its recognised importance, there is limited research on how to effectively establish and nurture this alliance. In the next chapter, after discussing treatment options for GAD in children with the emphasis on sandplay therapy, I propose a solution to this gap in the literature by offering a strategy for building and maintaining a strong parent-psychologist alliance. Addressing this research gap has the potential to further enhance the role of the parent-psychologist alliance in supporting the resilience and well-being of children with GAD.

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Chapter 3

Enhancing Resilience Through Collaboration in Therapy

3.1 Introduction

When trying to support children who struggle with GAD there are several challenges to navigate, which emphasises the importance of protective resources to bolster resilience against anxiety. These challenges and protective resources were discussed in the context of childhood anxiety in Chapter 2. As I transition into the next chapter, the exploration of additional protective resources starts with a focus on formal interventions for anxiety. Evidence-based interventions like medication for anxiety (Brown, 2019; Creswell et al., 2020; Doyle, 2022; Schwartz et al., 2019; Strawn et al., 2020), and Cognitive Behavioural Therapy (CBT) (Creswell et al., 2020; Doyle, 2022; Driscoll, 2020; Etkin et al., 2022; Lunn et al., 2023; Pollard et al., 2023; Reardon et al., 2020; Schwartz et al., 2019; Strawn et al., 2020), will be briefly discussed. This discussion is followed by an emphasis on sandplay therapy for treating anxiety (Akimoto et al., 2021; Batosh & Bartosh, 2019; Borghosian, 2022; Driver, 2022, Elkchirid & Motia, 2022).

The exploration of sandplay therapy lays the groundwork for the subsequent introduction of the parent-psychologist alliance, another subset of protective resources within the context of therapy when children are struggling with GAD (de Greef et al., 2017; Diamond et al., 2000; Feinstein et al., 2009; Fox, 2012; Gvion & Bar, 2014; Kazdin & Whitley, 2006; Nevas & Farber, 2001; Ruberman, 2009; Zemmelman, 2018). In this chapter, I discuss the value of this alliance for each roleplayer in a child's psychotherapy (the parent, the child and the psychologist). In addition, I address how this alliance can potentially be harnessed, responding

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directly to the existing gap in literature (i.e., the lack of guidance on how a psychologist creates an alliance with a parent when their child is in therapy). My proposed solution is the integration of child-client drawings into regular feedback sessions with parents. To effectively elucidate this concept, I conclude the chapter by discussing the broader advantages of sharing child drawings with parents before discussing the specifics of the HTFWP drawing (Groschwitz, 2016; Kreuter-Hafer et al., 2016; Lutz, 2007; Wienand, 2016, 2020).

3.2 Therapy and Resilience to Anxiety

Anxiety disorders, including GAD, require effective treatments that consider the individual needs of children. Seeking professional help when necessary is also important for addressing GAD symptoms effectively. Various evidence-based treatment options are available for GAD in children, including medication (Brown, 2019; Creswell et al., 2020; Doyle, 2022; Schwartz et al., 2019; Strawn et al., 2020), CBT (Creswell et al., 2020; Doyle, 2022; Driscoll, 2020; Etkin et al., 2022; Lunn et al., 2023; Pollard et al., 2023; Reardon et al., 2020; Schwartz et al., 2019; Strawn et al., 2020), and sandplay therapy (Akimoto et al., 2021; Bartosh & Bartosh, 2019; Borghosian, 2022; Driver, 2022, Elkchirid & Motia, 2022).

3.2.1 Medication

Medication can be useful in the treatment of anxiety. Several authors have highlighted that first-line treatments for paediatric GAD include serotonergic medications like “selective serotonin reuptake inhibitors” (SSRIs) or “serotonin and norepinephrine reuptake inhibitors” (SNRIs) (Beesdo, 2009; Brown, 2019; Doyle, 2022; Parikh et al., 2022; Zygouris et al., 2022). The effectiveness of medication as a treatment for anxiety was reported in a meta-analysis (18 studies with an overall sample size of 419 adults) of longitudinal functional magnetic resonance imaging (fMRI) studies based on anxiety (Schrammen et al., 2022). However, medication

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may take several weeks to take effect and some patients do not experience relief from their anxiety symptoms using this treatment (Beesdo, 2009; Parikh et al., 2022). Although SSRIs and SNRIs have fewer long term risks, they have potential side-effects like headaches, nausea, sleepiness, weight gain and irritability (Brown, 2019; DeMartini, 2019). Pharmacotherapy also holds potential risk for increased suicidal ideation (Brown, 2019). It is therefore not encouraged as a first-line treatment for young children due to these potential side effects and risks as well as the concern about long-term effects on brain development (Gouze et al., 2021). This is why advocacy for monitoring of dosage and effect or using alternative methods is important (Doyle, 2022).

Combining psychotherapy with pharmacotherapy is considered to result in the best outcomes (Strawn et al., 2020). Contrary to this understanding, a study with 32 youth aged 10 to 16 years, (16 of whom were diagnosed with GAD), showed that there were no significant positive effects for those receiving a combination of medication and psychotherapy when compared to those only receiving psychotherapy (Zygouris, 2022). Based on this finding one could infer that medication does not add value to mitigating the effects of anxiety for children in the context of evidence-based psychotherapeutic treatment. However, the limitations of this study (a small sample size and no follow-up examination of the control group) must be considered when interpreting the results. Moreover, the individual needs of children can differ significantly.

3.2.2 Cognitive Behavioural Therapy (CBT)

CBT has emerged as an evidence-based intervention for treating anxiety disorders in children (Beesdo, 2009; Creswell et al., 2020; Doyle, 2022; Lunn et al., 2023; Ollendick & Davis, 2013 Schiele & Domschke, 2018; Strawn et al., 2020). CBT

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focuses on identifying and challenging negative thought patterns and behaviours that contribute to anxiety symptoms and beliefs while teaching coping strategies to manage anxiety (Gouze et al., 2021). Cognitive restructuring techniques are used to help children challenge and reframe anxious thoughts. By modifying negative thought patterns, children develop a more adaptive and realistic mindset (Silverman et al., 2008). As a common behavioural therapy, components of a CBT programme could include focusing on feeling good, exposure trials for taking action despite being afraid in order to build tolerance, and changing expectations from being negative to being positive (Dadds & Barrett, 2001; Doyle, 2022). Psychoeducation also plays an important role in CBT; as psychologists educate children and parents about anxiety and its physical and emotional manifestations, their understanding and sense of control over their symptoms increases (Gouze et al., 2021).

CBT has successfully been used to treat anxiety-related difficulties among children who have Autism Spectrum Disorder (Driscoll, 2020). It has been successful in family-based interventions and reduces the accommodation families make (for example, allowing avoidance of activities) to try to alleviate anxiety symptoms, while inadvertently reinforcing them (Etkin et al., 2022; Ginsberg & Schlossberg, 2002). Parent-delivered CBT has also been successful in treating anxiety in children where parents are taught strategies and techniques to help their children (Hirshfeld-Becker et al., 2007; Pollard et al., 2023). CBT is effective in treating childhood anxiety over a wide range of ages (Schwartz et al., 2019). However, internationally, only a small percentage of children reported receiving an evidence-based treatment such as CBT (Reardon et al., 2020). Given the shortage of mental health services in SA (Bloom et al., 2022; de Man et al., 2022; Harrison et al., 2022; Subramaney et al., 2020; van

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der Berg et al., 2020), I anticipate that too few children with anxiety have the opportunity to engage in CBT

For children with GAD, CBT has demonstrated efficacy after a short course of treatment, such as 6 to 12 sessions (Doyle, 2022). For example, in a review of 32 studies it was reported that using a CBT treatment protocol, which included improving skills to manage anxiety, training individuals to gradually relax their muscles, and exposing them to anxiety induced situations during sessions, reduced anxiety symptoms in youth (Silverman et al., 2008). Similarly, a study conducted in Athens with 16 children aged 10 to 16 years (half of whom were diagnosed with GAD) indicated a positive response to CBT treatment (Zygouris et al., 2022).

A meta-analysis of longitudinal fMRI studies not only showed that CBT was effective for treating anxiety (including GAD), but also indicated that the underlying neural mechanisms impacted by psychotherapy for anxiety disorders may be similarly impacted across different types of treatments (Schrammen et al., 2022). These approaches included psychoanalytic and psychodynamic methods, mindfulness-based interventions, and Dialectical Behaviour Therapy (Schrammen et al., 2022). The implications of this latter finding are important for psychologists in that it establishes that various types of psychotherapy may effectively treat anxiety disorders. Put differently, this encourages psychologists to consider alternative therapies to CBT in order to serve their child-clients well. One such therapy is sandplay.

3.2.3 Sandplay Therapy

Sandplay therapy is my preferred modality when treating children with anxiety, for several reasons. I find that the non-verbal aspect of sandplay therapy is useful as children often struggle to verbalise their thoughts and feelings and it also makes the

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therapeutic process less threatening for them. Sandplay therapy is also a way of accessing emotions that children may not be aware of as it allows for the expression of a child's unconscious. Most children also seem to be naturally attracted to sand and miniature figures in play perhaps because it aligns with a child's inclination to play and explore (Green & Connelly, 2009; Jang et al, 2023; Jung, 2021). Sandplay therapy also uses imagination and creativity, which are often strengths in children or aspects that can be developed through this therapeutic modality.

3.2.3.1 An Understanding of Sandplay Therapy

Sandplay therapy is a type of therapeutic intervention that aims to help children express their feelings and deal with psychological challenges using miniature figurines and sand. It was initially developed in the 1950s by Swiss psychoanalyst Dora Kalff (Bradway & McCoard, 1997; Wiersma et al., 2022), and has gained popularity as an effective treatment for various mental health challenges in children and adults, particularly anxiety symptoms (Akimoto et al., 2021; Bartosh & Bartosh, 2019; Borghosian, 2022; Driver, 2022, Elkchirid & Motia, 2022). For example, an Indonesian study involving seven adults (aged 21 to 40) diagnosed with GAD, indicated the positive effect of sandplay on anxiety symptoms (Foo & Pratiwi, 2021).

In sandplay therapy, clients are provided with a diverse range of miniature figurines (see

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Figure 2) and wet and dry sandtrays (see

Figure 2) to create a three-dimensional representation of their inner world (Homeyer & Sweeney, 2023; Jang & Kim, 2012). The miniature figurines are representations of human and superhuman figures, animals, plants, forests, as well as inanimate elements such as rocks, stones, fossils, and shells (Maurer et al., 2017).

Figure 2 shows my sandplay room with my figurine collection, which is typically displayed in categories on the shelves, creating a sense of order. For example, all the male figurines, the mythical and fantasy creatures, the farm, wild, domesticated, sea animals, transport and places of dwelling like houses, castles, caves and tents are all individual categories. Each tray is painted blue on the inside bottom and sides to represent water and sky. Clients use miniatures, sand, and water to create scenes in the sandtray of their choice, which often reflects their emotional struggles, generating feelings and attitudes that are usually concealed

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from their conscious mind (Foo & Pratiwi, 2021). While the use of miniature figurines can be beneficial for clients in externalizing and expressing their inner experiences and emotions, it is not necessary for the therapeutic process to be effective (Bradway & McCoard, 1997; Homeyer & Sweeney, 2023). Some clients may prefer to use other natural objects, such as stones or twigs, or to work solely with the sand. In such cases, the psychologist would support the client's process regardless of the lack of miniatures used. It is important to note that the sandplay process is not about creating a visually appealing scene, but rather about expressing the client's inner experiences and emotions. This is another reason why the miniatures are not the primary focus, but rather a tool that can be helpful for some clients in their therapeutic process (Homeyer & Sweeney, 2023).

Figure 2

My sandplay room (photograph: my own)

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The sandplay therapist needs to approach the sandplay therapy process with caution and sensitivity, having a deep understanding of symbolic language and the unconscious (Maurer, 2017; Olaniyi et al., 2021; Zhou, 2009). Contact with the sand has the potential to evoke long forgotten memories or deep emotions (Ammann, 2022). Therefore, the complexities involved when working with the unconscious requires an awareness by the sandplay therapist in acknowledging the dynamic nature of the unconscious, while being attentive to psychological changes (Park, 2020). To provide emotional safety for the client, the sandplay therapist interacts empathetically with the client allowing for trust and feelings of protection (Park, 2020; Punnett, 2015). The sandplay therapy process is conducted in a respectful, non-judgemental and non-intrusive way (Han et al., 2017; Karpaviciute et al., 2022). This type of environment implicitly helps with the development of a client-therapist relationship (Jang et al., 2023). In order to provide this level of sensitivity as well as for the well-being of the clients, it is ethically imperative that the sandplay therapist

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receives training that includes supervision and personal sandplay experiences. (Homeyer, 2015; Zappacosta, 2012).

Part of the sandplay process is integrating unconscious elements into conscious awareness. As sandplay therapy is used as an adjunct to verbal therapies (Jang et al., 2023; Kaduson & Schaefer, 2006; Karpaviciute et al., 2022), this integration is achieved through conversation with the client about the sandplay scene they created, where they may want to explain the story behind their scene, the associations they experienced while building and/or their experience of their process of building the sandplay scene (Stein, 2023). In this way, sandplay therapy combines with verbal therapy. In addition, at the end of the process, the sandplay therapist and client may discuss the process by looking at photographs of the different sandplay scenes created during the process. This integration allows for a cognitive understanding of the feeling experience that the client expressed, thereby deepening the client's understanding of unconscious processes (Punnett, 2015).

3.2.3.2 The Evolution of Sandplay Therapy

Dora Kalff's therapeutic method combines central elements of Lowenfeld's World Technique, as well as the influence of Jungian psychology and Eastern philosophy and practice (Liu et al., 2021; Maurer et al., 2017; Park, 2020; Roesler, 2019; Zappacosta, 2012). In her treatment of children, Lowenfeld, a British paediatrician and child psychiatrist, observed the innate tendency of children to create worlds in sandtrays using a box of toys (Akimoto et al., 2021; Bradway et al., 2014; Homeyer & Stone, 2023; Lowenfeld, 1950; Nasab & Alipour, 2015; Wiersma et al., 2022). As originally reported by Lowenfeld (1950), these apparatuses were used by children to create a world in the sand that was a visual, tactile representation of their thoughts, emotions and experiences and could be used to guide therapy

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(Tunnecliff & O'Brien, 2004). Lowenfeld noted that sand and play was a natural interest for children and correlated their play to their psychological development (Tan et al., 2021). She called her technique the World Technique (Nasab & Alipour, 2015; Tan et al., 2021; Zhou, 2009). Kalff was introduced to the World Technique when she sought training from Lowenfeld (Nasab & Alipour, 2015; Punnett & Canfield, 2020). Kalff further developed Lowenfeld's technique into sandplay therapy that also uses sand and miniatures (Nasab & Alipour, 2015; Roesler, 2019; Wiersma, 2022). She adapted the World Technique as a Jungian modality (Gallerani & Dybicz, 2011; Zhou, 2009).

Due to the great influence of Jungian psychology (Ahn, 2020; Anboohi, 2020; Ammann, 2022; Boghosian, 2022), sandplay therapy is often termed Jungian sandplay therapy (Foo et al., 2020; Green & Connolly, 2009; Homeyer & Stone, 2023; Vaz, 2000). Jungian psychology emphasises the significance of the unconscious and "symbolic representation", which suggests that children can use symbols to express unconscious thoughts and feelings (Freedle, 2007, p. 7). Similarly, Jungian sandplay therapy, offers a means for individuals (children and adults) to access and engage with their unconscious material through symbolic means (Ammann, 2022; Campbell, 2007; da Matta & Ramos, 2021).

Using their imagination, clients construct a picture in the sand allowing their inner experiences to become visible (Maurer et al., 2017; Zarzaur, 2004) Clients use symbols within this imaginative realm, to manifest latent thoughts and emotions in their constructed landscapes. This symbolic representation within the sandplay context allows children to express and process their emotions in order to bring their inner experiences into tangible consciousness (Maurer et al., 2017).

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Central to sandplay therapy is the core belief in the inherent capacity of the unconscious to enable its own healing, with the sandplay therapist serving as a facilitator in this transformative process (Wiersma et al., 2022). The objective of sandplay therapy is thus closely linked to Jungian psychology's aim: to guide the incorporation of unconscious elements into conscious awareness, enabling deeper understanding of emotional challenges, personal development, and healing (Uzoekwe et al., 2023; Vosough Gerayeli, 2019).

Incorporating insights from Eastern philosophical concepts centred on introspection and accepting attitude, Kalff integrated the concepts of silence and openness within the framework of the therapeutic process (Kaduson & Schaefer, 2006; Roesler, 2019). As a result, the sandplay therapist undertakes the role of a silent observer, fostering a space that is both nurturing and supportive for the client (Zappacosta, 2012). Although the child may be encouraged to build in silence, some children need to verbalize their process while building (Punnett & Canfield, 2020). However, this accepting environment encourages the client to explore their inner world without fear of judgment (Ferreira et al., 2014; Kalff, 1991). In addition, Kalff's interest in Buddhism led to the recognition of the Buddhist practices of mandala rituals to restore a sense of harmony, peace, and equilibrium (Enns & Kasai, 2003; Vosough Gerayeli, 2019). A mandala, which is most often a circular design, is a common symbol in sandplay therapy and represents wholeness, balance and healing (Humphris, 2019; Jang et al., 2023; Jung, 2021).

3.2.3.3 The Effectiveness of Sandplay Therapy

Various authors have indicated the effectiveness of sandplay therapy in treating a wide range of mental health challenges including anxiety, depression, trauma, and addiction (Ammann, 2022; Yahaya et al., 2019; Zappacosta, 2012;

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Zhou, 2009). The effectiveness of sandplay was evidenced in a meta-analysis of 40 studies from eight countries which found that this modality was associated with significant improvements in internalizing (for example, anxiety) and externalizing behaviours as well as behavioural symptoms of attention deficit/hyperactivity disorder (Wiersma et al., 2022). Similar beneficial results have been found in a meta-analysis of 205 Korean research papers between the years 2009 and 2018 (Ahn et al., 2020). Individual studies have also shown the effectiveness of sandplay therapy. For example, a study with 32 Grade 7 learners from Malaysia found that sandplay therapy had a positive effect on the self-esteem of these learners (Yahaya et al., 2019).

Shifting the focus specifically to anxiety, several studies have focussed on the effectiveness of sandplay therapy for the treatment for anxiety (Anboohi, 2020; Foo et al., 2020; Foo & Pratiwi, 2021; Ghaljaei et al., 2023; Homeyer, 2015; Khojasteh, 2020; Kostyunina & Valeeva, 2016; Li et al., 2022; Nasab & Alipour, 2015; Park, 2020; Roesler, 2019; Tan et al., 2021; Wiersma et al., 2022; Yoo, 2015). In a study comparing the effect of sandplay therapy on the anxiety of a group of children (n = 20 children) to the anxiety of a control group (n = 20 children) who did not receive sandplay therapy, there was a distinct reduction in anxiety disorders in the former group (Anboohi, 2020). In South Korea, a similar benefit was found in a study with 20 children aged 10 to 13 of fathers struggling with alcohol dependency (Yoo, 2015). In addition, the same benefit of a reduction in anxiety when sandplay therapy was used, was noted in a study in Iran of 50 Grade 3 learners (Khojasteh, 2020). As anxiety can develop in children who have chronic diseases, research studies were also done on the effectiveness of sandplay therapy to reduce anxiety symptoms or mitigate the development of anxiety in children who are chronically ill (Li et al., 2022;

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Tan et al., 2021). The study conducted with 40 children diagnosed with childhood-onset systemic lupus erythematosus (cSLE) in China, indicated the benefit of sandplay therapy (Li et al., 2022). Similarly, this benefit was indicated in a study with 60 children between the ages of 6 and 12 in China who were critically ill (Tan et al., 2021). Overall, studies demonstrate the positive effect in the reduction of anxiety symptoms despite numerous methodological differences (Ghaljaei et al., 2023; Kostyunina & Valeeva, 2016; Li et al., 2022; Roesler, 2019; Tan et al., 2021; Yoo, 2015).

The methodological differences include the differences in study samples. For example, Kostyunina & Valeeva (2016) worked withpreschool children challenged by anxiety, Tan et al. (2021), Li et al. (2022) and Ghaljaei et al. (2023) worked with children with chronic diseases, cSLE and cancer respectively, while Roesler (2019) worked with junior high school students with test anxiety. The methodologies of other sandplay studies differed in that one used experimental designs with control groups (Nasab & Alipour, 2015; Yoo, 2015), another was a systematic review (Wiersma et al., 2022), yet another used case studies (Park, 2020; Foo et al., 2020; Foo & Pratiwi, 2021). There were also a quasi-experimental design (Nasab & Alipour, 2015) and outcome studies (Homeyer, 2015). Many studies took place in Asia (Foo et al., 2020; Foo & Pratiwi, 2021; Park, 2020; Kostyunina & Valeeva, 2016; Li et al., 2022; Nasab & Alipour, 2015; Tan et al., 2021; Yoo, 2015), while others were studies in Western contexts (Ghaljaei et al., 2023; Roesler, 2019). The different methodologies, cultural groups and different age ranges in these studies mentioned highlight the potential effectiveness of sandplay therapy in treating anxiety in children across developmental ages and cultures.

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There are a limited number of studies investigating the effectiveness of sandplay therapy in addressing anxiety among children in Sub-Saharan Africa. One case study involving a Grade 6 learner from Johannesburg found that sandplay therapy addressed emotional difficulties, potentially including anxiety (Forsyth, 2011). In Nigeria, a study with 145 guidance counsellors highlighted the beneficial use of sandplay in treating various mental health challenges, including anxiety (Uzoekwe et al., 2023). Another study, conducted with 15 Ugandan children averaging 15.27 years old, found that group sandplay therapy effectively impacted participants' psychological health and resilience, showing a positive effect on anxiety symptoms (Olaniyi et al., 2021). In the Northern Cape in South Africa, a study involving a 13-year-old girl demonstrated the efficacy of sandplay therapy in reducing her negative emotions and conflicts, potentially related to anxiety (Davids, 2005). Additional studies in South Africa, including one with a young child facing emotional challenges (Ferreira et al., 2014), and another in Uganda involving 8 boys and 8 girls aged 12 to 16, showed the positive effects of group sandplay therapy on improving post-traumatic stress disorder (PTSD) symptoms and participant resilience (Jang et al., 2019). Despite an extensive search, I was unable to find Sub-Sahara African studies specifically focussing on the effectiveness of sandplay therapy for GAD in children, including children aged 10 to 12 (as in my study).

My review of the literature shows that anxiety in children can therefore be successfully treated through the use of sandplay therapy. However, how is sandplay therapy understood by parents? How does the psychologist involve a parent in the therapy of their child without impinging on the child’s therapeutic space? These questions are important in the context of the literature on the importance of the relationship between the treating psychologist and the parents of the child in therapy,

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specifically, the parent-psychologist alliance. I explain this concept in the next section.

3.2.4 Parent-Psychologist Alliance

As initially developed by Bordin (1979, 1994), the concept of a parent-psychologist alliance is rooted in the therapeutic working alliance. As explained by several scholars, Bordin's comprehensive theory of the therapeutic working alliance describes it as the collaboration between the client and psychologist, fostered through the bond they develop and their shared commitment to therapy goals and tasks (Chandler, 2018; Grosberg, 2019; Halfon, 2021; Johnson & Wright, 2002; Metcalfe et al., 2021; Zilcha-Mano, 2017). The bond between the client and psychologist is defined as their compatibility and the level of trust in their relationship (Bordin, 1979; Chandler, 2018; Fairweather et al., 2021; Grosberg, 2019; Halfon, 2021; Pinsof et al., 2008; Zilcha-Mano, 2017). The bond between psychologist and client influences their connection and rapport, helping clients feel respected, supported and understood (Bram, 2021; Grosberg, 2019; Johnson & Wright, 2002; Metcalfe et al., 2021).

The psychologist and client then together decide on the goals of therapy to address the concerns of the client (Metcalfe et al., 2021). Setting goals implies a commitment by the psychologist to help the client achieve the desired outcomes (Grosberg, 2019; Johnson & Wright, 2002). An agreement on the therapy goals is said to increase the motivation and engagement of the client (Pinsof et al., 2008). The tasks, as outlined in Bordin's definition of alliance, relate to the actions needed to achieve these jointly established therapy goals (Bordin, 1979).

In child psychotherapy, however, there is an additional layer to consider: the triadic connection between the child, the parents, and the psychologist (Gvion & Bar,

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2014). In this context, it becomes essential to establish an alliance between the parents and the psychologist in addition to the child-psychologist alliance (Gvion & Bar, 2014). Research on child psychotherapy highlights the importance of creating a strong alliance between parents and the treating psychologist (De Greef et al., 2017; Diamond et al., 2000; Feinstein et al., 2009; Fox, 2012; Gvion & Bar, 2014; Kazdin & Whitley, 2006; Nevas & Farber, 2001; Ruberman, 2009; Zemmelman, 2018). A meta-analysis of 93 studies on play therapy conducted by Bratton et al. (2005), revealed that the alliance between parents and psychologists yielded the most substantial positive therapeutic outcomes. Diamond et al. (2000) emphasised the significance of the alliance within the context of family-based therapy where authors stated that when parents felt supported by the therapist, they were more inclined to adopt new ways of interacting with their child, thus fostering positive changes within the family system. Collectively, this literature draws attention to the importance of a strong parent-psychologist alliance in achieving favourable therapeutic results. It also highlights how the alliance empowers parents as active partners in the therapeutic process and contributes to the child's resilience and well-being (Bratton et al., 2005; Diamond et al., 2000). Parents are then able to reinforce and support therapeutic strategies outside of therapy sessions, which increase the likelihood of positive outcomes for the child as they experience a cohesive and unified approach to their development across different settings (Hawley & Garland, 2008).

A parent-psychologist alliance encompasses the psychologist’s proactive engagement with parents and the establishment of a collaborative, supportive, and meaningful relationship, which is regarded as one of the core objectives of therapy (de Greef et al., 2017; Diamond et al., 2000; Feinstein et al., 2009; Kazdin & Whitley, 2006; Nevas & Farber, 2001; Slade, 2008). Moreover, recognizing and honouring the

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significant role parents play as caregivers is an integral component of nurturing a robust parent-psychologist alliance (Bram, 2021; Chandler, 2018). By showing genuine respect for the caregiver-role, trust and cooperation are cultivated toward the psychologist.

To develop a strong parent-psychologist alliance, it is essential for psychologists to acknowledge their outsider status in the family's day-to-day experiences and exhibit empathy towards the unique challenges parents face (Hawley & Weisz, 2003). Through understanding and valuing the parents' viewpoints, psychologists can create an environment characterized by respect and collaboration, placing a premium on the insights and approaches parents bring to the therapeutic context (Bram, 2021). This respectful approach demonstrates care for the family, and thoughtful observations of the complex dynamics at play (Bram, 2021; Safran et al., 2011).

In the context of therapy, attunement is considered a key factor in fostering a deep and meaningful connection between psychologist and client, influencing the quality of the working alliance (Spiegel & Baker, 2020). Attunement is described as the psychologist’s dynamic ability to be aware of emotions that may arise in the client in order to adjust their own emotion so that it is in tune with that of the client, and then be able to sensitively respond to the client’s current state (Aafjes-van Doorn et al., 2022; Bram, 2021; Markman, 2020; Monticelli & Liotti, 2021). This awareness of the emotional state of the client is occasionally reflected by the psychologist synchronizing with/matching the mood of the client or imitating their gestures or repeating phrases the client uses, a technique called mirroring (Biddle, 2023; Talia et al., 2020). It is a process whereby the psychologist is aware of and responds to the needs of the client and provides a safe and secure environment (known as

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containment) for the expression of emotions (Talia et al., 2020). When there is attunement, clients feel accepted, heard, understood, and supported by the psychologist (Zalaznik et al., 2021). Attunement creates a connection between client and psychologist that fosters a harmonious working alliance.

The importance of attunement for building working alliances resonates across diverse studies conducted in various locations, contexts and with different demographics (Aafjes-van Doorn et al., 2022; Biddle et al., 2023; Talia et al., 2020; Zalaznik et al., 2021). For example, in a study based in an American psychotherapy training centre with 173 clients/participants who had been admitted to the clinic, it was found that tracking client-reported working alliance and the psychologist's attunement and responsiveness over time helped offer an enhanced understanding of the therapeutic relationship and its impact on treatment (Aafjes-van Doorn et al., 2022). In addition, another study of 18 first year master's level counsellor students (aged 22 to 47 years) found that attunement is important in building a strong alliance and promoting transformational healing, particularly in the case of relational trauma (Biddle et al., 2023). Furthermore, a study in Germany involving 50 psychodynamic therapists (mostly females with a mean age of 32.4) and 50 clients (with ages ranging between 15 and 70) found that the therapist's genuine curiosity and empathic understanding as demonstrated through attunement, play a critical role in the relationship between therapist and client (Talia et al., 2020). These diverse insights collectively emphasise the universal importance of attunement in fostering strong working alliances within a therapeutic setting and contributing to the overall success of psychotherapeutic intervention. Using the studies and commentary above on attunement, I deduced that a psychologist can use attunement to create a parent-psychologist alliance.

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3.2.4.1 Advantages of a Parent-Psychologist Alliance

The parent-psychologist alliance holds several advantages for each role player in child-psychotherapy. These role players include the parent, child and psychologist. I detail these benefits next.

3.2.4.1.1 Benefits of a Robust Parent-Psychologist Alliance for Parents

One of the primary benefits of a strong parent-psychologist alliance for parents is the enhancement of parenting skills (Accurso & Garland, 2015; Bram, 2021; de Greef et al., 2017; Gvion & Bar, 2014; Kazdin & Whitley, 2006; Núñez et al., 2022; Schmidt et al., 2014). Such alliances lead to significant improvements in parenting practices as parents adopt new strategies and techniques to better manage and interact with their children (Kazdin & Whitley, 2006). In addition, a positive alliance between parents and their child's psychologist facilitates the adoption of authoritative parenting techniques, which are known to foster healthy child development (Accurso & Garland, 2015). This results in effective parenting that is crucial for both the day-to-day management of child behaviour and for addressing more complex psychological issues (see Section 2.4.3).

Parental empowerment is another benefit of the parent-psychologist alliance (Bram, 2021; Campbell & Simmonds, 2011; Gvion & Bar, 2014; Kazdin & Whitley, 2006; Núñez et al., 2022). It involves not only acquiring new skills but also building confidence to implement these strategies effectively. For instance, parental empowerment has been linked to significant reductions in negative emotions such as helplessness, rage, and guilt, which are common among parents dealing with their child's behavioural and emotional challenges (Campbell & Simmonds, 2011). This shift from negative emotions to feelings of confidence in implementing new parenting strategies is important for maintaining a proactive approach to parenting and is supported by the parent-psychologist alliance.

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The emotional support that psychologists provide to parents is another important component of the therapeutic alliance (Bram, 2021; Campbell & Simmonds, 2011; Diamond et al., 2000; Ruberman, 2009). Bram (2021) characterizes psychologists as emotional buffers or facilitators who help parents cope with intense emotions. In addition, the emotional support of psychologists helps parents gain a deeper understanding of their child's inner world leading to more effective parenting (Gvion & Bar, 2014). The psychologist's support helps parents during therapy sessions and also extends beyond these sessions, helping them cope with daily stresses related to their child's challenges with anxiety (Bram, 2021). Through a supportive relationship with their child's psychologist, parents feel valued, understood, and respected, which empowers them to adopt active and effective roles in their child's therapy (Bram, 2021). Additionally, the support received from the psychologist helps to reduce the feelings of isolation that many parents experience, making them feel that the psychologist empathises with them with regard to the challenges they experience when trying to manage their child's anxiety (Fox, 2012).

Moreover, the improved skills and understanding gained through a strong alliance have direct impacts on family interactions (Accurso & Garland, 2015; Núñez et al., 2022; Ruberman, 2009). Better communication, conflict resolution, and emotional responsiveness are among the enhanced skills that parents develop through a strong alliance (Núñez et al., 2022; Accurso & Garland, 2015). These skills are essential for creating a supportive and nurturing family environment, which benefits not just the child in therapy but all family members (Ruberman, 2009).

A strong parent-psychologist alliance also enhances the parents' commitment to their child's therapeutic process (Marker et al., 2013; Núñez et al., 2022; Shirk et al., 2011). When parents feel aligned with and supported by their child's

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psychologist, they are more likely to adhere to treatment recommendations and remain engaged throughout their child's therapy (Marker et al., 2013; Shirk et al., 2011). This commitment is important for ensuring continuity and effectiveness of treatment.

3.2.4.1.2 Benefits of a Robust Parent-Psychologist Alliance for Psychologists

The strong parent-psychologist alliance facilitates a deep understanding of family dynamics and the child's behavioural patterns, which is important for developing tailored treatment plans. This close collaboration allows psychologists to address the unique needs of the family effectively (de Greef et al., 2017; Kottler, 2016). Such alliances enhance the psychologist's capability to recognise and address the individual experiences of both parents and children in ways that is fundamental in providing nuanced care (Gvion & Bar, 2014). By engaging actively with parents, psychologists can access insights that might be missed in direct interactions with the child alone, particularly when both parents are present, which offers diverse perspectives (Kottler, 2016).

Effective communication, a fundamental aspect of the strong parent-psychologist alliance, equips psychologists with essential insights into parents' level of commitment. Understanding the parents' dedication is important for modifying therapeutic approaches to optimally support the child's treatment (Chandler, 2018; Kottler, 2016). Enhanced communication with parents also aids psychologists in understanding treatment goals and monitoring progress, which are important for the timely adjustment of interventions and strategies (de Greef et al., 2021). This alliance therefore contributes significantly to building trust and rapport, elements that are essential for a successful therapeutic process (Kottler, 2016).

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The alliance not only supports the therapeutic process but also significantly impacts the professional satisfaction and psychological well-being of psychologists. Observing positive changes and improvements in clients enhances psychologists' sense of professional fulfilment and effectiveness (Bram, 2021; de Greef et al., 2021; Kazdin & Whitley, 2006; Ruberman, 2009). Kazdin & Whitley (2006) and Ruberman (2009) highlight that seeing tangible results from therapeutic interventions not only increases job satisfaction but also mitigates the risk of burnout—a prevalent challenge in psychotherapy.

A strong alliance promotes sustained parental engagement and adherence to the therapeutic plan, essential for the child's continuous improvement and long-term therapeutic success (Ruberman, 2009). Shirk et al. (2011) emphasise that such an alliance facilitates better participation in therapy and ensures treatment continuity, central for achieving lasting therapeutic outcomes. Additionally, Fox (2012) points out that the engagement fostered by the alliance aids in refining parenting strategies, further enhancing the effectiveness of therapeutic interventions.

By establishing robust alliances, psychologists can foster a supportive therapeutic environment that considers the well-being of the entire family. This holistic approach not only focuses on the child but also integrates the family into the care process, leading to improved clinical outcomes for all family members (Diamond et al., 2000; de Greef et al., 2017). Particularly in complex cases involving children or adolescents and their conflictual relationship with their parents, a strong alliance can leverage therapeutic efforts, facilitating the therapeutic process and promoting positive systemic changes within the family (Diamond et al., 2000).

3.2.4.1.3 Benefits of a Robust Parent-Psychologist Alliance for the Child-Client

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Several researchers have contributed to our understanding of how a strong parent-psychologist alliance benefits the child-client, highlighting its essential role in child therapy (Accurso & Garland, 2015; Bram, 2021; de Greef et al., 2017; Diamond et al., 2000; Fox, 2012; Gvion & Bar, 2014; Kazdin & Whitley, 2006; Kazdin et al., 2005, 2006; Kottler, 2016; Marker et al., 2013; Nevas & Farber, 2001; Núñez et al., 2022; Ruberman, 2009; Safran, et al., 2011; Shirk et al., 2011; Zemmelman, 2018; Zorzella, et al., 2017). A strong parent-psychologist alliance is closely linked to improved treatment outcomes for children. Accurso and Garland (2015) emphasise that such alliances are associated with reductions in the child's symptomatology, enhancing their psychological well-being and overall functioning. Similarly, studies by Kazdin et al. (2005) and Kazdin and Whitely (2006) have shown that a better quality alliance correlates with significant therapeutic changes in the child as rated by psychologists, indicating enhanced therapeutic effectiveness and better coordination of care.

When parents feel valued, respected, and understood by the psychologist, their investment in the therapeutic process deepens, typically leading to improved outcomes for the child (Bram, 2021). Collaborative and effective work between parents and psychologists ensures consistent, coordinated care for the child (de Greef et al., 2017). Additionally, as parenting skills are refined through this alliance, parents are better equipped to provide a stable home environment, thereby enhancing the parent-child relationship and the child's mental health (Bram, 2021; Diamond et al., 2000; Fox, 2012; Kazdin & Whitely, 2006).

These improved parenting skills, often reflecting authoritative parenting, which is a resilience enabler (see Section 2.4.3), encompass greater involvement in a child's life. This involvement includes enhanced supervision and developing empathy

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towards the child's challenges, thereby enabling parents to offer validation and emotional support for their child (Diamond et al., 2000). A large part of developing empathy in parents relates to their ability to mentalize (Arabadzhiev & Paunova, 2024; Arioli et al., 2021; Borelli et al., 2015; Camoirano, 2017; Luyten et al., 2020; Schwarzer et al., 2021; Stevenson-Hinde et al., 2013; Tollenaar & Overgaauw, 2020). The ability to mentalize, also known as reflective function (Fonagy et al., 1991), entails the ability to be aware of and understand one's own emotions and become better able to relate to the emotions of others and understand their perspective (Arabadzhiev & Paunova, 2024; Camoirano, 2017; Slade, 2005). Mentalizing therefore bolsters the development of empathy as parents are better able to understand the emotions and behaviours of their children; this is considered empathic attunement (Borelli et al., 2015; Camoirano, 2017; Stevenson-Hinde et al., 2013). Mentalizing or the reflective function of parents can be fostered through creating sensitive reflective interactions and mirroring (see Section 3.2.4) Biddle, 2023; Borelli et al., 2015; Talia et al., 2020). When parents continuously engage in trying to understand their own emotions and behaviours and the behaviours, emotions and intentions of their children, their mentalizing ability is fostered (Arabadzhiev & Paunova, 2024; Camoirano, 2017; Tollenaar & Overgaauw, 2020). This is particularly true when parents are able to reflect on difficult and sensitive emotional states (Luyten et al., 2020). In this way, parents also reinforce their ability to regulate their own emotions (Schwarzer et al., 2021). The resultant nurturing family environment creates deeper interpersonal relationships, further enhancing the child's well-being (Arabadzhiev & Paunova, 2024; Bram, 2021; Diamond et al., 2000). The psychologist's collaboration with the parent to develop their parenting skills also helps the child recognise that their parents share responsibility for their

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mental health, meaning that the child often feels less lonely when faced with the challenges of anxiety (Bram, 2021).

Overall, this parent-psychologist alliance consistently demonstrates a direct link to significant therapeutic improvements in the child and nurtures a supportive space for the child's emotional growth until the end of the therapeutic process (Feinstein et al., 2009; Fox, 2012; Kazdin & Whitley, 2006; Zemmelman, 2018). Consistent support and communication, a foundation of a strong parent-psychologist alliance, lead to a coordinated approach to managing the child's needs, thereby promoting their overall well-being (Bram, 2021). The resultant cohesive treatment approaches developed through these parent-psychologist alliances not only increase the child's motivation and engagement in therapy, but also enhance the likelihood of children willingly attending and actively participating in therapy sessions (Marker et al., 2013; Ruberman, 2009; Zorzella et al., 2017). Enhanced communication skills between the parents and the psychologist can also lead to better conflict resolution within the family, thereby improving relationship dynamics (Diamond et al., 2000; Gvion & Bar, 2014). This comprehensive network of support effectively facilitates the therapeutic process by involving parents actively and empowering them with skills to effectively support their child’s mental health (Gvion & Bar, 2014; Fox, 2012; Núñez et al., 2022).

3.2.4.2 Including Parents in Sandplay Therapy

Although literature draws attention to the importance and value of including parents/caregivers in some form when their child is in psychotherapy (Feinstein et al., 2009; Park, 2020; Zemmelman, 2018), there is limited literature on how to do this in a meaningful manner when sandplay therapy is the preferred modality. The existing sandplay therapy literature explores the various ways in which parents have

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engaged in their child's sandplay therapy sessions. For example, the "parent-child dyad sandtray therapy" involves having the parent and child create a sandplay scene together in a sandtray so that the therapist can assess parenting skills and improvement in the interaction between parent and child (Homeyer, 2015, p. 251). Another activity called the "Parent-Child Combined Session: Safe Place in the Sand" is designed to establish the parent as protector, fostering feelings of security and well-being within the child (Kaduson & Schaefer, 2006, p. 265). In addition, "Jungian Family Sandplay" is a method involving family members and bereaved children, emphasizing the role of family dynamics in the healing process (Green & Connelly, 2009, p. 84). Moreover, the "Parent-Child Sandplay Therapy" involves family play and sandplay therapy to support children with developmental challenges (Liu et al., 2023, p. 6). Interviews with parents before and after the sandplay therapy intervention were also conducted to determine the effect of the sandplay therapy on the client's challenging emotions (Cao et al., 2019). In another case study, parents were included in the child's sandplay therapy process by having 3 sessions of sandplay therapy with the child's sandplay therapist (Punnett, 2015). In a South African-based study parents were included in a focus group post sandplay therapy intervention to discuss their thoughts on the process (Rousseau et al., 2009). Overall, these methodologies highlight the need to include parents in their child's sandplay therapy, and provide advice on how to achieve this through actions like interviewing parents or inviting them into the therapy space to co-build sandplay scenes.

However, clinical experience has shown me that the above are tricky in practice. This includes ethical and practical concerns regarding parental involvement in sandplay therapy, which are pertinent yet not extensively addressed other than

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informed consent and confidentiality (Kaduson & Schaefer, 2006; Liu et al., 2023). For example, the following needs consideration: a parent's possible over-involvement in their child's therapy can interfere with the relationship between the child and their psychologist, thereby negatively impacting the effectiveness of therapy. Overinvested parents may exhibit controlling behaviours that hinder their children's autonomy, while underinvested parents may not actively engage in therapy (Chandler, 2018). Additionally, I have already discussed the high degree of heritability of anxiety (Troller-Renfree et al., 2019), and children possibly modelling the behaviours of anxious parents (see Section 2.3.2.1). Parents could have their own emotional challenges, which can interfere with the focus being on the child's emotional needs and therapeutic goals in the session.

These aforementioned concerns were mitigated in a Chinese study of 60 chronically ill children between the ages of 6 and 12 by children first receiving individual sandplay therapy sessions before two sessions of family sandplay were offered at the end of the child's process (Tan et al., 2021). However, involving parents only at the end of the process did not allow them to develop in their parenting or support with their child's therapy process or deepen their understanding while the process was taking place. Given this, I am sceptical that parents and children sharing sandplay sessions toward the end of the child's therapeutic process is a good enough solution to engaging parents in their child's sandplay.

3.3 Drawing as a Tool in Therapy: A Valuable Tool for Child-Clients, their Parents and Psychologists

As outlined in this chapter, one of the reasons for including parents in their child's sandplay therapy process is the development of a parent-psychologist alliance seeing as this alliance is beneficial for the therapeutic triad – parents, child-client and treating psychologist. Yet, how does one create such an alliance outside

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of the therapy time with the child? The assumption informing my study is that using drawings as a tool in therapy can create the alliance between parent and psychologist.

Drawings have emerged as a valuable and versatile tool in therapy, benefitting both children and their parents (Baghdadi et al., 2020; Kissos et al., 2020; Lev-Wiesel et al., 2021; Sheikh et al., 2019). They serve as a means of communication, stimulate discussion, and provide insights into the thoughts and emotions of children, facilitating better understanding for both parents and psychologists (Allan, 1988; Amod et al., 2013; Lev-Wiesel et al., 2021; Maloney, 1981). Through drawings, children are able to express complex emotions non-verbally; this is especially useful for children who find it challenging to articulate their thoughts and emotions verbally (Amod, 2013; Çetin & Güneş, 2021; Goodman et al., 2022; Kissos et al., 2020; Lev-Wiesel et al., 2021). Drawings can bridge language barriers in that children with communication difficulties, such as developmental delays or autism, can use drawings to share their feelings and experiences more effectively (Bain et al., 2013; Matthews & Bouwer, 2009; Or & Shalev, 2022; Pivnick, 2023). The act of drawing creates a safe and comforting environment where children feel less pressured and enables them to express themselves without fear of judgment (Bisagni, 2022; Goodman et al., 2022; Jue & Ha, 2019; Kissos et al., 2020). This type of atmosphere is helpful for building trust and rapport with the psychologist.

Children use symbols and metaphors in their drawings to convey complex emotions and experiences (Amod, 2013; Bain et al., 2013).) Interpreting these symbols can provide valuable insights into the child's subconscious feelings and conflicts (Bisagni, 2022).) Symbols in drawings can help psychologists and parents

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understand the child's perspective better, leading to more effective communication and therapeutic outcomes (Goodman et al., 2022; Jue & Ha, 2019). The child's verbal explanations are as important as the drawings themselves as the drawings can help reveal a child's imaginative ideas and/or associations (Amod et al., 2013; Bisagni, 2022; Or & Shalev, 2022). The verbal explanations of the drawings therefore provide additional information and context (Çetin & Güneş, 2021).

As drawings can reveal underlying issues that might not be apparent through verbal communication, it makes them valuable tools for expressing complex emotions and thoughts in therapeutic practice (Rashid et al., 2020; Springer et al., 2020; Tharinger & Stark, 1990; Truneckova, 2021; Tuttle, 1998). Several studies highlight the power of drawings as a therapeutic tool for children to communicate various aspects of their lives, including their thoughts, feelings, and experiences (Baghdadi et al., 2020; Çetin & Güneş, 2021; Goodman et al., 2022; Kissos et al., 2020; Lev-Wiesel et al., 2021; Sheikh et al., 2019). In their research into children's experiences, studies by Kissos et al. (2020) and Baghdadi et al. (2020), shed light on the role of drawings. In Israel and Thailand Kissos et al. (2020) focused on using self-figure drawings to detect child sexual abuse, while Baghdadi et al. (2020) examined drawings completed by children (n=12) from Canada during dental treatments. Both studies recognised the rich insights that drawings can provide, allowing for a deeper understanding of the child's perspective and supporting their narratives. Similarly, an online study (which took place in Israel) exploring the expression of social peer rejection through drawings and narratives provided by 21 children and youth, indicated the potential of drawings to shed light on the manifestation of social peer rejection experiences (Lev-Wiesel et al., 2021). In addition, a study conducted with 100 girls (aged 5 to 8 years) in Iran, highlighted the

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benefit of drawings in understanding family functioning, attachment disorders and parenting styles (Sheikh et al., 2019).

Children's drawings provide insight into a child's experiences, their understanding of family relationships, and a means for the psychologist to gauge therapeutic progress (Girish et al., 2023; Lev-Wiesel et al., 2021; Pivnick, 2023; Rashid et al., 2020; Sheikh et al., 2019; Søndergaard & Reventlow, 2019; Truneckova, 2021; Willer et al., 2018). This benefit for psychologists of gaining better insight, was exemplified in a study involving 60 preschool Ugandan children (Goodman et al., 2022), as well as in a study with 357 children aged 5 to 18 years in India (Girish et al., 2023). Similarly, Truneckova (2021) delved into the insights offered by the Family Portrait Evaluation Tool used to evaluate the difference in the child's series of drawings portraying family relationships. This study (i.e., Truneckova, 2021) emphasised the ability of children's drawings to capture shifts in both structural and conceptual complexity providing a visual measure of therapeutic progress. Structural shifts imply that the visual representation of the drawing changes over time. For example, it may become more differentiated and complex. Conceptual shifts imply the way in which children represent concepts like family relationships or anxiety in their drawings and how this representation changes over time. This shifting quality makes drawings a valuable tool for tracking changes in children's perceptions and experiences over time, thereby assisting psychologists in gauging therapeutic progress. Therefore, when using the serial technique (i.e., a child drawing on a regular basis), the drawings and the symbolism in the drawings tend to change over time reflecting the progression of the child's healing process (Allan, 1988; Baghdadi et al., 2020; Broecher, 2012). These changes can imply changes in the child's emotional state and coping mechanisms. This visual record

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can help psychologists and parents monitor the child's progress and psychologists can adjust therapeutic interventions as needed (Çetin & Güneş, 2021). Tracking progress through drawings can provide valuable insights into the effectiveness of therapy and guide future interventions (Springer et al., 2020). A study in Iran, involving 100 children aged 5 to 8 years illustrated how children's drawings provide the psychologist with valuable insights into family dynamics and the emotional states of children, both of which can evolve over the course of therapy, serving as indicators of progress (Sheikh et al., 2019). Consequently, drawings can effectively signify the therapeutic advancements achieved as they transform over time.

Allowing children to express themselves through drawings can empower them to have a voice in therapy sessions. Drawing empowers children by giving them a sense of control over their experiences and allowing them to communicate in a way that feels safe and comfortable (Baghdadi et al., 2020; Broecher, 2012). This empowerment can boost children's self-esteem and confidence, leading to better therapeutic outcomes (Pivnick, 2023). By observing and discussing their child's drawings, parents can gain valuable insights into their child's inner world, struggles, and strengths. This enhanced parental insight can improve empathy, communication, and support for the child (Bisagni, 2022; Çetin & Güneş, 2021).

Also, by incorporating drawings into therapy, professionals are better equipped to address the unique needs of children (as the drawing relates to that child’s personal narrative), leading to more effective and tailored interventions (Lev-Wiesel et al., 2021). Drawings can serve as a therapeutic outlet for difficult emotions, leading to emotional regulation and self-awareness (Molinari, 2013; Lev-Wiesel et al., 2021). Additionally, child drawings are useful for facilitating difficult conversations or those on taboo topics. Using drawings to provide a safe and creative outlet for

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children to express their emotions and communicate about difficult topics was demonstrated in a study in the United States with 147 children who completed drawings about their experience of the loss of a baby in their family for a visual narrative analysis of remembrance drawings (Willer et al., 2018). The use of drawings to facilitate communication for children on sensitive, difficult or taboo topics around emotionally charged family issues like parental illness, family conflicts, and domestic violence, was also found in a study with 6 families who had children aged 6 to 12 in Denmark (Søndergaard & Reventlow, 2019).

In summary, drawings are a valuable tool when used in therapy. This section has reviewed how they give voice, as it were, to children's innermost thoughts and emotions and make it easier for difficult topics to be explored. This section has also shown that drawings support psychologists to track progress and understand their child-clients better. There was also passing mention to how drawings aid parental insight into their child. The next section develops that passing mention as I build my argument for using drawings to benefit the therapeutic process when a child is in sandplay therapy for GAD. Part of that therapeutic process is a parent-psychologist alliance that is grounded in meaningful communication.

3.3.1 The Use of Child-Clients' Drawings for Communication with Parents

The use of drawings in therapy, when the child assents to this, acts as a stimulus for discussion between parents, children and the treating psychologist. As far back as the 1980s (Maloney, 1981), studies have reported that when drawings completed by children were shared with their parents, it helped improve family communication. Subsequent studies (Broecher, 2012; Molinari, 2013; Rand, 2020) have reiterated the value of drawings to facilitate communication of the child's experiences and concerns with parents. These studies draw attention to the

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significance of drawings in improving parents' grasp of their children's emotional experiences. Additionally, by examining the drawings created by their children and engaging in discussions about their significance with the psychologist, parents are less likely to feel a sense of exclusion from the therapeutic process. Engaging in this way with the psychologist enhances their understanding of their children, empowering them to foster their child's resilience (Broecher, 2012; Molinari, 2013). Through drawings, children have a visual medium to express themselves, providing parents with valuable insight into their inner thoughts and feelings. As discussed in Chapter 2 (see 2.4.2), when parents understand their children's emotional experiences it enhances their parenting, which benefits the parent-child bond (Accurso & Garland, 2015).

Despite using different methodologies, the studies of Broecher (2012); Maloney (1981) and Molinari (2013) all report similar beneficial outcomes when psychologists shared and discussed the child's drawing with parents. Maloney (1981) focused on using drawings in multiple family group therapy sessions to improve family communication and understanding. Broecher (2012) explored how expressive drawing helped a six-year-old cope with the fear and pain of surgery – with his parents gaining insight into their child's experiences through the child's drawings. Molinari (2013) described the sharing of the drawings of a five-year-old with her parents, which resulted in alleviating the parental sense of exclusion from her therapeutic process and helped parents to better understand their child's emotional world.

Even though the above offer a limited number of examples (despite my repeatedly searching the literature), it is therefore evident that there is value in the psychologist using the child's drawings to communicate with and establish an

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alliance with parents. Doing so is valuable as it can cultivate better parenting skills and offer parents insight into their child's anxiety. However, despite an extensive search of the relevant literature, I could find no African study documenting the benefits of using the child's drawings to establish an alliance with parents. I also could not find a study documenting the specific benefits of psychologists sharing the HTFWP drawing. As explained in Chapter 1, my clinical experience sensitized me to the potential value of the HTFWP, including it offering a meaningful way to include parents in their child's therapy.

Next, I will elaborate on what is currently documented about the HTFWP drawing.

3.3.2 The House-Tree-Fire-Water-Person Drawing

The House-Tree-Fire-Water-Person (HTFWP) drawing is a projective technique used in psychodiagnostics and psychotherapy, primarily with children and adolescents (Groschwitz, 2016; Kreuter-Hafer et al., 2016; Lutz, 2007; Wienand, 2016, 2020). Rooted in the psychology and symbolism established by C.G. Jung (Adler & Hull, 1966), it was developed by Ursula Eschenbach at the C.G. Jung Institute Stuttgart in the 1970s (Usländer & Reitz, 2015). It evolved from previous projective drawings, such as human figure drawings, the House-Tree-Person drawing, and kinetic drawings (Kreuter-Hafer et al., 2016; Lutz, 2007).

This technique was used for more than 50 years at the C.G. Jung Institute in Stuttgart and its validity was researched in 2015 by Usländer and Reitz (2015). In their pilot study, they examined how the HTFWP drawing captured the dimensions of affect, psychic energy, complexes, intra-psychic conflicts, and resources in 16 children and adolescents undergoing psychological treatment. The treating therapists and a team of experts completed a qualitative questionnaire based on

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their observations and interpretations of the HTFWP drawing. This small study found partial agreement in the drawings and therapy progress for four of the five dimensions mentioned above (affect, complexes, intra-psychic conflicts, and resources) and overall supported the potential of the drawing to generate hypotheses about the child's development, despite minimal background information about the child (Usländer & Reitz, 2015).

3.3.2.1 How the Drawing is made

In the drawing process the child is given a blank white page, a pencil, an eraser and pencil crayons. Child-clients are asked to draw a house, a tree, fire, water, and a person on the blank page in any way they want (Lutz, 2007; Kreuter-Hafer et al., 2016; Usländer & Reitz, 2015; Wienand, 2016). The psychologist records the order of drawing, spontaneous comments made by the child, the child's mood, and any observable behaviour of the child like the speed or rhythm of the drawing or any erasures. This would include observations like the child asking for a ruler, erasing several times, using sketchy lines, pausing for long periods seemly stuck in the process, or the child steadily completing the drawing. The child is asked at the end of the drawing process, what story their drawing is telling, which is also recorded by the psychologist.

3.3.2.2 Elements in the Drawing

It is important to note that each child's drawing will vary, as they bring their own unique perspective, creativity, and interpretation to their drawings (Groschwitz, 2016; Kreuter-Hafer et al., 2016). Children may add other elements to the drawing as well, such as additional people, elements suggesting the weather (for example, a sun, clouds or rain) or a fire engine. However, the standard elements are the house, tree, fire, water, and person. These individual elements in the drawing also hold their own symbolic meanings.

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For instance, the house can symbolize the human body, home, security, and family dynamics (Kreuter-Hafer et al., 2016; Lutz, 2007; Wienand, 2016). The manner in which the child draws the house can therefore reflect their experiences of safety and security or their perspective of family dynamics (Kreuter-Hafer et al., 2016). Different rooms or parts of the house can also represent different parts of the self (for example, the roof could represent the intellect while doors could represent boundaries, defence mechanisms or openness (Wienand, 2020; Wyder, 2019).

The tree represents life, growth, connection and renewal (Kreuter-Hafer et al., 2016; Lutz, 2007; Wienand, 2016). How the child draws the tree can also represent their experiences of groundedness. Fire can represent energy, transformation, and constructive or destructive forces (Wienand, 2016). An uncontained fire therefore has a different effect to one that is being used to cook food. Similarly, a fire burning down a house or tree has a very different sense when compared to a candle flame. Fire and the resultant ash can symbolise grief (Awuzie, 2021).

Water symbolizes life, energy, death, separation and connectivity (Kreuter-Hafer et al., 2016; Lutz, 2007; Wienand, 2016). It comes in various forms such as a flood, waves, a well, ocean, river, puddle, waterfall or rainfall. It is used in purification rituals (Teodorescu, 2021). In religion, water is a symbol for life and the meeting of heaven and earth as symbolised by a well (Sahi, 2022). Human figure drawings have been widely used by psychologists to gain an understanding on a variety of topics like assessing stroke patients (Martinelli et al., 2023), assessing children with Autism Spectrum Disorders (Papangelo et al., 2020), assessing developmental delays in children (Tükel et al., 2019). The human figure represents the self or ego, and its size, proportions, and position provide insights into self-esteem, autonomy, and attachment aspects (Lutz, 2007; Wienand, 2016).

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3.3.2.3 How the Drawing is understood

Besides understanding the symbolic significance of the five specific elements, psychologists interpreting the drawing should take into account their placement on the page, the structure of lines, the utilization of colour, and the interactions between these elements (Wienand, 2016). These factors collectively contribute to shaping the overall composition of the drawings, which adds to the interpretation of the HTFWP drawing. In addition, the relationship between the elements (for example, the tree could be drawn far away from the house and the person could be depicted as small and distant from the house and tree), and the emotional reactions of the child making the drawing as observed by the psychologist are also taken into account (Kreuter-Hafer et al., 2016). The client's history and symptoms are also considered in understanding the drawing, aiming to gain insight into the client's subjective experience and the emotional content the client portrays (Wienand, 2016).

For example, Wienand (2020) presents a case study to illustrate diagnostic insights gained from a HTFWP drawing involving a 12-year-old girl facing severe bullying in school due to a slight developmental delay. Wienand commented that despite downplaying her situation in conversation and emphasizing her ability to cope, the girl’s HTFWP drawing (Figure 3) reveals her hidden struggles.

Figure 3

An illustration from Wienand (2020)

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The person does not seem to be present in the drawing so the assumption is that she is inside the round, fortress-like house with locked doors and windows. Alongside these self-protective symbols, there are threatening signs that include circling birds of prey and a possible forbing sign of a setting sun. The house is built on a green field and the fact that there are no flowers in this field may carry connotations of sadness. A river seems to flow from the sky, indicative of a tornado, with scorched earth on the right-hand side. The tree crowns, alight with bright fire, resemble bombs that are exploding, adding to the overall sense of havoc and distress in the drawing (Wienand, 2020). This example highlights the significance of the HTFWP drawing as it can reveal nuanced aspects of a child's inner world that might not be readily expressed through verbal communication alone.

3.3.2.4 Compatibility with Sandplay Therapy

The HTFWP drawing and sandplay therapy share several similarities. Both provide a means for children to express themselves nonverbally. The opportunity for non-verbal communication is valuable as children may find it challenging to articulate their emotions or experiences through traditional verbal communication (see also Section 3.3). Instead of speech, they can utilize visual and symbolic representations

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to convey their thoughts and feelings. In addition, both approaches (i.e., sandplay and the HTFWP drawing) involve the use of symbols and metaphors as they are both grounded in Jungian psychology (Groschwitz, 2016; Kreuter-Hafer et al., 2016; Liu et al., 2021; Maurer et al., 2017; Park, 2020; Roesler, 2019; Wienand, 2016; Zappacosta, 2012). In the HTFWP drawing, children use simple images to represent their psychological state, including conscious and unconscious themes, developmental stages, conflict, and psychodynamics (Groschwitz, 2016). Similarly, in sandplay therapy, children create scenes using miniature figurines and objects, symbolically representing their inner world and personal experiences (Clark & Reddy, 2021; Homeyer & Sweeney, 2023; Jang & Kim, 2012). Furthermore, both modalities encourage exploration and self-discovery. Through the drawing or the creation of sandplay scenes, children are provided with a safe and contained space to explore their thoughts, emotions, and life experiences (Usländer & Reitz, 2015). This process allows them to gain insight, process challenging feelings, and make meaning of their experiences. In addition, both approaches aim to enhance understanding and foster a positive therapeutic relationship between the child and the therapist (Wienand, 2020). By engaging in these expressive activities, children can establish a sense of trust, develop a connection with the therapist, and feel understood and validated (Clayborne et al., 2021; Vigdal & Brønnick, 2022). Finally, both the HTFWP drawing and sandplay therapy offer flexibility in their application (Lee & Jang, 2020; Wienand, 2020). They can be adapted to suit the unique needs and preferences of each child, allowing for individualized therapeutic experience. The similarities between the HTFWP drawing and sandplay makes this drawing uniquely compatible with this therapeutic modality.

3.4 Conclusion

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Resilience plays a pivotal role in helping children navigate challenges, such as GAD, and thrive (Masten, 2014, 2021b; Wu & Ou, 2021). A child's resilience to anxiety is supported by protective resources that are found across systems (Ungar & Theron, 2020). One of these protective resources is sandplay therapy (Foo et al., 2020; Foo & Pratiwi, 2021; Ghaljaei et al., 2023; Homeyer, 2015; Khojasteh, 2020; Kostyuninaa & Valeeva, 2016; Li et al., 2022; Nasab & Alipour, 2015; Park, 2020; Roesler, 2019; Tan et al., 2021; Wiersma et al., 2022; Yoo, 2015;). Related to therapy, another protective resource is the parent-psychologist alliance. In child psychotherapy, a strong alliance benefits parents, children, and the psychologist (Bram, 2021; Diamond et al., 2000; Fox, 2012; Kazdin et al., 2006). It helps enhance parental insight into the child's behaviour and bolsters parenting skills (Campbell & Simmonds, 2011; Fox, 2012; Grosberg, 2019; Kazdin & Whitley, 2006; Kazdin et al., 2006). It also helps the psychologist establish rapport and develop effective treatment plans (de Greef et al., 2017; Kottler, 2016); while it has spill-over effects that provide the child with a nurturing family environment (Bram, 2021; Diamond et al., 2000).

Likewise, the parent-psychologist alliance, a critical component of therapy for children with GAD has the potential to reinforce a parent's resilience to the challenges of parenting a child with GAD (de Greef et al., 2017; Diamond et al., 2000; Feinstein et al., 2009; Fox, 2012; Gvion & Bar, 2014; Kazdin & Whitley, 2006; Nevas & Farber, 2001; Ruberman, 2009; Zemmelman, 2018). These factors contribute to bolstering the resilience of the child in their challenge of managing GAD. This alliance implies parents becoming active partners in their child's therapeutic journey (Bram, 2021).

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However, beyond suggesting that parents are included in sandplay and/or interviewed (Cao et al., 2019; Green & Connelly, 2009; Homeyer, 2015; Kaduson & Schaefer, 2006; Liu et al., 2023; Punnett, 2015; Rousseau et al., 2009), the existing literature lacks specific guidance on how best to establish a strong parent-psychologist alliance when the child is sandplay therapy (Accurso & Garland, 2015; Zorzella et al., 2017). This limits the treating psychologist's ability to fully harness the potential benefits of a parent-psychologist alliance. The literature on the value of drawings to children in therapy, their parents, and the treating psychologist encourages consideration of using drawings to create a parent-psychologist alliance, but I could find no African studies confirming this. Similarly, I could find not studies focused on how to build robust parent-psychologist alliances when a child is in therapy for GAD (even though the incidence of childhood GAD is high, also in South Africa; Subramaney et al., 2020).

In response to this uncertainty of how to create the parent-psychologist alliance and in recognition of the importance of this alliance to the therapeutic process of a child-client, my study explores the benefits of using the HTFWP drawing method within the framework of sandplay therapy for children facing the challenges of GAD. In so doing, my study builds on the evidence-informed potential of the parent-psychologist alliance to foster resilience in children with GAD and the unique potential of drawings to so, with specific attention to HTFWP drawings that have hitherto not been researched as a potential tool to support the therapeutic process of the child who is in sandplay therapy for GAD. In the next chapter I detail the methodology I used to achieve my study's purpose.

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Chapter 4

The Methodology of My Study

4.1 Introduction

According to Merriam and Grenier (2019) I understand that for my doctoral research to contribute meaningfully to the field of child psychotherapy it is essential to provide a description of my research methodology. This detailed methodology allows other researchers and fellow mental health professionals to evaluate my study's contribution to the field of child psychotherapy. My main goal for this chapter is to outline my research design, case selection process, data collection methods and procedures, as well as the data analysis and interpretation techniques I utilized in my study. Additionally, this chapter addresses the quality criteria for ensuring research rigour and ethical considerations that guided my research process. I start out by providing an outline of the purpose of my study.

4.2 Purpose of My Study

The purpose of my study was to explore the benefits, if any, of sharing the child-client's series of HTFWP-drawings with their parent/s during parent-feedback sessions when this child is in therapy for GAD. An additional purpose, which was contingent on this exploration yielding benefits, was to provide pointers for psychologists on how to effectively incorporate the child-clients' HTFWP drawing series into parent feedback sessions should it prove to be beneficial. To this end my study had an exploratory purpose. Flick (2010), Yin (2014, 2018), Mason (2002) and Price (2015) suggest that an exploratory purpose is apposite when there are knowledge gaps in the topic under investigation. This idea is echoed by Guest (2013), Cohen et al. (2007) and Thomas, (2010) who state that the less there is known about the topic, the more likely the purpose for that research should be

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exploratory in nature. Through my study I wanted to address the lack of information regarding how best to provide feedback to parents whose child is in therapy in ways that foster a parent-psychologist alliance and advance parenting skill. Specifically, I wanted to address researcher and practitioner inattention to incorporating children's HTFWP drawings made during sandplay therapy, and using these drawings to facilitate conversation in feedback sessions with parents. Given these gaps in existing literature, I found it fitting to adopt an exploratory stance for my research.

Yin (2014, 2018) also emphasises that when researchers can propose theories and ideas for exploration through their work an exploratory research purpose holds significance. As there is no prevailing theory or practical guidelines to inform the use of the HTFWP drawing in the way I did, I deemed my choice of an exploratory purpose appropriate. My initial hope was that my study would potentially generate new ideas, perspectives, and understandings on how sharing these drawings might be beneficial in child psychotherapy and, hopefully, spark larger follow-up studies. In addition, my purpose was exploratory as I was initially driven by interest and curiosity about how other psychologists could perhaps be advised to use HTFWP drawings to support their therapeutic practice. Again, this resonates with the ideas of Stake (2006), Yin (2014), and Merriam and Grenier (2019), on the exploratory purpose of research.

Furthermore, when the purpose of a study is exploratory, it allows one to deeply investigate a topic (Creswell, 2007, 2012, 2024; Yanow & Schwartz-Shea, 2015). As I intended to deeply explore the possible benefits of sharing HTFWP drawings of children in psychotherapy for GAD with their parents, adopting an exploratory purpose seemed fitting. I did not have a defined set of outcomes in mind aligning with Lucas et al's (2018) view on research with an exploratory purpose that

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involves examining situations without predefined outcomes. In addition, Guest (2013) suggests that the absence of predefined outcomes makes the approach of exploratory research appropriate since there are no preconceived notions. The alignment of my ideas with these two researchers further emphasised the suitability of my choice of an exploratory purpose.

Furthermore, Price (2015) supports this aspect of exploratory research by stating that it is appropriate when the research question is broad and tentative or when the aim is to grasp what it feels like to undergo a particular experience. Aligning with this is Creswell's (2007; 2013; 2024) assertion that exploratory research questions are characterized by their open-ended and non-directional nature. My study was aligned with these principles as it was guided by two research questions that were broad and non-directional (see Chapter 1, Section 1.4).

However, while valuable for generating new ideas and hypotheses for follow-up large-scale studies, exploratory research comes with inherent limitations that I carefully considered and strategically managed. One common limitation associated with exploratory research is that it does not allow the researcher to make general claims (Maxwell, 2022). However, in keeping with the tenets of a qualitative approach as outlined in Chapter 1 (see Section 1.7.3), the purpose of my study was not to generalise findings; instead, it was to explore the potential benefits of sharing the child-client's HTFWP drawing with their parents in order to provide possible insights and pointers for other mental health practitioners working with children undergoing therapy for GAD. By detailing the context of my study and the informants included in it, I make it possible for others to decide how transferable my study's findings are to their context and clients.

4.3 Research Design

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In Chapter 1 (see Section 1.7), I clarified the paradigmatic lenses that framed my study. Briefly, my ontological lens was social constructivism, which considers the co-construction of reality through discourse and symbols within a social context (Creswell & Creswell, 2023; Willig, 2021). Building on this belief is my epistemological framework, namely, Symbolic Interactionism. This lens considered knowledge to be socially constructed with the aid of the interpretation of the meaning of symbols where symbols could be drawings, non-verbal language and verbal language. My theoretical lens was based on multisystemic resilience, Bronfenbrenner's social ecological theory and the supporting alliances model. This framework indicated the influence of different systems on the risks for anxiety and the protective resources for resilience to anxiety. Fostering resilience is therefore dependent on the social ecology of the child, which includes parents and treating psychologists. To maximise therapy it is important to develop the supporting alliance between the parents and treating psychologists. With this framework in mind, I will discuss my research design, which is an instrumental multiple case study. I will start out with a discussion of multiple case study design.

4.3.1 Multiple Case Study Design

In order to understand multiple case study design I first needed an understanding of what constitutes a case. According to Merriam and Tisdell (2016) and Price (2015), a case can be an individual, an organisation, a community, a family, an event or process whose characteristics are determined by the focus of research. A multiple case study design is therefore defined as a number of cases that are complex, bounded, studied in their natural context and analysed holistically (Merriam & Tisdell, 2016; Price, 2015; Tight, 2022; Yin, 2018). A multiple case study design aligns with my ontological belief of social constructionism, which is based on

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multiple realities as each informant presents with their own reality (Creswell & Creswell, 2023; Merriam & Tisdell, 2016; Willig, 2021).

When researchers bind a case they delimit the parameters, boundaries and characteristics of the case so that the study remains focused and guides the selection of cases in order to respond adequately to the research question (Creswell & Creswell, 2023; Merriam and Grenier, 2019). Aligning with the theoretical framework of multiple case studies, I adopted a systematic exploration of seven cases (i.e., each case comprising a child-client and their parent(s)). Adhering to the principles of multiple case study design, each case formed a distinct and bounded system (Creswell, 2007, 2012, 2024; Merriam & Tisdell, 2016; Tight, 2022). As set out by Thomas (2010), the parameters, which set the boundaries for my cases, were determined by my research questions and the purpose of my study. Bounding or delimiting my cases helped me manage the scope of my study in order to ensure that my research remained feasible and practical (Flick, 2018; Tight, 2022). In addition, it allowed me to draw comparisons and contrasts across cases (Cohen et al., 2007; Flick, 2018). My exploration of these bounded systems provided a nuanced and rich description of the experiences and dynamics within each case. In addition to the criteria that made a case eligible or not (see Section 4.5), the bounded system of each case was governed by explicit parameters that included physical and temporal criteria (Creswell, 2007, 2012; Merriam & Tisdell, 2016).

4.3.1.1 Physical Boundary

The physical setting, where interaction between myself, the child-client and/or their parent(s) occurred, was limited to my practice, which is situated in Table View. My therapy space is divided into two sections with an inter-leading archway. When you enter my practice there is a consultation room that is triangular in shape with two

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walls completely of glass that can be covered by blinds. The glass is one way that allows one to look out but not in, allowing some privacy. There is a couch on your right and table with chairs on your left (see Figure 4). As you walk into this space and then go through an archway you enter my sandplay room (see Figure 5). Specifically, interaction with the child-client takes place in either the sandplay area (for sandplay therapy) or consultation area (for drawing). Interaction with the parent(s) takes place in the consultation room at the ‘drawing’ table.

Figure 4

Entering my consultation room



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Figure 5

The archway leading to the sandplay therapy room



4.3.1.2 Temporal Boundary

The temporal boundary of my interaction with the cases stretched from August 2022 to December 2022, bridging two school terms. During this period, I had sufficient contact with both the child-clients and their parents, which helped me gather comprehensive data to address my research questions. Moreover, having a clear temporal boundary helped parents manage their time amidst their other responsibilities.

4.3.1.3 Advantages and Limitations of Multiple Case Study Design

My selection of a multiple case study design for my research was particularly fitting, as it enabled an in-depth exploration of the focus of my research (Merriam, 1998; Merriam & Tisdell, 2016; Yazan, 2015). Specifically, my focus was to explore the benefits, if any, to the therapeutic process of sharing the child-client's series of

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HTFWP-drawings with their parent(s) during parent-feedback sessions when the child was in sandplay therapy for GAD. Working with multiple cases meant I could compare and contrast these potential benefits and so develop a fuller understanding.

Multiple case study design also encourages diverse data sources. In my study, data was derived from forms requesting biographical detail completed by primary informants, the child behaviour checklist and sessions I facilitated with my informants. These sessions included: two semi-structured interviews (primary informants), three feedback conversations (primary informants), drawings (secondary informants), and the accompanying stories related to their drawings (secondary informants) (see Section 4.7). These diverse sources of data yielded rich information.

Additionally, as highlighted by Flick (2018), multiple case studies rely on constructed knowledge, which formed part of my paradigmatic framework (see Chapter 1, Section 1.7). The in-depth, detailed explorations intrinsic to a multiple case study facilitated the co-construction of knowledge through the interpretation of symbols via HTFWP-drawing elicitation conversations with parents creating new understandings and meanings (Merriam, 1998; Merriam & Tisdell, 2016). This process also aligned well with my epistemological lens of Symbolic Interactionism (Gallin, 2022; Quist-Adade, 2019; Salvini, 2019; Segre, 2019; Totkova, 2019; van der Vaart et al., 2018; Willis Hepp et al., 2019; Yazan, 2015). A multiple case study design therefore allowed for the social construction of knowledge and the consideration of a multisystemic or social ecological approach thereby maximising the supportive relationships in the lives of children.

Using a multiple case study design enhanced the quality and depth of my study while also potentiating theory building (George & Bennett, 2005; van der Vaart

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et al., 2018). Given the limited existing theory on how best to provide feedback to parents whose child is in therapy, including the potential value of the HTFWP drawings in the facilitation of parent-psychologist alliances in child therapy and other benefits, I deemed a multiple case study design well-suited for my study. Essentially, it allowed me to theorise the benefits of the HTFWP drawings to the therapeutic process and to suggest aligned pointers for other mental health practitioners.

4.3.2 Instrumental Case Study Design

Multiple case studies can include various types of studies such as exploratory, explanatory, replication, holistic, longitudinal, instrumental and intrinsic (Kekeya, 2021; Tight, 2022; Yin, 2018). I adopted an instrumental case study design. An instrumental case study design is a research methodology aimed at providing insight into an issue or refining a theory where multiple cases are instrumental (i.e., influential or instructive) in fulfilling this role (Lucas et al., 2018; Luck et al., 2006; Baxter & Jack, 2008; Laframboise & Shea, 2009; Gordin, 2006; Kekeya, 2021). Aligning with the ideas of Mason (2002) and Merriam and Tisdell (2016), the findings that I generated from my multiple case study were instrumental in allowing me to theorise what benefits the HTFWP drawings hold for the therapeutic process of children in therapy for GAD. They were also instructive to the guidelines that I generated to potentially inform the practice of psychologists about practical applications and implications for sharing child-clients' drawings with parents.

The focus of an instrumental case study is not on the intrinsic characteristics of the case but on how it facilitates understanding of a broader phenomenon or concept (Nowell et al., 2017). It involves an in-depth examination of the case's context, activities, and circumstances to support the researcher's external or research interests (Kalu & Bwayla, 2017). In other words, my cases were selected

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because they were instrumental (i.e., relevant or useful) to providing significant answers to my research questions. Typical of instrumental case studies, my study delved deeply into the possible benefits of sharing the child-client's drawings with their parents. Consequently, employing an instrumental case study design enabled me to gain a nuanced understanding of the advantages of sharing the child-client's drawings with their parents. This facilitated comprehension of the practical applications and potential challenges when sharing the child's drawing series with their parents, while also contributing to theory building associated with the utilization of these drawings (Baxter & Jack, 2008).

Despite its usefulness, instrumental case study design also presents a significant limitation that I needed to address and manage. This limitation revolved around the challenge of transferring findings from instrumental case studies, which are designed to inform practice and build related theory, to various real-world settings or contexts where those findings may need to be applied (Cohen et al., 2007; Flick, 2018). To address this limitation, I added detailed descriptions of the cases, methods and analyses used to provide a more comprehensive understanding of the phenomenon under investigation, thereby enhancing the applicability and relevance of the findings beyond the immediate practice context (Yanow & Schwartz-Shea, 2015). I selected multiple cases to ensure that a wide variety of instances were examined (i.e., I explored the benefits of sharing the child's HTFWP drawing series with their parents in parent feedback sessions with 7 cases). Aligning with the ideas presented by Flick (2018) on theory building and informing practice, a multiple case study increased the possibility that my findings could be relevant to mental health practitioners working with child-clients diagnosed with GAD as well as those wanting to bolster parent-psychologist alliances.

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4.4 Contextualising My Study

As noted in the physical boundaries of my case study (see 4.3.1.1), my study was based at my private psychological practice in Table View. Table View with a population of 17 390 is a suburb in Blouberg (population – 106 222) (Statistics South Africa, 2011). Table View is diverse in its socio-economic make-up. To the far west of my practice is the well-known Blouberg Beach, popular for its long sandy beach, water sports, and beautiful sunsets (see Figure 6). To the east of my practice is Dunoon, an informal settlement characterized by informal, makeshift housing that lacks basic amenities and services (see Figure 7). According to the 2011 census (Statistics South Africa, 2011) 17.2% of the population of Blouberg earn less than R5000 per month (14.8% having no income), while 9.3% earn above R614 000.

Figure 6

Table Mountain at sunset



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Figure 7

Dunoon



According to recent newspaper reports by Luhanga (2023, 2024) and Tshwete (2023), as well as a synthesis report by Misago (2017), Dunoon experiences high population density, overcrowded schools, limited access to clean water, sanitation issues, high crime, poor infrastructure and a lack of formalized roads. This is in stark contrast to the affluent families living along the Blouberg beach front.

There are 29 public and independent primary schools in Blouberg (National Department of Basic Education, 2021). The two primary schools I approached to be part of my study were previously known as ‘Model C’ schools. One was in the Table View area and the other was in Milnerton, a suburb next to Blouberg; both with a similar student body comprising a blend of low, middle and high socioeconomic status students.

In South Africa, the term ‘Model C’ originated from the apartheid era when government schools were categorized into different models based on the racial composition of their students. Model C schools were previously designated for white students under the apartheid system (Spaull, 2013). After the end of apartheid in the

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early 1990s, South Africa underwent significant educational reforms. Although it was noted by Wray et al. (2018) that the efforts to transform and integrate schools were not good enough, Model C schools nevertheless adopted non-racial policies, transforming into open-admission schools that could admit students of any race or background. I selected two Model C schools as they represented a diverse student population with diverse socio-economic origins. In addition, my choice of these two schools was influenced by the convenience of their proximity to my practice, making travel easier for informants. Finally, my choice related to the fact that each of these schools had a mental health professional on the staff, which was important to my case selection as these mental health professionals were the gatekeepers in my study (see Section 4.5).

My practice operates as a private psychology practice, meaning it is independently operated by me. I maintain full control over its operation and management. Clients, typically parents, directly seek services from me. I advertise my practice through an online platform called Findhelp, but most of my clientele come through word-of-mouth referrals.

My practice is located at the back of my home, with a separate entrance for clients. When scheduling appointments, I ensure a 15 to 30 minute gap between clients to maintain confidentiality and prevent overlaps. Consequently, I do not have a waiting room. Parents who choose to wait for their children do so in their cars. For those arriving via public transport, there is an outside, partially enclosed area available for waiting. The consultation space for child-clients and parent feedback sessions is entirely private (see Figure 4 and Figure 5). Private consultation space in my practice is therefore completely different to a public clinic that typically only has a dedicated day for child and adolescent mental health clients and few, if any,

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dedicated therapy or parent/family consultation spaces (Mokitimi, 2024). Additionally, my practice includes its own restroom to ensure a clear separation between my home and business.

4.5 Case Selection

I used purposive sampling techniques to select the cases that would further the objectives of my study. Purposive sampling, also known as purposeful or non-representative sampling, is a qualitative research method used to select informants deliberately based on specific criteria that are relevant to the research objectives (Merriam & Grenier, 2019; Yin, 2018). The advantage of this technique is that it ensures that the selected informants have pertinent experience and/or perspectives relating to the topic of a research study, therefore providing information-rich cases (Braun & Clarke, 2022; Kekeya, 2021; Petty et al., 2012). When viewed through a quantitative lens, the use of purposeful sampling is considered a limitation as the results of the study are not generalizable (Green et al., 2023). However, the findings of my qualitative study were not meant to be generalizable. These information-rich cases served rather to maximise the potential for learning and understanding within the ambit of my research.

The utilization of purposive sampling enabled me to select cases according to my predefined inclusion criteria, guiding the eligibility criteria of cases for my study (Levitt et al., 2018). Each case comprised of a mother and/or father (i.e., the primary informant) and their child (i.e., the secondary informant). The child exhibited symptoms of Generalized Anxiety Disorder (GAD) and was between the ages of 10 and 12 years. The children needed to attend one of the two Model C schools I had identified to be apposite for my study. The children and their parents needed to be willing to engage in the therapy process. They also needed to fulfil all the

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commitments of the research process (i.e., 10 therapy sessions for the child-client and 6 parent contact sessions).

Upon receiving ethical clearance from the Department of Education and the Department of Health Sciences at the University of Pretoria (see Appendix A and B) I was able to select my informants. I started this process by meeting with the gatekeepers at the two schools. Gatekeepers facilitate access to the research site and to the target population (Aspers & Corte, 2019; Billups, 2020; Creswell & Creswell, 2023). The involvement of gatekeepers in my research process helped me navigate the complexities of recruitment (Flick, 2018). The gatekeepers in my study refer to the two mental health professionals at the two government primary schools who facilitated access to my target population (see Section 4.4). The mental health professionals at these schools were, respectively, a clinical social worker and a psychologist. These mental health professionals were registered with the Health Professions Council of South Africa and therefore qualified to identify behavioural concerns specifically related to GAD. I met with these gatekeepers to explain my study and then promoted the study using a recruitment flyer (see Appendix C). The gatekeepers were enthusiastic about the study because they are typically overwhelmed by the number of referrals they deal with at their respective schools, particularly related to anxiety. Subsequently, these gatekeepers sought permission from the principals of their respective schools to advertise my study. They then identified children for my study, specifically those who were not currently engaged in therapy. They did this through referrals they had received from educators at their respective schools who were either concerned about the anxious behaviours of these children or whose parents had approached them concerning the anxious behaviours of their child. Once the children were identified, the gatekeepers

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contacted the parents, explaining my study using a script that I had authored (see Appendix D). When parents of these children indicated their interest in participating in my study, the gatekeepers provided them with a written, comprehensive explanation of my study, which I had authored (see Appendix E). This comprehensive explanation also contained the consent forms for parents to complete (see Appendix E) and assent forms for their child who had been identified with GAD symptoms (see Appendix F). Considering the guidelines of both the Protection of Personal Information Act (POPIA) (2013), which states that personal details of individuals cannot be disseminated without their consent, and the ethical guidelines regarding confidentiality and privacy of the Health Professions Council of South Africa (HPCSA), the contact details of the interested parents were given to me with their consent. I contacted each parent and set up our first meeting. At the first meeting the parents brought their completed consent forms as well as their child's assent forms. The terms of consent and assent were explained once again to ensure that the parents fully understood. At this first meeting parents were also asked to complete a demographic questionnaire (see Section 4.5.1. and Appendix G) as well as a Child Behaviour Checklist (CBCL) (see Appendix H) as created by Achenbach (2018). In addition, parents had to commit upfront to key engagements, including 3 feedback sessions, 2 semi-structured interviews and 10 therapy sessions for their child. Participation in these activities was crucial to gaining comprehensive insights into my research objectives.

As advocated by Creswell (2007, 2013), Merriam (1998), Merriam and Tisdell (2016) and Yin (2018), I included multiple informants to enable a rich exploration of the focus of my research. The gatekeepers referred nine cases to me for this study. I did not include two of these cases as those parents were unable to fulfil the

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commitments of all the contact sessions needed and were therefore not eligible for my study (see Section 4.3.1). In most cases (n = 5) only the mother was available to participate. In the remaining two cases, both parents were able to participate in all the parent sessions. A total of nine parents (i.e., primary informants (seven mothers and two fathers)), and seven children (i.e., secondary informants (four boys and three girls)) participated in my instrumental, multiple-case study.

4.5.1 Informant Demographics

Detailed demographic information for the primary and secondary informants of each case was collated from the form requesting biographical information and is provided in Table 1 and Table 2, respectively. In order to draw up the biographical form and the columns for information related to the primary informant I included individual, parental and family related information. I used my review of the literature on anxiety and the risks and protective resources related to anxiety, particularly for the column related to family stressors. The number of stressors related to each case is indicated in column 7. The stressors considered for this column included:

- parents' divorced
- one/both parents are also anxious
- a parent/sibling has mental health challenges other than anxiety
- a mother losing her job,
- financial constraints in the family
- the family moving to another part of town,
- a deteriorating neighbourhood in terms of safety,
- the loss of a loved one,
- a family member becoming seriously ill,
- a family member being injured,

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- the child being the victim of bullying,
- the child having challenges with his/her sibling relationships,
- the child having academic challenges, and
- the child changing schools.
- the child resisting attending school

In most of the cases (six of the seven cases), the secondary informant reported that one or both parents were anxious. With regard to financial constraints, the employment of the parent seemed to be a challenge in cases where only one of the parents was employed, as well as in one case where both parents were employed but still faced financial insecurity.

The second column in Table 2 related to the gender of the secondary informant. As there were 4 boys and 3 girls in my study, there was little difference in terms of gender difference. In all instances the secondary informant was in the intermediate phase of school (Grade 4 to Grade 6). In two of the cases, the relationship between siblings was acrimonious adding to family stress. In all cases, anxiety-related symptoms had been noticed for more than six months. No comment was made over the course of my study related to the birth order of the secondary informant, but I do report this in Table 2. Finally, there were step siblings in two of the cases. This was considered a challenge for the secondary informant in one of the cases. This challenge could be related to the fact that this step sibling and secondary informant were the same age, whereas in the other case, the step-sibling was an adult.

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Table 1

Demographic Details of Primary Informants

Pseudonym	Which parent was the primary informant	Age range	Marital status	Parent employment	Familial history of anxiety	Stressors in the family	Parent-reported level of concern
Kate	Mother	46 – 50	Married	Both parents employed	Yes	• a deteriorating neighbourhood in terms of safety • Loss of loved one • Parent has mental health challenges	Borderline Clinical
Alice	Mother	31 – 35	Divorced	Both parents employed	No	• Parents divorced • the child having challenges with his sibling relationships • the child having academic challenges • the family moving to another part of town	Borderline Clinical
Cathy	Mother	26 – 30	Married	Father	Yes	• financial constraints in the family	Clinical

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				employed		• the child having challenges with his sibling relationships • the child having academic challenges • the child resisting attending school • the child changing schools	
Hadley (M) and Ashley (F)	Both parents	36 – 40	Married	Both parents employed	Yes	• Parent has mental health challenges • the child being the victim of bullying • the child having challenges with his sibling relationships • the child having academic challenges • the child having challenges with his sibling relationships	Clinical
Hailey (M) and Grant (F)	Both parents	41 – 45	Married	Both parents employed	Yes	• a family member becoming seriously ill • sibling has mental health challenges • the child resisting attending school	Borderline Clinical

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Kimberley	Mother	41 – 45	Divorced	Mother Employed	Yes	• Parents divorced • the family moving to another part of town • a family member becoming seriously ill	Borderline Clinical
Winnie	Mother	36 – 40	Married	Father employed	Yes	• mother lost her job • One/both parents have anxiety • the child resisting attending school	Clinical

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Table 2

Demographic Details of Secondary Informants

Pseudonym	Gender	Grade	When was anxiety first noticed	Number of children in home	Birth order of child-client related to siblings in the home	Step-siblings
Michael	Male	4	>1 year	2	Oldest	Yes
Kurt	Male	5	>1 year	1	Only child	Yes
Eric	Male	5	>1 year	4	2nd oldest	No
Clint	Male	4	>1 year	2	Oldest	No
Ella	Female	5	>1 year	2	Youngest	No
Tessa	Female	6	>1 year	2	Oldest	No
Eliana	Female	6	>6 months	2	Youngest	No

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4.6 Study Process

The research process was conducted at my private practice over approximately 16 weeks, with each session lasting approximately 40 minutes. The therapeutic/research events and activities and the order in which I employed them are provided in Table 3, where the left column indicates the session number, the middle column specifies the targeted informant for each activity, and the right column denotes the specific activity conducted during that session.

Table 3

Schedule of Activities

Session	Informant	Activity
1	Primary	Information processing session for demographic detail
2	Primary	Pre-study semi-structured interview with parent
3	Secondary	First HTFWP drawing
4	Primary	First parent feedback session to discuss the first HTFWP drawing
5	Secondary	Sandplay
6	Secondary	Sandplay
7	Secondary	Sandplay
8	Secondary	Sandplay and second HTFWP drawing
9	Primary	Second parent feedback session to discuss the second HTFWP drawing
10	Secondary	Sandplay
11	Secondary	Sandplay
12	Secondary	Sandplay
13	Secondary	Sandplay
14	Secondary	The final HTFWP drawing
15	Primary	Final parent feedback session to discuss the final HTFWP drawing
16	Primary	Post-study semi-structured interview

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4.7 Data Collection Procedures

Data collection for multiple case studies is typically extensive (Creswell, 2007; Yin, 2018). The following sections describe the specific data collection methods I employed in my study.

4.7.1 Data Collection with Primary Informants

4.7.1.1 Demographic Details

I asked parents to complete a demographic form to help me understand the child's home and developmental context. This form, which was self-developed, included enquiries about the presenting problem, educational background, family data and information on parenting and family life (see appendix H). The results of this form are tabulated in Table 1 and Table 2.

I also asked parents to complete the Child Behaviour Checklist for ages 6 to 18 years (CBCL/6-18) (Achenbach, 2018) (see Appendix H). The CBCL/6-18 is a component of the commonly used Achenbach System of Empirically Based Assessment and is completed by parents to assess behavioural, emotional, and social competencies of children and adolescents (Achenbach, 2018). Previous South African studies have also utilized the CBCL/6-18 (Louw et al., 2016; Rochat et al., 2017). The CBCL/6-18 has demonstrated the ability to distinguish between children with or without behavioural and emotional problems and disorders, and it exhibits credible predictive validity (Novick, 1999). Moreover, the CBCL/6-18 has strong external, criterion-related, and construct validity (Achenbach, 1998; Novik, 1999). I used the CBCL/6-18 to gain a better understanding of the reason for referral and the level of parental concern regarding their children's anxiety. Parental concerns are assessed on distinct scales within this checklist, ranging from not prevalent, or typical for age, to increasingly prevalent or borderline clinical, and ultimately most

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prevalent or clinical. In my study, four cases denoted the child-client's anxiety as borderline clinical while three cases indicated anxiety within the clinical range (see Table 1, column 8). In other words, across all cases parents had high levels of concern.

4.7.1.2 Initial Semi-Structured Interview

I designed a semi-structured interview protocol for administration after my information processing session with the primary informants (i.e., parent participants) (see Table 4). Semi-structured interviews contain a mix of more or less structured questions that are open-ended and non-directive in nature (Billups, 2020). This means that responses to these questions have several options, not just 'yes' or 'no', and respondents can choose their own words, context, descriptions and meanings when responding to the question. The interview is guided by the encounter with the informants and is based on a list of questions or issues that need to be explored.

A semi-structured interview has several advantages. These interviews allow for a balance between structure and flexibility, enabling me to adapt the interview process based on my primary informant's responses (Billups, 2020; Creswell & Creswell, 2023; Levitt et al., 2018; Merriam & Grenier, 2019). The sequence of the questions I asked in the semi-structured interview aimed to develop a coherent storyline, thus this sequence could be adapted to lead to a deeper exploration and understanding of the secondary informant's experiences (Billups, 2020; Merriam & Grenier, 2019; Roulston & Halpin, 2022). Additionally, it enhanced the richness of the data collected as I could pursue new leads as they arose through the use of probing questions that gave informants the opportunity to elaborate on their responses, providing real-life examples as illustrations in some instances (Billups, 2020; Creswell & Creswell, 2023; Levitt et al., 2018; Merriam & Grenier, 2019;

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Weston et al., 2022). Probes were therefore used to gather sufficient detail, examples and stories from each informant's perspective (Billups, 2020).

My pre-study semi-structured interviews began with the following introduction: "In this interview, I will ask you a few questions about your child, your relationship with your child, your parenting with regard to your child's anxiety, and your expectations of the therapy process." Table 4 displays the interview questions (in bold) along with prompts for elaboration (in italics). The second column outlines the rationale for each question, illustrating the alignment between concepts generated from the research question and gaps in the literature review.

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Table 4

Interview Questions

	Interview Questions for pre-study	The concept being explored
1	**What is your understanding of your child's anxiety?** *What is the cause?*	Insight into their child's anxiety
2	**How is your child's anxiety evidenced in their behaviour?** *What does it look like, what coping mechanisms does your child use?*	Insight into their child's anxiety
3	**How do you respond to that behaviour?**	Co-management of their child's anxiety
4	**What three words would best describe how you try to support your child when they are anxious?** *Can you give me an illustration/example of what this would look like?*	Co-management of their child's anxiety
5	**What are your expectations of a parent-psychologist feedback session?**	Parent-psychologist alliance
6	**How do you think a collaborative working relationship between parent and psychologist fits into a child's therapeutic process?**	Parent-psychologist alliance
7	**What aspects of parent feedback sessions could be considered particularly useful?**	Parent-psychologist alliance
8	**What do you think the possible value of parent feedback sessions could be?**	Parent-psychologist alliance

I was aware of the limitations of semi-structured interviews. Firstly, they require a level of skill in navigating the balance between structure and flexibility (Billups, 2020; Merriam & Grenier, 2019). Drawing upon my years of experience (i.e.,

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17 years) as an Educational Psychologist proved invaluable in striking this balance, given that my profession demands insight into human behaviour, honed active listening skills, and adeptness in flexible communication. Additionally, my probing during the semi-structured interviews had the potential to introduce bias into the data collection process (Billups, 2020; Creswell & Creswell, 2023). To mitigate this limitation, I employed open-ended probes and carefully selected a few to include in my interview protocol. Furthermore, analysing data from semi-structured interviews is challenging due to the diverse nature of responses (Merriam & Grenier, 2019). Utilizing reflexive thematic analysis (Braun & Clarke, 2013, 2021a, 2021b, 2022; Braun et al., 2022) facilitated the systematic analysis of my data, while also prompting continuous reflection on my role as a researcher. I therefore explicitly acknowledged my assumptions to support reflection on how they influenced the analysis.

4.7.1.3 HTFWP-Drawing-Elicitation Conversations

Qualitative researchers often supplement traditional interviews with other ways of eliciting data (Roulston & Halpin, 2022). These elicitation methods encourage the exploration of research topics through reflections on physical objects, images (photographs), graphics (diagrams of time-lines and genograms), and vignettes (Billups, 2020; Roulston & Halpin, 2022). They are sometimes used prior to the traditional individual interview as an ice-breaker (Billups, 2020). They can also be used to incite emotion and bring feeling to the conversation in interviews (Johnson & Reavey, 2022). At times the elicitation tool (image or object) is brought to the interview by the informant or the researcher brings existing resources to discuss in the interview in order to prompt discussion, enhance communication, and elicit deeper insights from informants (Bagnoli, 2009; Glaw et al., 2017; Johnson &

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Reavey, 2022). The outcomes, when using elicitation tools, are collaborative endeavours, characterised by shared theorizing that aligns with an epistemological lens. However, the researcher fulfils the role of facilitator guiding the informants in framing and articulating their responses (Glaw et al., 2017).

I adapted these elicitation methods for my study. In my study, the elicitation tool for parent feedback sessions was the HTFWP drawing created by the child-clients during therapy sessions with me (not in the presence of their parents). I termed my adapted elicitation methodology an 'HTFWP-drawing elicitation conversation'. I engaged each parent (or parent dyad) in three HTFWP-drawing elicitation conversations.

With the child-client's assent each time, I brought their most recent HTFWP drawing to each HTFWP-drawing elicitation conversation where I asked primary informants to respond to the drawing in a specific way indicated as a statement below. Aligning with Bravington and King (2019), my introduction of the drawings served as a catalyst for conversation, and enriched the dialogue, helping my primary informants to articulate their thoughts, feelings, and experiences in a more tangible and accessible way. Coinciding with the ideas of Hense (2023), I found this method to be particularly useful in exploring complex or sensitive topics relating to their child's anxiety (such as divorce), as well as in engaging parents who may have difficulty expressing themselves verbally. I used open-ended questions or prompts to guide the conversation and encouraged parents to share their perspectives.

These HTFWP-drawing elicitation conversations were scheduled a few days after each HTFWP drawing was completed by the child. The elicitation conversations happened at the beginning, approximately halfway through, and at the end of the therapeutic process (see Table 3). In each of these sessions, the parent(s) and I

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discussed the most recent HTFWP drawing created by their child. I encouraged the parent/s to engage in free association. According to Hollway and Jefferson (2000), free association is verbalizing any emotions, thoughts and associations without censorship. In our HTFWP-drawing elicitation conversations we practiced free association by exploring the different elements of colour, composition, the relationship between elements, their child's inner resources, and the emotions evoked by their child's drawing. I elicited these free associations by asking open-ended questions (see Table 5).

Before showing the parents the HTFWP drawing, I provided a statement:

> I am about to show you a drawing done by your child that they have given permission for me to share with you. I am showing you this drawing so that we can better understand your child's challenges and gain a glimpse of the way they view life. It may be your natural response to focus on what you see rather than how it makes you feel, but the first thing I would be interested in are the feelings the drawing evokes and then what the various aspects of the drawing make you think of with regards to your child, your family, or yourself. You could start with your immediate emotional reaction to the drawing.

This process where one first explored one's feelings when exposed to a visual stimulus was taught to me by my sandplay therapy supervisors, when we examined sandplays of children I brought to supervision. However, I adapted the process that was used in conjunction with sandplay therapy supervision to support parent exploration of the HTFWP drawing and to enhance the parent's and my understanding of the HTFWP drawing.

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At the end of discussion of each drawing, I shared the narrative their child had shared with me of their drawing. I also shared some of their child's insights of their drawing with the parents. This allowed them to gain insight into their child's interpretation of the drawing and to compare it with their own perspectives, highlighting any differences or similarities.

4.7.1.3.1 Advantages and Limitations of Elicitation Methods

According to Bagnoli (2009) and Johnson and Reavey (2022), the advantages of elicitation methods are that they facilitate communication between the researcher and informants. Visual stimuli can evoke deeper responses and insights from informants, thereby aiding rich exploratory work (Bravington & King, 2019; Glaw et al., 2017; Hense, 2023; Johnson & Reavey, 2022). Additionally, they provide additional insights as the researcher can observe non-verbal behaviours during interaction (Billups, 2020). Researchers can immediately ask follow-up questions during the interaction, leading to deeper insights (Billups, 2020).

The limitations relate to the bias of the researcher as drawings and other artefacts can be interpreted subjectively (Bagnoli, 2009; Glaw et al., 2017; Johnson & Reavey, 2022). I managed this limitation as I did not provide my analysis of the drawings but rather elicited the parents' understanding and brought in the child's interpretation.

In addition, not all informants may feel comfortable using visual methods, which could lead to incomplete responses. To manage this limitation, I showed my respect for the opinions and perspectives offered by the parents during the HTFWP-drawing elicitation conversation. This set the tone for a non-judgemental, discursive environment, enhanced our rapport, and encouraged parents to feel more at ease with using this visual method.

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Furthermore, elicitation methods are not easily generalizable (Bagnoli, 2009). However, I prioritised depth and rich detail in my study and not generalizability, which is a quantitative construct. I was more interested in exploring and understanding the unique perspectives, experiences and contexts of the informants in my study and in exploring the benefits, if any, of sharing the child-client's series of HTFWP-drawings with their parent(s) during HTFWP-drawing elicitation conversations when their child is in therapy for GAD.

Table 5

Open Ended Questions

	Open-ended questions
1	What emotions or feelings arise for you as you look at this drawing?
2	What thoughts or associations come to mind when you look at the different elements of the drawing?
3	How do you understand the use of colours and symbols in the drawing?
4	What aspect of the drawing resonates with your child's experiences, your family dynamics or your own reflections?
5	Are there any particular details or patterns in the drawing that stand out to you? If so, what do you think they might represent?
6	Which part of this drawing tells you about your child's anxiety?
7	Which part of the drawing speaks about your child's autonomy/self-sufficiency or dependency?
8	Just looking at the elements of the drawing, which parts do you wish were different?
9	Which aspects speak about resources and resilience in your child?
10	What gives you a sense of hope?

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4.7.1.4 Final Semi-structured Interview

The final semi-structured interviews took place a few days after the third and last HTFWP-drawing elicitation conversation. The interview questions were based on the pre-study semi-structured interview. I started the final semi-structured interviews with the following statement: "Now that we are in the final week of this research and therapy process, I am going to ask you some questions like the ones asked in the very first interview". Table 6 shows the questions that I asked. As in the pre-study interview, the interview questions are in bold, and the prompts for elaboration in italics. The rationale for each question is in the right column.

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Table 6

Semi Structured Interview Post Study

	Interview questions for post-study	The concept being explored
1	**Now that we've completed the study, what is your understanding of your child's anxiety?** *What is the cause?*	Insight into their child's anxiety
2	**How is your child's anxiety evidenced in their behaviour?** *What does it look like, what coping mechanisms does your child use? How is this different to what you saw before intervention?*	Insight into their child's anxiety
3	**How do you now respond to that behaviour?**	Co-management of their child's anxiety
4	**What three words would best describe how now you try to support your child when they are anxious?** *Can you give me an illustration/example of what this would look like?*	Co-management of their child's anxiety
5	**If your child went to therapy again, what are your expectations of a parent-psychologist feedback session?**	Parent-psychologist alliance
6	**How do you think a collaborative working relationship between parent and psychologist fits into a child's therapeutic process?**	Parent-psychologist alliance
7	**What aspects of parent feedback sessions could be considered particularly useful?**	Parent-psychologist alliance
8	**What do you think the possible value of parent feedback sessions could be?**	Parent-psychologist alliance

4.7.2 Data Collection with Secondary Informants

4.7.2.1 HTFWP Drawing Sessions

Drawings created at intervals during the therapy process are often indicative of the progress made in treatment (Allan, 1988; Baghdadi et al., 2020; Broecher,

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2012; Çetin & Güneş, 2021; Springer et al., 2020; Truneckova, 2021). With this understanding, I implemented a partially directive technique (i.e., a HTFWP drawing), requesting the child to create a specific image three times throughout the therapeutic process. The technique was directive in that I provided a specific prompt: “I would like you to draw a picture of a house, tree, fire, water and person. You can do it in any order. It is not about how well you draw, but more about the story your drawing is telling me”. It was non-directive in that the child could draw the elements in any order and had a choice to use a pencil, pencil crayons and/or retractable wax crayons. The child was asked to draw at the beginning of the therapy process, after the fourth therapy session, and at the end of the therapeutic process.

It has been noted that storytelling is a more spontaneous and creative means for children to express their feelings and more comprehensively represent their perspectives compared to direct statements (Bain et al., 2013). Consequently, after each drawing, I posed the question, "What story is your drawing telling?" to the child. This open-ended question aimed to encourage the child to reflect on the narrative or meaning embedded within their artwork. Open-ended questions are designed to encourage elaboration and discourage dichotomous (yes/no) responses (Billups, 2020). To further explore their drawing and elicit deeper insights, I followed up with the probing questions given in Table 7.

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Table 7

Probing Questions

	Probing questions
1	How has the way you have drawn the house/tree/fire/water/person helped you tell that story?
2	Can you tell me more about the characters/objects in your drawing?
3	What emotions/feelings do you think the drawing represents?
4	Are there any specific details in the drawing that stand out to you? What about that detail makes it stand out?
5	How does the drawing relate to you experiences/thoughts about anxiety?
6	In which way have the colours you used helped convey that story?

These probing questions were designed to prompt the child to reflect on the specific elements and features of their drawing and consider how those choices contributed to the overall narrative they intended to convey. By exploring the child's use of symbols, imagery, and colours, I aimed to gain a deeper understanding of the personal significance and meaning attached to their artwork. With the child's verbal consent, which I asked for each time they did a drawing (in addition to the written assent granted at the beginning of the research), I shared their HTFWP drawing and the narratives associated with the drawing during the HTFWP-drawing elicitation conversations with their parent(s).

4.8 Data Documentation

To ensure comprehensive data collection, pre- and post-study semi-structured interviews and HTFWP-drawing elicitation conversations with primary informants were video and audio-recorded. All recordings were later transcribed by a third party transcriber. The decision to use both video and audio recordings was based on the advantages they offered. Video recordings captured nonverbal information such as

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body language, while audio recordings were easier to transcribe (Byrne, 2022; Cohen et al., 2007; Flick, 2010). These recordings, along with the transcriptions, were saved on my password-protected laptop to ensure data security. The stories about their drawings, as expressed by the children, were written in my therapy process notes. The original HTFWP drawings and therapy process notes were kept in a locked filing cabinet at my practice. The series of HTFWP drawings were also stored in two electronic formats: digital photograph format and as a portable document format (PDF). In these formats, the drawings and their accompanying stories from the secondary informants were stored on my password-protected laptop.

4.9 Data Analysis

I included the following data in the analysis: Two semi-structured interview transcripts and three HTFWP-drawing elicitation conversation transcripts for each primary informant, as well as the HTFWP-drawing series with their stories for each secondary informant. It is important to note that I used the child's explanations of their HTFWP drawings and the parents' reflections of their child's HTFWP drawings. I did not conduct a clinical analysis of the HTFWP drawings for the purposes of my study.

I employed a Reflexive Thematic Analysis (RTA) approach to analyse the transcribed data, following the guidelines outlined by Braun and Clarke (2021a; 2021b; 2022) and Braun et al. (2022). Reflexive thematic data analysis is a qualitative research methodology that builds on Braun and Clarke's earlier version of thematic analysis (Braun & Clarke, 2006). Whereas thematic analysis focuses on identifying patterns or themes within a dataset (Braun & Clarke, 2006), RTA emphasises the researcher's reflexivity in shaping the analytic process, including which themes are identified and how they are understood and interpreted (Braun &

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Clarke, 2021a; 2021b; 2022). Reflexivity is defined as the process of recognizing and comprehending one's beliefs, values, and experiences that influence the process of data interpretation (Campbell et al., 2021). Reflexivity opposes detached objectivity, valuing the subjective perspective of researchers in data perception (Jones et al., 2022). Integral to qualitative research, reflexivity fosters transparency, rigour, and depth when exploring social phenomena by encouraging researchers to embrace subjectivity and engage in reflexive dialogue (Lazard & McAvoy, 2020). In order words, RTA acknowledges that my working assumptions (see Chapter 1, Section 1.5) and background, experiences, and perspectives (see Chapter 1, Section 1.6) will inevitably influence the interpretation of data (Braun & Clarke, 2021a; 2021b; 2022). RTA informs recursiveness; although the six phases of RTA are presented in a logical sequential order (see Section 4.9.1), analysis is not a linear process but rather encourages iterative cycles of reflection and refinement (Braun & Clarke 2013, 2021a, 2021b, 2022; Byrne, 2022). I therefore analysed my data from multiple angles in my search for the answers to my research question (Braun & Clarke, 2013).

Throughout the analysis, I cautiously revisited my data to ensure that the theme I was identifying spoke to the data. I therefore tentatively defined and refined my themes, carefully ensuring they accurately captured the essence of the data and reflected answers to my research questions. By employing this recursive approach to thematic analysis, I aimed to uncover meaningful patterns and insights within the data, allowing for a comprehensive exploration and interpretation of my research topic.

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4.9.1 The Six Phases of RTA

4.9.1.1 Familiarising myself with the data

In the initial phase of RTA, I focused on becoming familiar with the data, as emphasised by several researchers (Braun & Clarke, 2006, 2013, 2021a; Braun et al., 2022; Byrne, 2022). This step involved immersive reading and re-reading of all the transcripts of the video and audio recorded research activity, which included the two semi-structured interviews, and three HTFWP-drawing elicitation conversations as well as revisiting the drawings created by my secondary informants and their accompanying stories. I familiarised myself with the information provided in the biographical form by tabulating the information. I also scored the CBCL/6-18 to determine the level of concern from parents.

The transcriptions provided a meticulous account of informants' verbatim statements, along with documentation of non-verbal cues and expressions (Braun & Clarke, 2006, 2021). Throughout this process, I thoroughly examined the transcriptions, occasionally revisiting the original audio or video files to analyse nuances in tone of voice and observe body language. When regarding the transcriptions of the HTFWP-drawing elicitation conversations I also considered the relevant drawing and accompanying story (from the secondary informants) informing this conversation. Through this immersive and thorough approach I aimed to identify initial ideas relating to the possible benefits of sharing the child's series of HTFWP drawings, aligning with the key goals of the familiarization phase (Braun & Clarke, 2021a, 2022). At the same time, I made a point of observing any initial trends in the data or intriguing aspects within the drawings and their accompanying stories, along with identifying passages in the transcripts that held potential interest (Braun & Clarke, 2012, 2019; Byrne, 2022; Campbell et al., 2021).

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This immersive engagement, characterized by extensive reading and re-reading, enabled me to establish a robust knowledge foundation crucial for subsequent analysis phases (Dwarika, 2019; Ebersöhn, 2019; Jones et al., 2022; Olamijuwon & Odimegwu, 2022. Essentially, this initial phase served as a fundamental starting point, providing a solid groundwork for the exploration and comprehensive interpretation of the data, setting the stage for subsequent analytical processes (Braun & Clarke, 2013; Braun et al., 2022; Warner et al., 2022).

4.9.1.2 Generating Initial Codes

Aligning with the methodology of Braun and Clarke and Braun et al. (Braun & Clarke, 2006; 2013; Braun et al., 2022), during this phase of RTA, I systematically identified and labelled meaningful data segments with a specific focus on addressing my research question. I deemed segments of data meaningful if they had the potential to contribute to answering my research question, as outlined by Braun and Clarke (2021a; 2021b; 2021c). Each code represented a succinct descriptor capturing the essence of how individual data segments addressed or provided insightful perspectives on my research question.

Upon identifying each data segment, I paraphrased its content concisely, creating clear and succinct paraphrases that served as the initial codes for subsequent analysis (Creswell, 2007). Embracing a dual perspective, I considered both semantic and latent codes throughout the coding process (Braun & Clarke, 2012; 2021b; Braun et al., 2022). Semantic codes extracted the surface-level meaning, capturing explicit expressions within the text, while latent codes delved into implicit suggestions, implications, and underlying assumptions (Braun & Clarke, 2012). My strategic integration of both semantic (explicit) and latent (underlying themes or interpretations) codes aimed to capture the richness and complexity

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inherent in my data, laying the groundwork for systematic organization and categorization. For example, the following extracts (see Table 8 and 9) are Kimberley's (mother) reflection on Tessa's (daughter) emotional state as it relates to family circumstances. The semantic (see Table 8) and latent (see Table 9) codes are indicated in column 2.

Table 8

Examples of Semantic Codes

	Extracts	Semantic Codes
1	She adores him [Tessa's father]. She adores him ja.	This statement clearly expresses Tessa's affection for her father
2	She had a lot of anxiety, my sister passed away in Grade 3...	This quotation straightforwardly describes Tessa's anxiety linked to her maternal aunt's death.
3	I try and be quite a matter of fact about it.	This reflects Kimberley's explicit approach to managing Tessa's anxiety

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Table 9

Examples of Latent Codes

	Extracts	Latent Codes
1	I think as she's getting older she's realising that you know he's unreliable	This implies a growing awareness in Taylor about her father's inconsistencies, hinting at themes of disappointment and maturity.
2	It brought all that up so she actually saw a psychologist in Grade 3 cause she had separation anxiety from me.	This suggests a deeper connection between Taylor's health anxieties and her emotional attachment to her mother, indicating themes of fear and loss.
3	I try and not like I try and I don't know if there's one word that could sum up matter of fact, reassuring, uhm and probably balance	This reflects the complexity of Kirsten's parenting approach, indicating a struggle to find the right balance between acknowledging fears and not indulging them, hinting at broader themes of parenting and emotional management.

These selections illustrate the difference between semantic coding, which focuses on the explicit content without requiring deeper interpretation, and latent coding, which seeks to uncover deeper meanings and themes within the text.

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I took a reflexive stance by being mindful of my subjective interpretations that may influence the coding process. I reflected on how my background, experiences and expertise may impact the interpretation of data. In addition, I engaged in dialogue with the supervisor of my study to challenge my coding decisions, trying to keep a balance between keeping close to the data and acknowledging my own perspectives.

4.9.1.3 Searching for Themes

In the "Searching for themes" phase of RTA, the focus is on sorting codes into potential themes and collating relevant coded data extracts within these themes (Braun & Clarke, 2006). My objective was to generate themes that would conceptualize how the data addressed the research question (Creswell, 2007). This process involved clustering codes within individual cases and across cases (see Section 4.9.2) based on shared features, and reflecting meaningful patterns in the data (Braun & Clarke, 2012). To identify potential themes, I conducted a thorough review of the coded data, considering potential similarities and differences among the codes (Braun & Clarke, 2021a; Byrne, 2022). Throughout this process I aimed to pinpoint overarching themes that captured the essence of these patterns and provided a comprehensive understanding of the research question.

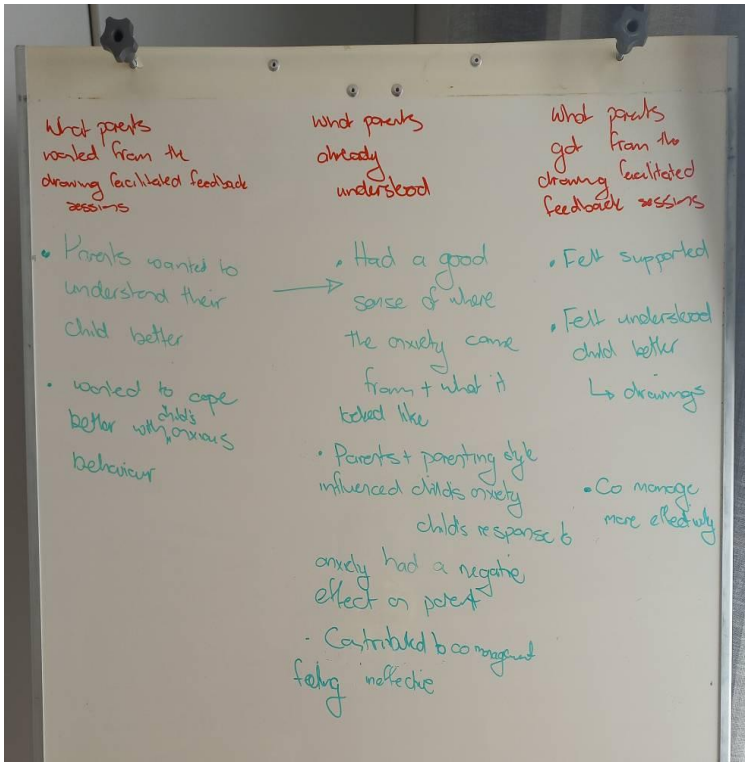
Initially using *Nvivo*, and later intermittently using a whiteboard (see Figure 8), I sought to find similar codes (Braun & Clarke, 2022). Eventually, I returned to a more familiar method, utilizing paper and pencil. I printed out all my codes, cut them into strips, and grouped them into themes (see Figure 9), pasting these themes onto large sheets of newsprint (see Figure 10). Embracing a hands-on approach, my transition to manual analysis, depicted through the utilization of paper, pencil, and tangible materials (see Figure 8, Figure 9, and Figure 10), emphasised my belief that

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manual analysis, as supported by Braun and Clarke (2013), offered a more profound and nuanced grasp of the data. Braun and Clarke (2021c) also assert that electronic software coding is not better than manual coding and is most useful in the earlier phases of coding and theme identification. My shift to manual analysis highlighted the importance of tactile, in-depth engagement throughout the analytical process. In addition, working manually supported an iterative, cautious process which supported my reflexive stance.

Figure 8

White board



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Figure 9

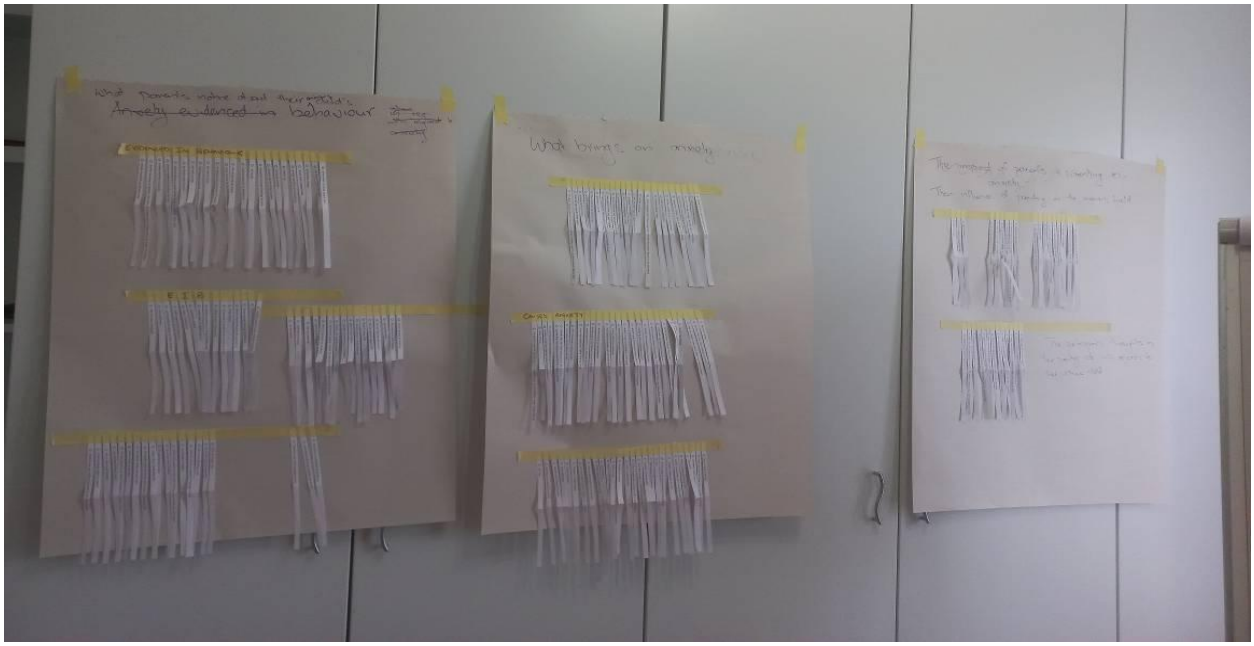
Manually integrating themes



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Figure 10

Grouping themes using newsprint



4.9.1.4 Reviewing and Refining Themes

In the fourth phase of RTA, which involves "Reviewing and Refining Themes" (Braun & Clarke, 2013, 2021b; Byrne, 2022; Campbell et al., 2021), my focus was on critically evaluating the identified themes to ensure coherence, relevance, and alignment with the research question (Byrne, 2022; Jones et al., 2022). I systematically examined and re-examined the extent to which each theme captured the essence of the related data.

In this phase of my study, I took measures to ensure the quality of generated themes by conducting thorough checks against the coded data and the entire dataset (Braun & Clarke, 2012). I critically examined theme boundaries, distinguished between themes and codes, and ensured each theme had sufficient supporting data for a rich and detailed narrative (Braun & Clarke, 2021a). Reviewing

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the data associated with each theme helped determine validity and coherence, assessing consistency and alignment with core concepts (Braun & Clarke, 2013).

I actively avoided themes that were overly diverse or fragmented, recognizing the potential compromise to the overall quality and integrity of the analysis (Braun & Clarke, 2012). Therefore, I ensured that supporting data for each theme was focused and homogeneous, facilitating a comprehensive exploration and representation of the underlying phenomena (Byrne, 2022). This thorough and iterative approach contributed to the development of a robust and well-supported thematic analysis (Braun & Clarke, 2021a, 2021c).

Concurring with Smith et al. (2022), collaboration was pivotal during this phase. In my study, the collaborative effort involved my supervisor playing an auditing role, where her feedback on my identified themes helped me refine them where necessary. Together, we reflected on my codes and themes, ensuring they accurately captured the essence of the data thereby concurring with the ideas of Byrne (2022). For example, initially my three themes with their subthemes were:

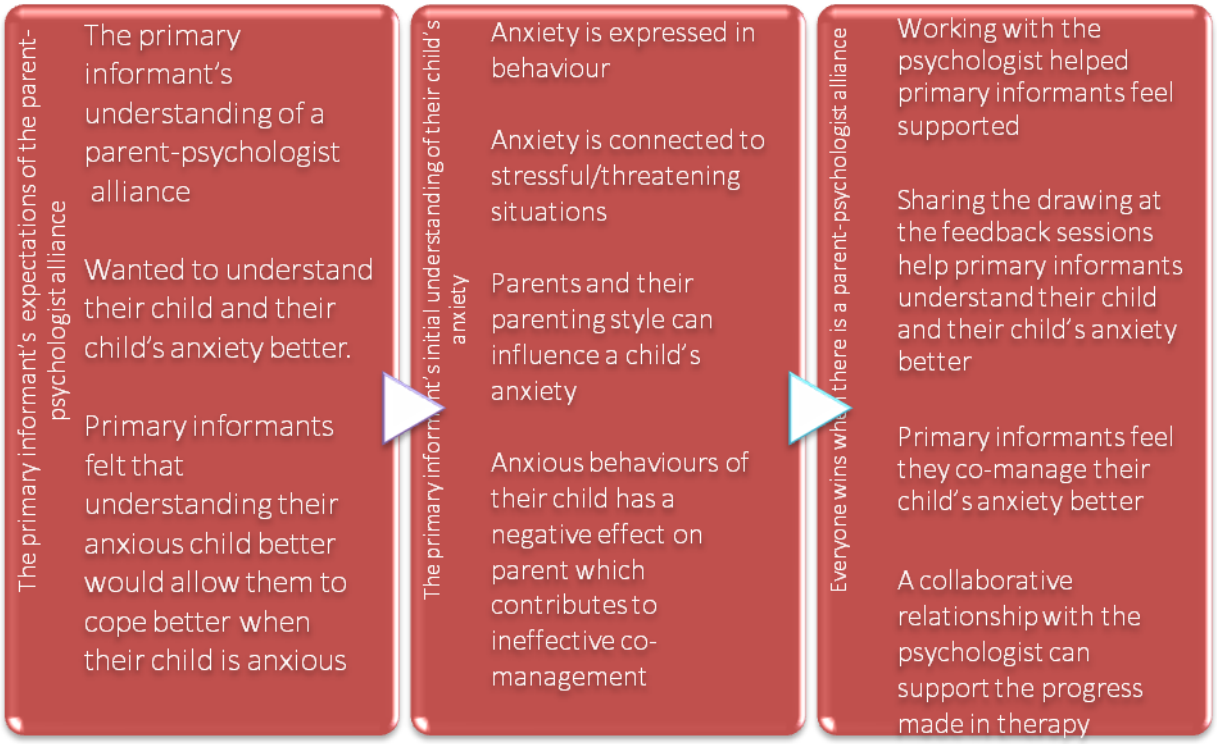
- The primary informants' expectations of the parent-psychologist alliance
- The primary informants initial understanding of their child's anxiety, and
- Everyone wins when there is a parent-psychologist alliance (see Figure 11)

As a result of my discussion with the supervisor of my study, I recognised that the first and second theme seemed more about me still making meaning or filling the context whereas the last theme reflected an essence of my meaning making. This resulted in my refinement of my themes. Therefore, theme 3 became my main theme with the first and second theme becoming the subthemes reflecting my understanding of this 'Win' (see Appendix I) .

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Figure 11

Initial themes and subthemes



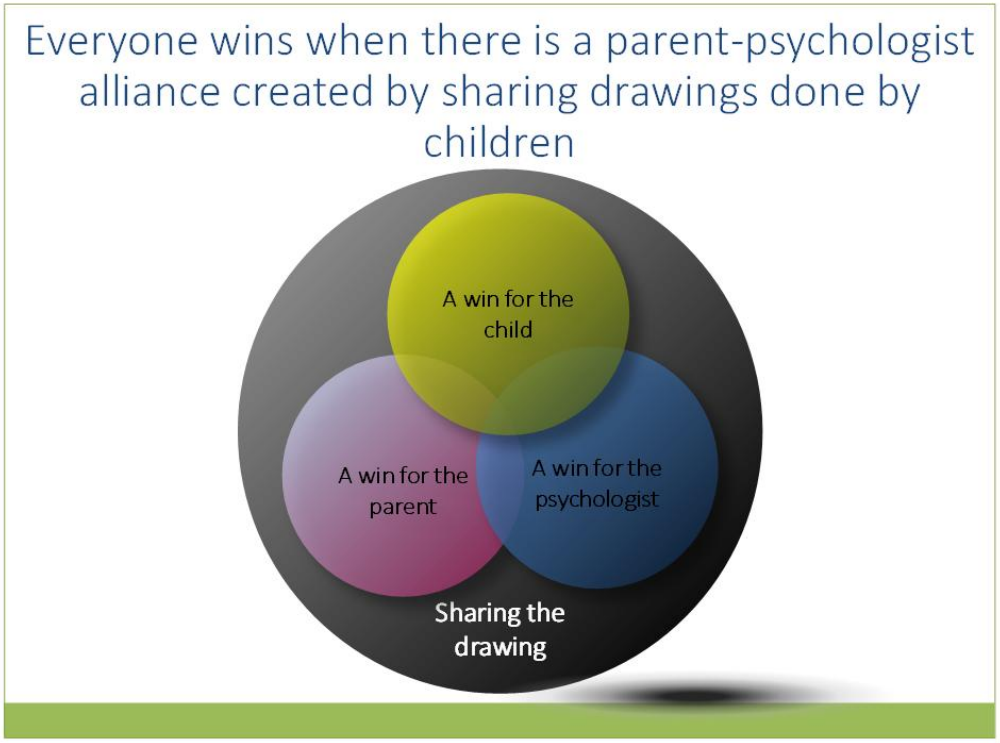
4.9.1.5 Defining and naming the themes

During the fifth phase of RTA, I defined and articulated themes by drawing on patterns and meanings identified in the data, as emphasised by Braun and Clarke (2013; 2021a; 2021b; 2022) and Byrne (2022). In order to define my themes I organised the story of each of the themes, aligning with Campbell et al. (2021), by stipulating the scope and boundaries of each theme as encouraged by Braun and Clarke (2013). For example: my overarching theme, "Everyone wins when there is a parent-psychologist alliance created by sharing drawings done by children", had three subthemes: A win for the parent, a win for the psychologist and a win for the child (see Figure 12) .

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Figure 12

Overarching theme and subthemes



To use one of the subthemes as an example – a win for the parent was defined as relating to the transformation of the empathy of the parent(s), and awareness and empowerment in supporting their child's anxiety. The parents' self-compassion increased as well as their understanding and acceptance of their child's anxious behaviour. Furthermore, I needed to determine what did not fit with that theme. This was the parent's prior knowledge with regard to anxiety and any transformation related to myself as psychologist/researcher, or to the child.

I paid careful attention to ensuring that each theme maintained a singular focus, avoiding overlap and directly addressing the research question, in line with the guidance of Braun and Clarke (2012; 2021b). During this phase, collaboration with my supervisor once again played a significant role, involving iterative discussions and careful definitions to construct cohesive and meaningful themes. Collaboration

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with an experienced researcher helps ensure that themes are robust, valid and accurately represent the informants perceptions and experiences (Smith et al., 2022). It allowed for cautious consideration of alternative explanations and interpretations of the data contributing to a reflexive mindset. In addition I had conversations with mental health colleagues about the themes I was generating from my data. My ultimate goal of this phase was to produce a final set of well-defined, named themes that effectively captured the meaning and essence of the data, finalizing the thematic structure for interpreting and reporting the findings.

4.9.1.6 Producing the Report

In the concluding phase of my study, I finalized the report, completing RTA. The primary goal of this phase was to craft a comprehensive and coherent narrative of the findings that effectively addressed the research question, supported by the literature. As reported by Byrne (2022), this final stage is a recursive process as my thesis is the formal product of continuous writing I did throughout my research. During this concluding stage, I strategically integrated identified themes and related data extracts into a logical, cohesive narrative, effectively addressing the research question while drawing support from relevant literature, thereby concurring with several scholars (Braun & Clarke, 2012, 2021a, 2021b, 2021c, 2022; Byrne, 2022; Campbell et al., 2021). Based on the guidance of Creswell (2007, 2013) and Yin (2018), integration of literature not only enriched the narrative but also positioned my research within the current understandings of the multisystemic resources that support children's resilience to mental health challenges (like GAD), and contributed to a comprehensive interpretation of the results. In doing so, I aimed to deepen my understanding of how sharing of the child-client's HTFWP-drawings with their parent(s) during parent-feedback sessions within therapy for children displaying

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behaviours characteristic of GAD fostered a stronger alliance between parents and myself (the treating psychologist), thereby enhancing the therapeutic process for all the stakeholders (parent, child and psychologist). My findings are discussed in Chapter 5 and Chapter 6.

When writing up my findings I aligned with the ideas of Smith et al. (2022), by including vivid, compelling quotations from my informants to support my themes and interpretations. In addition, I ensured anonymity of my informants during my report writing by assigning pseudonyms as advised by Owolabi and Chu (2022). As stated by Braun and Clarke (2022) it was essential to my study that I make my voice heard by using the first-person pronoun.

4.9.2 Within and Cross Case Analysis

I conducted within-case analysis during various stages of reflexive analysis (see Section 4.9.1). During the familiarization stage I got acquainted with data from each individual case. During the initial coding stage I assigned codes to segments of data for each individual case. With theme development I grouped codes to form broader themes and patterns that were case-specific. When reviewing and refining themes I evaluated the identified themes to ensure that they captured the essence of the data in each case, thereby aligning with the ideas of Creswell (2007, 2013) and Nowell et al. (2017). The purpose of this analysis was to gain a detailed understanding of each case and generate themes that would help address the research questions (Creswell, 2007, 2012; Yin, 2018). This process involved closely examining the data and coding data for each informant until saturation was reached. Saturation is coding to the point when no new information or themes can be developed from the data (Creswell & Creswell, 2023; Thompson et al., 2020). Achieving saturation required a recursive process, coding the same transcript more

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than once. I constructed several themes for each case and was satisfied that they were information-rich and saturated.

Concurring with the ideas of Baxter and Jack (2008), Nowell et al. (2017) and Saunders et al. (2018), I followed the within-case analysis, with a cross-case analysis. This analytical phase involved several key steps to extract meaningful insights across multiple cases. To facilitate this process, I printed out all the codes developed with the use of NVivo and cut them into strips, each labelled with an abbreviation of the assigned pseudonym. Subsequently, I grouped these codes under their respective themes. While comparing themes in cross-case analysis is customary, I exercised caution and maintained an iterative approach. Printing out the codes enabled me to physically manipulate them, deepening my understanding of the data and its underlying patterns. This tactile approach offered a more intuitive exploration compared to relying solely on digital analysis tools. Grouping the codes under their different themes provided a visual organization aiding in the identification of commonalities and differences across cases.

In alignment with the methodology employed by Mollet and Kaudela-Baum (2022), I utilized a hand-written tabular analysis. This manual method involved structuring and comparing data from different cases in a table format to discern patterns, similarities, and differences across cases. My tables consisted of separate sheets of newsprint (see Figure 10). By manually creating tables and organizing data, I could visually compare and contrast information from multiple cases, facilitating the identification of key relationships. Aligning with the ideas of Fyffe et al. (2022), I reduced the dataset to concentrate on pertinent information in order to focus on the most significant conceptual clusters. This process also included winnowing the data, as described by Creswell and Creswell (2023), which entails

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carefully selecting and prioritizing data points relevant to the research objectives. Consistent with the approach outlined by Thompson et al. (2020), I sought common themes and categories emerging across all seven cases. These themes encapsulated the major findings related to my exploration into the benefits of sharing the child's HTFWP-drawing series with their parents. Therefore, I grouped cases based on emerging patterns and themes, following the guidance of Weston et al. (2022).

4.10 Ensuring Trustworthiness

Trustworthiness in research is a concept developed by Lincoln and Guba (1985), to help ensure that a qualitative study is worthy of serious consideration. Creswell (2007, 2013), Creswell and Creswell (2023) and Levitt et al. (2018) use the term "qualitative validity", which is concerned with ensuring that the researcher's interpretations and understandings of the data are faithful to the perspectives and experiences of the informants and the context under study. As indicated by Billups (2020), the concept of trustworthiness was initially comprised of credibility, transferability, dependability and confirmability. Authenticity was added to this list in a later work by Lincoln and Guba (1994), and endorsed as an equally important element. I have ensured the trustworthiness of my study by fulfilling the criteria of credibility, transferability, dependability, confirmability and authenticity. The discussion which ensues explains how I addressed each criterion within this framework.

4.10.1 Credibility

According to Lincoln and Guba (1985), credibility refers to believability or trustworthiness of the findings. The importance of credibility has been underscored by other researchers in the field of qualitative research (Mason, 2002; Price, 2015; Yin, 2018). Using the ideas of these authors, I endeavoured to ensure the

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believability and trustworthiness of my findings so as to establish credibility. In order to do this, I employed several strategies in my research process.

4.10.1.1 Triangulation

There are several different levels of triangulation (Beck, 2021; Cohen et al., 2007; Creswell, 2007; Morse, 2015; Pratt et al., 2020). As referred to by Creswell and Creswell (2023), Korstjens and Moser (2018) and Schwandt et al. (2007), I used data triangulation as one of the methods to ensure credibility. Data triangulation refers to researchers collecting data from diverse sources and comparing them, enabling the drawing of conclusions based on converging findings from multiple data sources (Beck, 2021). The various types of data I used included: transcriptions of the interviews and HTFWP-drawing elicitation conversations, HTFWP drawings of the children and their accompanying stories and my observations during my sessions with my primary and secondary informants. Not only did I have different types of data but they were also gathered at different times over the course of my study and came from different informants as I used seven cases in my case study.

As highlighted by Pratt et al. (2020, p. 10), I used triangulation to ensure credibility by giving voice to “different constructions of reality” I found in my data. Additionally, I chose triangulation as it is considered useful when trying to understand a complex phenomenon when a case study is being employed and varying viewpoints of informants are being considered when applying the same method (Cohen et al., 2007). The triangulation process not only increased the trustworthiness of my findings but also diminished the limitation of potential biases inherent in the use of individual data sources (Mason, 2002).

4.10.1.2 Prolonged Engagement

Another construct of credibility which I used was prolonged engagement, thereby aligning with the work of Cohen et al. (2007) and Sabnis and Wolgemuth

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(2024). Prolonged engagement constitutes investing sufficient time to become familiar with the topic of research, to develop rapport with informants, to become familiar with the data and develop a data set rich in content (Baxter & Jack, 2008; Korstjens & Moser, 2018). My engagement with informants (which spanned 16 weeks) extended beyond the formal sessions of three HTFWP-drawing elicitation conversations, two semi-structured interviews, and an intake session with parents. In addition to these scheduled interactions, I interacted informally with the parents every time they brought their child to therapy. This informal engagement strategy also contributed to rapport building, in line with Flick's (2010; 2018) perspectives on the significance of sustained and continuous involvement.

However, in order to maintain a reflexive stance, I remained cognizant of the potential for bias arising from these formal and informal engagements. This aligns with Creswell's (2007) insights into the need for reflexivity to address biases. Additionally, RTA encourages researchers to critically reflect on their own biases and assumptions throughout the research process (Braun & Clarke, 2022). Despite the potential risks, the ability to establish a strong connection with informants was recognised as a contributor to the credibility of my study as it helped augment my data (Billups, 2020). This highlights the delicate balance between active engagement and methodological rigour, emphasizing the nuanced dynamics involved in qualitative research (Creswell, 2007; Mason, 2002).

4.10.1.3 Presentation at Conferences

Furthermore, another layer of credibility was the presentation of my findings at conferences organised by the Psychological Society of South Africa (PSYSSA) in 2023 and the South African Association of Child and Adolescent Psychiatry and Allied Professions (SA-ACAPAP) in 2024. I presented papers at both these

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conferences (5 October, 2023 and 8 March, 2024) (Bredekamp & Theron, 2023; 2024). Aligning with the ideas of Merriam and Tisdell (2016), presenting findings at these reputable conferences subjected my research to peer review (particularly fellow child and adolescent mental health practitioners), and facilitated dissemination within the academic community, contributing to the overall credibility of my study. The feedback and questions from the audience endorsed my findings.

4.10.1.4 Data analysis software

Additionally, the use of qualitative data analysis software, Nvivo, at the beginning of the data analysis process (familiarising myself with the data and generating initial codes during within-case analysis), played a crucial role in maintaining the rigour of my research. This, along with the reflexive journal (see Appendix J), as encouraged by Braun and Clarke (2021a; 2022), contributed to a meticulous and well-documented research journey, enhancing the credibility and reliability of my study. A reflexive journal serves as a tool for researchers to document daily research logistics, methodological decisions, and rationales, as well as to record personal reflections on values, interests, and insights. This insight is vital as it illuminates the researcher's function as the primary instrument in the research process. My research journal allowed me to reflect on the research process and document the decisions I made throughout the study. This journal served as a valuable tool, providing insights into my thoughts, observations, and reflections.

4.10.2 Transferability

While generalizability is not a primary focus in qualitative case study research, findings can still be transferable (Creswell & Creswell, 2023; Maxwell, 2022). Transferability refers to the extent to which the findings drawn from a study conducted in one context can be applied to another context beyond the original research setting (Cohen et al., 2007; Creswell & Creswell, 2023; Maxwell, 2022;

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Morse, 2015). According to Lincoln and Guba (1985), the reader should be able to decide if transferability is possible after reading the rich descriptions of informants and context. Transferability is not a straightforward process as it requires a nuanced understanding of the research context and informants' characteristics (Facca et al., 2020). In agreement with Cohen et al. (2007), Creswell (2007, 2013), Arifin, (2018) and Surmiak (2018), I promoted transferability by providing detailed descriptions of the informants (see Section 4.6) and the setting of my study (see Section 4.4). This was done to ensure that readers of my research can assess the transferability of my findings to their own study settings and make informed decisions accordingly (Creswell, 2007, 2012). For example, when assessing transferability, readers of my study need to acknowledge the context of my research (see Section 4.4). I conducted my study at my private practice (see Figure 4 and Figure 5); the photographs included will aid readers to assess transferability. It is worth noting that the nature of a private practice, especially concerning privacy considerations, differs from a community-based mental health clinic as discussed by Mokitimi (2024).

4.10.3 Confirmability

Confirmability, a cornerstone of qualitative research, ensures that data interpretations and findings are firmly rooted in the data, without taking the researcher's biases or preferences into account (Korstjens & Moser, 2018; Morrow, 2005; Stahl & King, 2020). However, it should be noted that Reflexive Thematic Analysis acknowledges the subjectivity inherent in knowledge generation and emphasises the importance of considering this subjectivity rather than attempting to remove it (Braun & Clarke, 2013; Braun et al., 2022). As I employed reflexive thematic analysis, I also took my subjectivity into account.

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In ensuring confirmability throughout the research process, I took deliberate steps to clarify my own views and assumptions as indicated in Chapter 1 (see Section 1.5 and 1.6). Recognizing the potential impact of my personal perspectives on the interpretation of data, I engaged in a reflective process to scrutinize and articulate my preconceived notions and biases (Braun & Clarke, 2021a; Lamba et al., 2022). By critically examining my own stance and acknowledging the influence of my background, experiences, and beliefs, I aimed to minimize the introduction of undue subjectivity into the research. This commitment to clarity in my views and transparency about my assumptions contributes to the confirmability of the study, ensuring that the findings are rooted in the data rather than being unduly influenced by my personal perspectives, an idea underscored by Merriam and Tisdell (2016).

4.10.4 Dependability

Dependability as defined by Stahl and King (2020), involves establishing confidence in the research process. Ensuring the dependability of data was a paramount consideration in my research. Verbatim accounts, capturing both verbal and non-verbal utterances, were incorporated into the transcribed interviews, offering a faithful representation of the data (Nowell et al., 2017). Simultaneously, I placed a strong emphasis on transparency as a crucial element to guarantee the trustworthiness of my findings over time. Throughout the research process, as underscored by Yin (2018), I meticulously documented each phase, providing a detailed account of the research design (see Section 4.3), data collection procedures (see Section 4.7), and analytical techniques employed (see Section 4.9). This was demonstrated in my audit trail.

An audit trail serves as documented evidence of the researcher's decision-making process regarding theoretical and methodological aspects throughout the

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study, requiring a clear rationale for these decisions (Sabnis & Wolgemuth, 2024; Vilbas & King-Sears, 2021). This allows another researcher to easily trace the decision trail (Nowell et al., 2017). To create a clear audit trail, researchers should maintain records of raw data, field notes, transcripts, and a reflexive journal. Reflexivity is central to the concept of an audit trail. As documentation for my audit trail I have appended a sample of a coded transcript (Appendix K) and attached three samples from my reflexive journal (Appendix J).

4.10.5 Authenticity

Authenticity, as defined by Beck (2021), refers to the extent to which the researcher accurately and faithfully represents the diverse range of experiences encountered by the informants. In my research, authenticity was a guiding principle, ensuring the genuine representation of my informants' experiences and perspectives in alignment with Braun and Clarke's emphasis on transparency and reflexivity (2021a; 2021b). Aligning with several researchers, my commitment aimed to present unfiltered insights, avoid any manipulation that could distort the authenticity of my findings, and to capture the nuanced narratives of my informants (Arifin, 2018; Billups, 2020; Flick, 2018; Merriam & Tisdell, 2016; Yanow & Schwartz-Shea, 2015).

In my research, I found that fairness, as highlighted by Lamba et al. (2022), was paramount. It ensured that all informants were treated equitably and their voices were represented without bias. This dedication to fairness did not end with data collection—it extended into the reporting phase. Here, I took deliberate steps to authentically convey each informant's perspective, ensuring accuracy and avoiding distortion. Upholding the ethical responsibility outlined by Merriam and Tisdell (2016), I strove to accurately represent the diverse range of experiences within my study.

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Reflexivity played a pivotal role in ensuring authenticity. This introspective practice, fundamental to reflexive thematic analysis, maintained transparency regarding my positionality (see Chapter 1, Section 1.6) and potential influences on my study, actively addressing my personal perspectives and biases. This cultivated self-awareness significantly contributed to the authenticity of my research, as advocated by Braun and Clarke (2021b). It enabled me to navigate my subjective lenses and develop a more genuine understanding of informants' perspectives.

4.11 Ethical Considerations

I received ethics clearance from the Department of Education and the Department of Health Sciences at the University of Pretoria (see Appendix A and B). In addition, I was guided in making informed decisions about ethics by the professional code as laid out in the rules of conduct pertaining specifically to the profession of psychology (Health Professions Council of South Africa, 2006), as well as that of Protection of Personal Information Act (POPIA, 2013). The purpose of POPIA is to protect people from harm by protecting their personal information The ethics clearance I received contributed to the ethical considerations outlined next.

4.11.1 Dual Role as Psychologist and Researcher

One of the core ethical dilemmas in my study revolved around my dual role as both a researcher and a treating psychologist. The secondary informants in my research were also clients engaged in a therapeutic process. Since the therapy clients were also research informants, they did not incur charges for their therapy sessions. This dual role presented significant ethical considerations, particularly concerning the potential for professional boundaries to be crossed between psychologist and researcher. To navigate this complex dilemma, I maintained open communication with the informants regarding the dual role I was assuming. In

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addition, I ensured their understanding of this situation of duality by explaining the research and therapy activities during the informed consent process.

Drawing from the insights of Billups (2021) and Leggett (2017), I consulted regularly with the supervisor of my study to avoid boundary violations. Recognising the challenges of entering the research field as both a researcher and a psychologist I took pro-active steps to manage this complexity. I sought personal therapy to help navigate potentially overwhelming circumstances. My clinical psychologist, who is a Jungian analyst, provided me with support through fortnightly therapy sessions over the course of a year.

Another instance presented itself with regard to my dual role when two of the referrals were excluded as their parents could not participate in all the activities of my study due to their time constraints. To ensure that their child received the necessary support and care, even though they were not directly involved in my study, I encouraged that they seek the support of the mental health professional based at their child's school. I also informed these parents of the no-cost therapy centres in the area where the challenges of their child's anxiety could be addressed, thereby providing information of support and resources beyond the scope of my study. By prioritizing the welfare of these children I demonstrated a commitment to ethical practice in both my clinical and research roles.

In accordance with the moral obligations outlined by Arifin (2018), the possibility of referral to no-cost therapy centres for further sessions was discussed with two parents from my study during the final feedback session. The parents of the child-informants in question, however, considered the upward trajectory of their children's behaviour in relation to anxiety to be a positive outcome. They also felt empowered to co-manage their child's behaviour and instead opted to monitor

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matters closely and consider referral if matters became too difficult to manage. In all the cases, especially those two, I let parents know that they were welcome to contact me if they had overwhelming concerns.

4.11.2 Informed Consent and Assent

Trustworthiness, a key aspect of both therapy and research, was central to addressing concerns about the respectful handling of sensitive information shared during therapy or HTFWP-drawing elicitation conversations, and the potential vulnerability experienced by clients, including children and their parents (Axline, 1969; Hense, 2023). To ensure my trustworthiness as a psychologist and researcher, I adhered to the professional code of conduct outlined by the Health Professions Council of South Africa (2006) and the provisions of the Protection of Personal Information Act (POPIA, 2013). Guidelines stipulated in POPIA (2013) aim to protect individuals by safeguarding their personal information, including rights to confidentiality, privacy, and concepts of written informed consent and assent. As POPIA (2013) defines a child as anyone younger than 18 years of age, consent must be given by a legal guardian. Blank copies of the consent and assent forms I developed are attached as Appendices E and F.

4.11.2.1 Informed Consent

In agreement with Billups (2021) and Arifin (2018), it was important for me to incorporate rigorous ethical practices into my research, including obtaining informed consent. The primary informants (i.e., parents) consented to their participation in the study and to their child's involvement. They agreed to audio and visual recordings of the semi-structured interviews and HTFWP-drawing elicitation conversations. In addition, they consented to all the materials that were part of the study, including the child behaviour checklist, feedback and conversational session recordings and written records to be used for research purposes. Furthermore, they consented to

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scanned copies of their child's drawings being posted on research websites and used in research-related publications/conference papers. They also consented to their contributions (conversations) being publicly reproduced and/or quoted with the understanding that their identity and that of their child would remain confidential.

Written informed consent was obtained from the primary informants (i.e., parents) at the outset of my study. Verbal confirmation of consent was reaffirmed at the start of each HTFWP-drawing elicitation conversation to ensure ongoing understanding and acknowledgement of the informed consent process. Additionally, I explicitly communicated to the parents each time I shared the child's HTFWP drawing, clarifying that I was sharing the drawing with their child's permission.

4.11.2.2 Informed Assent

Aligning with the ideas of Price (2015), on informed assent, I considered the potential limitations of relying solely on legal guardians to provide consent on behalf of children. I therefore also asked the secondary informants (i.e., child-clients) for their informed assent regarding their participation in my study, the sharing of their drawings with their parents and the use of the drawings as research data. As explained earlier (see Section 4.5), parents brought their child's signed assent forms with them. To ensure that parents did not coerce that assent I asked parents how they went about obtaining their child's assent. Parents described how they communicated the study's details to their child, encouraged them to read the assent form before signing it, and then ensured they understood that participation was voluntary. I mentioned to parents that I would revisit assent with their child to ensure their continued understanding. I reiterated the concept of assent during my first meeting with the child to emphasise their voluntary participation (they could still decline even if their parents had consented).

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In addition to the child's assent for participating in my study, I recognised the importance of ensuring that the child's assent for sharing their drawings was given without any harmful consequences or undue influence from myself or their parents. To achieve this, I reiterated verbally that they retained the right to change their mind about assenting to me sharing their drawings with their parents, without facing any repercussions. I made it clear that I had already discussed this with their parents during our initial meeting.

I repeated this message each time the child completed a drawing, emphasizing that they always had the option to withdraw their assent. This approach may have contributed to the child readily giving their assent on each occasion. Their willingness to assent could have been influenced by their need to manage their anxiety, and as the study progressed, it may have reflected positive changes in the child's relationship with their parents and their overall level of anxiety, which they wanted to maintain.

4.11.2.3 Withdrawal of Consent and Assent

I reminded all informants of their right to withdraw their informed consent and assent at any time throughout the study. While withdrawal was an ethical right of the informants, it could pose a practical dilemma as finding a replacement case would be necessary. In such cases, ethical principles of non-maleficence (doing no harm) and beneficence (promoting well-being) would direct my decision-making, prioritizing the client's best interests, even when conflicting with my (i.e., the psychologist and researcher) self-interest (Health Professions Council of South Africa, 2006). Although I was aware of these implications, it was not necessary in my study as none of the informants withdrew their assent (child-clients) or consent (parents).

4.11.3 Anonymity and Confidentiality

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In agreement with Sommer et al. (2020), I ensured the anonymity of informants. In order to conceal their identity, I assigned a pseudonym for each informant, and all identifying data were omitted from transcripts and their drawings. Anonymity of informants was part of the informed consent that they signed at the beginning of the study. Confidentiality agreements were also signed by the professional transcriber to maintain data security (Appendix L). Surmiak (2018) also advocated for protection of data. Electronic copies of the transcripts from my study and children's drawings were stored on my password-protected laptop, while original drawings and signed consent and assent forms were securely stored at the University of Pretoria (and will be retained there for a period of 15 years before being destroyed). The audio and visual recordings will be deleted when my thesis has been finalised and accepted by the University of Pretoria.

4.11.3.1 Limitations of Confidentiality

However, there were limits to the right to confidentiality. Throughout the study, the best interests of the child were prioritized. Part of this duty relates to the mandatory reporting of suspected child abuse and neglect. The Children's Act 38 of 2005 (Parliament of South Africa, 2005), imposes a duty on certain professionals (e.g. psychologists) to report suspected abuse or neglect of children to the designated authorities (i.e., South African police services, designated child protection organization and the Department of Social Development). The professionals who have this duty to report are called mandated reporters. As a mandated reporter, if there were reasonable grounds to believe, based on the drawings, sandplays, observations, or discussions with the child or caregiver that the child was in need of care and protection, I was legally obligated to report this to the relevant authorities. The parents and children in my study were made aware of this stipulation in the

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consent and assent forms completed before the research process began. Fortunately, I did not need to make such reports during my study.

4.12 Conclusion

In Chapter 4, I have provided a comprehensive, rich and detailed overview of the methodology I employed in conducting my study so that my process can be easily understood by other researchers should they want to replicate my study. Therefore, I have given a detailed account of the purpose of my instrumental, multiple-case study guiding readers through the research design, case selection process, and the intricacies of data collection, analysis, and interpretation. Chapter 4 serves as a robust foundation for understanding the intricacies of the research methodology I chose with the purpose of instilling confidence in the trustworthiness of the findings of my study. The findings are reported in the next chapter.

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Chapter 5

Findings of My Study

5.1 Introduction

This chapter presents the themes I identified through the application of RTA, as proposed by Braun and Clarke, (Braun & Clarke, 2021a; 2021b; 2022; Braun et al., 2022), in order to answer my primary research question posed in Chapter 1. That primary research question was: How does sharing the series of the child-client's HTFWP drawings in parent feedback sessions benefit the therapeutic process, if at all, when a child is in psychotherapy for GAD? My study was conducted using an instrumental multiple case study design, analysing multiple forms of data (i.e., biographical details, insight into the child's anxiety via the CBCL/8-16, pre- and post-semi-structured interviews, and three HTFWP-drawing elicitation conversations); all these data were generated by my primary informants. From my secondary informants, there were three HTFWP drawings and the accompanying narrative for each drawing from each of the child-clients.

Essentially, I identified a single theme. Chapter 5 provides an overview of that main theme, followed by a presentation of the sub-themes in response to the primary research question.

5.2 Everyone Wins When There Is a Parent-Psychologist Alliance Created by Sharing HTFWP Drawings Done by Children

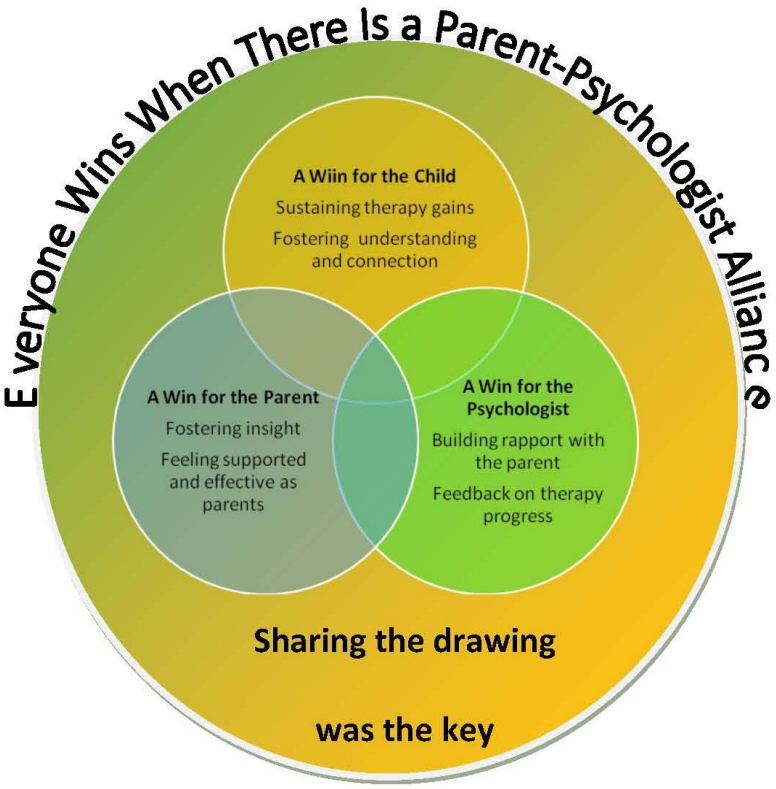
"Everyone wins when there is a parent-psychologist alliance created by sharing drawings done by children" was the main theme which I developed. It shows that when the child's HTFWP drawing series is shared with the parents, everyone wins – the child receives better care, parents feel more supported in their role as

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caregivers, and psychologists are better equipped to provide effective treatment (see Figure 13). This 'win-win' situation was facilitated by the sharing of drawings done by children during therapy sessions in HTFWP-drawing elicitation conversations with their parents. As I will explain next, the HTFWP drawings were key (i.e., integral) to each of these wins. As I will show, using various metaphors, the drawings afforded a conversational space that (i) scaffolded parental insight and parental experience of support and parenting efficacy; (ii) nurtured rapport between me and the parents that assuaged the loneliness and sense of parental inadequacy they initially presented with and also helped me guage therapeutic progress; and (iii) advanced therapy gains for the child-clients.

Figure 13

Sharing the drawing was the key



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5.2.1 A Win for the Parent

I have tried growing a passion fruit plant in my garden because I love the fruit and the flower is so unusual. As I took care of my plant, I soon realised that something essential was missing that would allow it to thrive. This missing element was the backing of a trellis that provided a framework for the plant to climb, providing the support for it to thrive. In addition, as the plant grew along this framework it needed to be guided occasionally as I hooked new growth under and through the trellis guiding the growth of my plant.

I have used the metaphor of a trellis supporting a passion fruit climber (as shown in Figure 14) to highlight the significance of support and guidance in fostering growth, particularly for parents raising a child with anxiety.

Figure 14

Trellis supporting plant



Note. Passion fruit vine with a flower growing on a trellis.

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The parent informants involved in my research seemed to benefit from having their form of a "trellis" – in this case the sharing of their child's HTFWP-drawing series, which occurred during HTFWP-drawing elicitation conversations. This sharing allowed the development of insights into their child's anxiety and the influence of their parenting on this anxiety. Like the trellis supports a climbing plant's growth, this metaphor symbolizes the role that support and guidance play in nurturing both personal growth and understanding for parents when faced with challenges such as parenting a child challenged with anxiety. Showing parents the HTFWP drawings and exploring their meaning scaffolded that support and guidance.

Initially, the parents relied on their own observations and experiences of their child's anxiety to comprehend it. However, through the collaborative exploration of their child's HTFWP drawings, they achieved a profound and empathetic understanding, leading to heightened insights into their child's anxiety. This HTFWP-drawing-supported process enabled parents to actively consider their child's perspective and contemplate diverse hypotheses with regard to their understanding of their child's anxiety.

5.2.1.1 Fostering Insight

The experience of better insight, following a conversation about the HTFWP drawing, was shared in all seven of my cases by nine primary informants. As I will show in the examples that follow, the elements in the drawing and consideration of what they might mean supported parents to better understand their child's anxiety and emphathise with them. I observed that the discursive, open-ended nature of the HTFWP-drawing elicitation conversations (see Chapter 4, Section 4.7.1.3) encouraged parents to consider multiple interpretations of their children's drawings

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and to be open to how their child had explained the drawing. Both were important to fostering empathy and insight.

Cathy's experience was a clear example of this, as she gained valuable insight into her son's anxiety by discussing the tree in his HTFWP drawing (Figure 15):

> Obviously I know Eric's a structured and routine-based child. However, I didn't realize that the biggest thing that stood out was the floating tree [referring to the drawing in Figure 15]. Obviously that sense of belonging or that sense of stability or routine or structure or whatever that represents, is missing. So that helps me a lot to see what's happening in his mind and figure that he clearly is feeling a little lost and drifty I suppose.

Figure 15

Eric's first HTFWP drawing



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Like Cathy, other parents highly valued the opportunity to gain a deeper understanding of their child and their child's anxiety by sharing in their child's drawings. Ashley said, "But I mean, the drawings. There was so much information for us in those drawings which is amazing". Sometimes this information required parents to explore various interpretations, including the way their child had made the drawing. For example, upon examining their son's first HTFWP drawing (

Figure 16), Hadley (mother to Clint) and Ashley (father to Clint) were able to consider various hypotheses specifically regarding the manner in which their son drew the house. Looking at the drawing and trying to make meaning of it supported insight into their child and a sense of understanding him better, as indicated by Ashley's statement below.

> The thing that stands out to me that I think would speak to his anxiety is how perfectly straight the house lines are... Yes, very, very perfectly straight, where I would have thought a child his age would have drawn it freehand perhaps. But it's very straight and I know Clint is a bit of a perfectionist and if he gets things wrong, he's very, very hard on himself. Extremely hard on himself.

When discussing their son's HTFWP drawing during the feedback session, Hadley and Ashley wondered if it could be referring to their parenting playing into his anxiety. They wondered if the 'house with the perfectly straight lines' [see

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Figure 16] related to their parenting as illustrated in the following interaction between Ashley and Hadley:

> Ashley: The rigidity of the house, I don't know if its…I don't think we are that rigid in our parenting?
>
> Hadley: Maybe me.
>
> Ashley: Or maybe he wants a little more structure? I dunno... cause sometimes it gets a lot unstructured [meaning disorganised]. It gets like very unstructured. Sometimes it goes chaotic in the house.

Hadley and Ashley's first hypothesis (as per above excerpt) related to their son and their perception of his perfectionism, which they felt added to his anxiety. However, with their second hypothesis, they reflected on their parenting skills and wondered about being too rigid in their parenting style. Their being able to see and reflect on the drawing was key to these two parents gaining insight into their own contributions to their child's anxiety. Both Hadley and Ashley felt that they had benefitted through the sharing of this drawing. "Yoh! That was very interesting, I've never had a break down [of information] like this" (Hadley); "Ja, and for me that we can understand him a little bit more" (Ashley).

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Figure 16

Clint's first HTFWP drawing



Likewise, Grant (father to Ella) and Hailey (mother to Ella) both found the process of considering and discussing their daughter's drawing to be helpful in gaining insight into her emotional state, which they initially felt they fully understood. Having the space to explore possible meanings of her drawing supported revision of what they had believed. Grant commented:

> like that first picture [Figure 17]... I think of Ella as quite steadfast and you know, headstrong, and all those things. But in that first picture, how insecure it sort of came

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across. It was helpful to get that feedback to understand more of where she is and then being able to help her a bit.

Both Grant and Hailey recognised the value of discussing their daughter's drawings as a way to better understand her, especially over time.They both also appreciated seeing and considering the series of her drawings as they saw them change over time. The changes added to what they were learning about their child. In Grant's words, "I think it was very helpful to see the picture and how it changed. And to think about what it meant, in terms of where she was, in terms of her anxiety and stress". Similarly, Hailey expressed appreciation for "explaining the drawing, well discussing the drawing …and seeing that progression."

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Figure 17

Ella's first HTFWP drawing



Gaining insight was not just about what the drawings appeared to communicate, also over time, but also about learning to value their children's own insights into their anxiety. For example, Winnie (mother to Eliana) emphasised the importance of considering her daughter's perspective when examining her drawings. She acknowledged that while the drawings themselves were important, there was not necessarily a right or wrong way to interpret them. Instead, the drawings provided guidance in understanding her daughter's thoughts and emotions. Winnie explained:

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> So, the pictures were important but I don't think, necessarily what I thought of it, or what you thought of it was necessarily the right or wrong way. Ja, I think it was just a guidance and we could look at it from that point of view, from her point of view.

Winnie gained a deeper understanding of her daughter's experiences and emotions by considering her daughter's perspective when discussing her drawings. For example, when examining her daughter's drawing (see Figure 18), depicting a man barbequing in the rain, Winnie interpreted it in a way that possibly reflected her daughter's emotional state. She considered that the man in the picture could represent her husband's stubbornness, which made him unswayable once he made a decision. However, she also noticed the raindrops and the umbrella in the picture, which she believed could symbolize her daughter's emotion and her husband's disconnection from them. As such, Winnie explained that Eliana's drawing could represent her daughter's desire for a closer bond with her father, which she expressed through her artwork. She had previously overlooked her daughter's perspective of her husband's inflexibility.

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Figure 18

Eliana's second HTFWP drawing



For some parents, the insight they gained was not just about their child's possible perspective on what was challenging them, but also about their child's perspective on their own resilience. This challenged deficit-saturated understandings of their child. For example, when considering her daughter's first drawing (see Figure 19), Kimberley (mother to Tessa) suggested that the fire in the picture represents her daughter's anxiety, which she explained as all-consuming and overwhelming. She imagined that her daughter might feel helpless and trapped inside the house, unable to put out the flames. Kimberley saw herself in the fire-fighter, and believed that it might represent her own attempt to suppress Tessa's emotions and anxiety, but acknowledged that it was not working. In Tessa's drawing the fire was coming from within the house which helped Kimberley recognise that Tessa needed to find ways

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to deal with her anxiety from within, rather than relying on external factors. She then considered her parenting style, which she felt was too intrusive and over protective, and was possibly not helping the development of her daughter's self-efficacy. Although she felt it natural to be worried about her daughter's anxiety, she also now considered the importance of believing in Tessa's ability to cope with it. Kimberley thought that she should not try to be the hero, but that instead Tessa could be her own hero and put out the flames herself. With that thought she decided to take a step back. With regard to the tree in the drawing, Kimberley was not entirely sure of its significance, but suggested that it might represent how Tessa's anxiety affects other areas of her life as the tree was also on fire. She said:

> I don't really know about the tree. Maybe, that's just like it affects other things around her... Big house and this big strong tree. I'm rather small [pointing at the fire-fighter]. I thought she would have drawn me bigger (giggle). I'm feeling a bit diminished. Maybe she doesn't need me as much. You know maybe she doesn't need me. Uhm, ja. I just need to be there as like a reference, but I actually don't play as major a role as I feel the pressure that I do. (Kimberley)

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Figure 19

Tessa's first HTFWP drawing



Kimberley's comments on Tessa's first drawing can be contrasted to her comments on the last drawing (see Figure 20) about which she stated:

> Just it was quite a light-hearted picture like quite a, the colours and just the whole vibe of it you know, the colours the arms around each other you know such a good feel kind of kind of thing you know uhm so all round it was just, it gave me like a positive, positive feeling... Her house is still standing strong...and she looks strong in the picture...she looks like she's got her feet firmly on the ground and she's ready to face climbing those hills.

The initial concern about her daughter's challenge with anxiety and her perceived helplessness now seemed to be replaced by a confidence in Tessa's inner

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strength and her ability to show resilience during anxious times. As in other examples that I provided in this section, recognising the progression in the series of drawings completed by her daughter, was important to advancing Kimberley's insight into her daughter's anxiety.

Figure 20

Tessa's last HTFWP drawing



Overall, the subtheme that I reported here, showed that through the exploratory conversation of the elements of their child's HTFWP-drawing series, parent's insight into their child's anxiety and capacity to show resilience to that anxiety deepened. These HTFWP-drawing elicitation conversations also allowed for the reflection on their parenting styles and grew their insight.

The subsequent subtheme delves into the positive outcomes experienced by parents via the HTFWP-drawing elicitation conversations, emphasizing how

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discussing the drawings with them provided them with a sense of support and increased efficacy in their parenting role.

5.2.1.2 Feeling Supported and Effective as Parents

At the end of my study and in all seven cases, the nine primary informants expressed feeling supported and effective as parents with regard to co-managing their child's anxiety. According to Kimberley, "it wasn't just you and her [meaning myself and her daughter]; it was actually you, me and her, which I liked". Parents were grateful for this triadic alliance. They attributed it largely to the continuous sharing of their child's HTFWP-drawing series – something Hailey called the "in-between-the-sessions" (meaning the HTFWP-drawing elicitation conversations where her child's drawings were shared and discussed). These feedback sessions allowed them to witness progress and make necessary adjustments to their parenting as elements in the drawing changed.

Essentially, the parents no longer felt alone in the process of trying to cope with their child's anxious behaviour and were thankful for my guidance as the psychologist. Their sense of isolation was pronounced at the start of my study (see 5.2.2.2 for detail). Being included in regular HTFWP-faciltiated feedback sessions lessened their anxiety about parenting their anxious child. As Kimberley explained, "just someone guiding me as to how I can empower her as opposed to me having to manage the whole process, you know. That was helpful". Similarly, Winnie said "we both, Eliana and I, both went through changes and that wouldn't have been possible if I didn't get regular feedback sessions".

Additionally, in all seven cases, the nine primary (parent) informants, expressed feeling more empowered to cope with their child's anxiety at the end of the study. Via the insights gained in HTFWP-drawing elicitation conversations, their

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awareness and empathy had increased, leading to greater patience when dealing with their children. In this regard, Kate shared how their family is now more aware of their child's struggles and how they had adjusted their response to his anxiety:

> I think we're a lot more aware of where he's at. Instead of just accepting that he's just a child who's going through moods and us going on with our daily living, we're more aware that he is struggling; that he needs guidance; and we talk to him more often.

Likewise, Ashley emphasised the importance of showing their child that he is not alone and can rely on them for support when he said:

> To show him that he's not going through it alone. We are still there; he can lean on us... [We say] "You're not alone. Yes, you're feeling overwhelmed, but we're here to help you. We're here to support you. You can come to us... when you feel overwhelmed [and] we'll work it out together".

While parents' patience and understanding were not always absolute, they worked towards that goal. Hailey recognised that her child's behaviour is often rooted in anxiety and tried hard to stay calmer in response. "I think I've realized it's more anxiety than [bad] behaviour in some instances. And I think I've sort of not reacted as much...I think I've tried to stay calm, calmer than I was before." Parents were also kinder and more forgiving to themselves, acknowledging that they sometimes did lose control but were trying to improve. As Cathy stated, "I'm not always calm and patient, but I try to be".

Parents reported other more effective parenting too. For example, Kimberley admitted to initially being controlling and wanting to fix everything for her child but has since learned to step back and let her child figure things out on her own.

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> I don't try to solve it. Fights against my natural instinct but I've got to because she's got to figure it out on her own, you know?...coz I'm like a bit of a controlling [parent]. I wanted to, like fix it all for her and then got frustrated when it wasn't like fixing, you know.

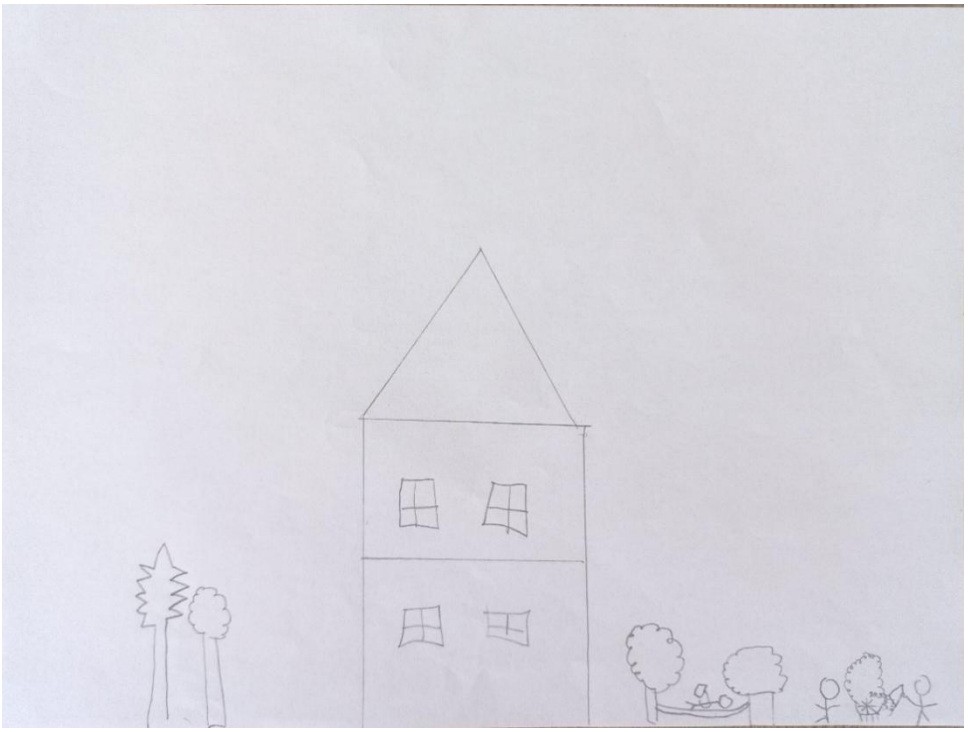
Alice also adjusted her parenting following the HTFWP-drawing elicitation conversations. She highlighted the insights she gained through the sharing of her son's (Kurt) drawings and his stories of his drawings during feedback sessions. After each drawing was completed, I would ask the secondary (child) informants what was happening in the drawing. This step was particularly important for Kurt as he struggles with fine motor skills (i.e., Figure 21 was his most legible drawing). Kurt's parents divorced when he was two years old and Alice had not realized that her son was yearning for his parents to reunite after their divorce; until we discussed his HTFWP drawing (see Figure 21) during one of the HTFWP-drawing elicitation conversations. With his story of the drawing, Kurt explained that the drawing showed a father who kept making fires that got out of control and a mother who continuously needed to extinguish the fire (in the far right corner). It also showed a boy lying in a hammock, playing on his phone. This family in the drawing all lived in the house, which was in the middle of the picture. When Alice and I discussed the significance of this drawing, she understood Kurt's perception of the relationship between herself and her ex-husband as 'fiery' or antagonistic. She understood her role as the one constantly trying to make things better. Furthermore, she understood the impact this relationship had on Kurt who was so disengaged and yet had a longing for his parents and himself to live together in one home even though his father was remarried and there was another baby on the way. It was only with this realisation

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that Alice could adjust her parenting and take action to address Kurt's feelings. Like Kimberley (and others) she learnt to step back and trust her son's resilience.

Figure 21

Kurt's first HTFWP drawing



At the end of the process, Alice indicated how proud she was to see her child starting to manage his anxiety independently. She said, "He's starting to manage it without my help. Well, I'll give him the tools, but he can do it on his own".

In the subsequent subtheme I shift focus to examine the impact of the shared HTFWP drawing on me as the psychologist. In my experience, this win (which was the rapport built with the parents and children) was intertwined with parents gaining insight and parents feeling more supported and efficacious. Again, the HTFWP-drawings and the conversations that they facilitated were key to the win I experienced.

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5.2.2 A Win for the Psychologist

My win as a psychologist was being able to foster rapport between myself and my primary informants. As I explain in 5.2.2.2, parents brought experiences of isolation and perceptions of inadequacy that could easily have jeopardised rapport building. In my experience, the HTFWP-drawing-facilitated conversations were key to building that rapport.

To illustrate the idea of rapport between a parent and a psychologist, I chose to use a metaphor of two pairs of hands, the one supporting the other, while holding a delicate plant (see Figure 22). The pair of hands holding the fragile plant represents the parent's efforts to support their child, who is perceived by the parents as a delicate plant. These parents already have the ‘fertile soil’, which could be representing their love for their child and their desire to make things better, when it came to their child’s anxiety. The pair of hands supporting the pair of hands holding the plant represents the psychologist working alongside the parent, providing a sense of support and guidance in the parent’s co-management of their child's anxiety. For my primary informants to feel adequately supported, it was crucial for me as the psychologist, to establish rapport with them.

In addition, another win I experienced as psychologist was the ability to track therapy progress via the child-client’s HTFWP drawing series. This win was particularly important for my study as time with child-client’s was limited by my temporal boundary (see Chapter 4, Section 4.3.1.2).

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Figure 22

Relationship building between psychologist and parent



Note. In the public domain (https://ideasforus.org/wp-content/uploads/2021/10/environmental-conservation-plant-sustainability-2021-08-27-00-02-10-utc-min1-768x513.jpg)

5.2.2.1 Building Rapport with the Parent

Sharing the drawings helped me as the psychologist build a relationship with the parent. The resulting rapport was beneficial for both parties. Four out of the seven cases (i.e., six of the nine primary informants) explicitly referred to this benefit. The value of sharing the HTFWP-drawing to establishing rapport was voiced by Grant. He said, “That's [discussing the drawing] helpful for us. That shared knowledge of something. It’s more than just information, it’s kind of aspects of having seen something together. It’s a connection”.

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Hadley also expressed the significance of rapport that was built between us as we discussed Clint's HTFWP drawings. Whereas Grant experienced it as a connection, Hadley felt 'seen'. For her, being seen yielded dividends that went beyond the parent-psychologist alliance to her family. She said:

> All of that that has changed.... the interaction that we have with him, the interaction that Donny [Clint's younger brother] has with him, the more loving [I am as a mother]...[it has] brought so much to our family as a whole, and not just helped Clint get from the point where he couldn't see tomorrow to now where he's looking at his muscles in the mirror. No, absolutely Judith, this process has been completely different to anything we've had. And with me going for therapy, and me being in a clinic, and me being... this experience is also completely different to, to that. It's good for me to have been seen. I came in also at a stage where I was broken. And just being able to get that guidance to be able to help my child, help the family. Calm down a bit. Show a little bit more empathy... So, not only helped him but helped me in the process as well to change. So, I thank you big time for that. Like, I think there's nothing we can do to repay you. (Hadley)

In the context of Hadley's experience (as reported in the preceding excerpt), I believe the HTFWP-drawing elicitation conversations were transformative for their family as a whole. Hadley also noted that the experience of sharing the HTFWP drawings was unlike anything she had experienced before. This implies that there is a unique rapport-building benefit to using the HTFWP drawings to include parents in their child's therapy process, one that benefitted the child in therapy and their family. In short, sharing the HTFWP drawing established rapport between myself and the parent that seems to have had spill-over benefits that I had not anticipated.

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Moreover, parents conveyed their gratitude towards my collaborative, non-judgmental and personalized approach during feedback sessions, which contributed to establishing rapport and positively impacted the entire family. Using the drawings facilitated a discursive space that took the focus off the parents. As we considered the drawings and what they could possibly mean, opportunities arose spontaneously for me to affirm what parents were doing right. The parents appreciated that affirmation. Hadley noted that I did not focus on pointing out their mistakes as parents when discussing her son's drawings, but also acknowledged what they were doing right while offering suggestions to improve, when she said, "I also liked the fact that you didn't find everything that we were doing as parents wrong. You found like; 'Okay, no you are doing that, do this. Or add this in to make it better'". This drawing-facilitated approach allowed for a more collaborative effort to make positive changes within the family.

As noted in Chapter 4, Section 4.7.1.3.1, I took care not to impose my interpretation of the drawings. This also facilitated rapport because it made parents equal partners in the conversation. Like other parents, Kimberley appreciated that I did not impose my interpretations, but rather allowed for open discussions on how she perceived the situation. When speaking about this in relation to our discussion about the drawings she explained:

> So, I did like that, uhm, I liked the fact that you, uhm, without sort of guiding... but it was sort of like, "What do *you* think? How do *you* interpret?" You know. It wasn't like; "This is how I see it. This is how". You know. It was more like; "How do, how are you, sort of seeing it". If you know what I mean. And then also, me being able to offload a little bit [during the feedback sessions].

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This collaborative approach enabled us to explore Kimberley's perspectives and for us to work together to develop solutions that worked for her. Simultaneously, this drawing-facilitated discursive space provided Kimberley opportunity to speak about the challenges she experienced as a parent and opportunity for emotional support and validation or exploration of alternate parenting strategies.

In their reflection on this drawing-facilitated collaborative space, parents commented on how it was a safe space to learn new skills. For example, Ashley explained:

> In the past [previous therapy experiences], we will get told this, this and that, but we don't get told... look at this point, your child is perhaps feeling like this, and this is what you can do. I've never had that before, which you've given us, I think you've given us more tools, more even than what you've given him.

Sharing the HTFWP drawings with parents and discussing them together also provided an opportunity for us to consider topics that could potentially rupture rapport, like the relationship between divorced parents and how that was impacting their child. The drawing-facilitated conversation allowed these conversations to happen spontaneously and in non-threatening ways. For example, Alice reflected on the experience of the sharing of Kurt's drawing (see Figure 21). She said, "I found it useful when you spoke to me about his dad [referring to Kurt's explanation of his drawing which included his perception of the relationship between his mother and father and also wanting the three of them to live as a family]... with the drawing. That he [Kurt] thought we would still be a family. So, once I knew... I spoke to him [Kurt's father] about that, and he changed". Alice also mentioned that following this drawing-conversation facilitated understanding, she was able to speak to Kurt's father about

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the impact of their relationship on Kurt and together they started making changes. For example, Alice and her partner visited at Kurt's father's house and the two households had barbeques together. Kurt and his mother went to visit the new baby, Kurt's half-brother, born during my study. In order for this type of action taken by Alice to be possible, she would need to trust that the insights shared during the discussion of the drawing were valid. Alice spoke of trust in relation to therapy when she said:

> ...a child can rely on someone else other than the parent. So the child...knows that someone...someone that's going to help him. Even if it's not mommy, I can trust them. He doesn't like something I'm doing. He can trust the therapist to come and speak to them about it. And say also, I don't like that mom's doing that. I don't know how to talk to her...he can rely on someone else other than me.

The trust was made possible, at least in part, by the rapport that sharing Kurt's HTFWP drawing had established between Alice and myself.

Although not all parents explicitly spoke of rapport between us, I believe there was an implicit understanding of rapport. As explained in the next section (see Section 5.2.2.2), the parents were able to share their needs and vulnerability with me, which I feel could not have been possible without the establishment of a trusting relationship. In my experience, the sharing of the HTFWP-drawings was essential to this relationship.

5.2.2.2 Why Was There a Need For Support and Efficacy as a Parent?

In our conversations about their children's drawings, parents shared their vulnerability with me and their feelings of inadequacy with regard to their parenting. Their vulnerability came in the form of expressions like: "I'm not a good enough parent", "Am I too soft", "Am I too angry", "Help me", "I can't cope". This vulnerability

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is illustrated by the metaphor of two hands gently holding a plant planted in some soil (see Figure 23). This image symbolises my sense of the parents' desperation when they first brought their child to therapy. To me, they seemed desperate to better understand their child's anxiety and better parent their child challenged by anxiety. In this scenario the plant represents the child; and the soil the environment and upbringing. The plant could also symbolise parenting, as parents wanted to strengthen the way in which they parented.

Figure 23

My child and my parenting



Note. A plant in soil (https://leadinginlimbo.weebly.com › leading-in-limbo). In the public domain.

These parents, who (in my experience) seemed desperate for an understanding, seemed to feel like they were holding a fragile plant in their hands, unsure of what to do next, but trying their best to help it grow. They were looking for advice on how to nurture the plant, enabling it to grow into a healthy and resilient

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child and/or parent. Just as a plant cannot grow to its full potential without being planted in nutrient-rich soil, a child cannot thrive without a supportive or nurturing environment. The metaphor underscores the importance of the crucial role of parents in creating a healthy environment in which children can grow. Involving their child in my study enabled parents to seek expert advice on how to plant the child in the right soil and how to tend to their growth. As the psychologist, I acted as the gardener, providing guidance and tools for parents to create a healthy and conducive environment for their child's growth. My gardening tool was the HTFWP-drawing and the conversations it elicited. During these conversations, parents could disclose their sense of parental inadequacy, their desire to learn new or better parenting skills, and their incomplete understanding of the roots of their child's anxiety.

5.2.2.2.1 A Sense of Parental Inadequacy

In all of the seven cases, the nine primary (parent) informants expressed feelings of inadequacy as parents and often used the phrase "help me". They spoke about being impatient and quick to anger, with one parent describing herself as "broken". There was a general sense of being unable to cope with their child's anxious behaviour and questioning whether they were" too angry" or "too soft". For the most part, they voiced a sense of helplessness. Kate shared, "It's actually quite scary to see [referring to his anxious behaviour] because we just don't know what he's going to do"; while Ashley admitted, "Friday night was, I was almost in tears Friday night, coz I didn't know what to do". Others disengaged, often in an attempt to control their sense of helplessness. As Cathy explained:

> I would say a lot of the time, it looks like I play on my phone a lot, but sometimes I just mindlessly scroll to just go away from everything, you know...sometimes I myself am struggling and it comes out with me shouting and getting angry.

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Meanwhile, Hadley admitted to losing patience and getting upset, saying, "I don't think I even had a strategy to help him, I was just very irritated...So I would always be the one that shouts and screams". Kimberly also shared, "I sometimes get irritated. Ja, I do. Like I say to her, 'you need to; you old enough now to also manage it'".

5.2.2.2.2 A Desire to Learn Better Parenting Skills

All of my nine primary (parent) informants expressed several needs during the HTFWP-drawing elicitation conversations, including the desire to change. As Winnie stated, "I don't want her to just walk back into a household and everything is exactly the same, yet I expect her to be better". In particular, this change included them wanting to be guided in their parenting so that there could be lasting, positive changes in how they parented and functioned as a family. As Hadley explained when asked about the value of drawing-elicilitation conversations, "In your helping Clint and educating us...we can implement it with Donny [younger son] then with this little one as well when he comes [indicating pregnancy], so we can just break the cycle".

Overall, the HTFWP drawing- elicilitation conversations helped me understand that parents wanted to cope better when their child was anxious. As Cathy expressed, "I just want to know what I can do better, like what I can do to help him...encourage him to be the best thing he can be and help him to grow healthy".

5.2.2.2.3 Some Inkling of the Roots of Childhood Anxiety

The primary (parent) informants in my study sought to understand their child and their child's anxiety better. The HTFWP drawing- elicilitation conversations provided parents with the opportunity to ask for help with this understanding, while also acknowledging their limited understanding. As Kate noted, "Children talk a different language...I think a psychologist could explain it to him better and to us

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better". Kimberley added, "You know it's helpful to get an outsider's sort of take on it [the child's anxious behaviour]".

Despite using the HTFWP drawing- elicilitation conversations to ask for a better understanding, initially all nine primary informants already had some understanding of their child's anxiety. Mostly this was because they had observed several examples of how their child's anxiety was expressed in behaviour. For instance, Kate stated that her child "becomes teary and will cry very often at the smallest things", while Kimberley shared that her child "goes into a full anxiety attack, clammy hands, heart pounding, she loses all the colour in her face. She literally has an anxiety attack... She was helpless in it...because she was completely dependent on me".

The parents' initial understanding of their child's anxiety also extended to their ideas of the source of the anxiety, such as stressful or threatening events. All nine primary (parent) informants alluded to at least one stressful or threatening event. These stressful or threatening events included experience of bullying at school, going to new places or meeting new people, being overwhelmed by schoolwork, and having a home environment where a parent or sibling is struggling with depression or their own anxiety. For example, Winnie shared her thoughts on the effect of her husband's anxiety on her child and the rest of the household:

> I think my husband has very bad anxiety, but he will react. He's like this little bomb. So, he will swear and he will do his thing and he will smack the table...he makes us nervous because he works from home as well and then he'll get angry about work or something.

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When talking about these stressful or threatening events, the primary (parent) informants invariably also talked about their inadequacy to manage them. For example, Hadley explained the bullying that her son experienced and the difficulty in dealing with that situation, "With the bullying at crèche, and...us being first-time parents at that point, not knowing how to deal with it".

Additionally, the parents recognised their own role in their child's anxiety. Hadley acknowledged, "I think a lot of it has to do with me also and the way that I handle Clint growing up, always just very strict, there was no balance". Ashley pointed out that this strictness was intertwined with societal expectations, "Both of our parents are ministers in the church. So, my whole life, and I'm sure her [Hadley's] whole life also, you hear, 'Jy's 'n priest se kind.' [You are a priest's child]". Kate also noted that "unwittingly placing too much expectation on the child" could be a contributing factor to anxiety.

5.2.2.3 The Drawings Provide Feedback on the Child's Progress in Therapy

Other than the HTFWP-drawing elicitation conversations helping me foster rapport with parents that included opportunity for them to disclose their feelings of parental insecurity, the HTFWP drawings made by my secondary (child) informants also offered me insight in the child's therapeutic progress. In all seven cases, the visual content in the series of drawings changed over the course of the sandplay therapy. This change in the drawings allowed me to gauge the progress the child was making in therapy and to share this progress with their parents.

As I reflected on the change in the various elements, like the fire, water, person, use of colour, in the children's drawings, I could determine how they were progressing in therapy. This in turn helped me feel more confident as I had some tangible form with which to record progress other than reports from parents on the

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child's anxiety symptoms abating. For example, Tessa's tree changed from one that was on fire to one that provided shelter (see Figure 24). When comparing the tree in two of Tessa's drawings, the trunk of her tree became thicker and her tree was not just a cause for fear, but one that provided shelter. The fire in Tessa's drawing changed from something that was uncontrollable and destructive to a fire that was useful and contained. These changes in Tessa's drawings suggested that she was feeling more contained and more capable of managing her anxiety. The changing elements of the drawing gave a sense that she felt emotionally stronger, not so alone and less helpless.

Figure 24

Tessa's tree in her first and second drawing



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Ella's person (see Figure 25) changed from a stick figure to a three dimensional but helpless figure (the second picture in her series) to someone who is capable of extinguishing a fire (the final picture in her series). Ella's person became more detailed (possibly indicating development) and more capable. In her first drawing her person did not have a body, hands or feet. In addition, it was not standing on the ground. In her second drawing the feet were not visible as her person was jumping up (according to Ella's narrative), but there was also no ground. The people in the first two drawings were therefore limited in being able to act and practice self-efficacy. However, the person in the third drawing had a body, hands and feet and was grounded. These changes seemed to show that Ella was feeling more self-sufficient, stable and supported.

Figure 25

Ella's person in each of her drawings



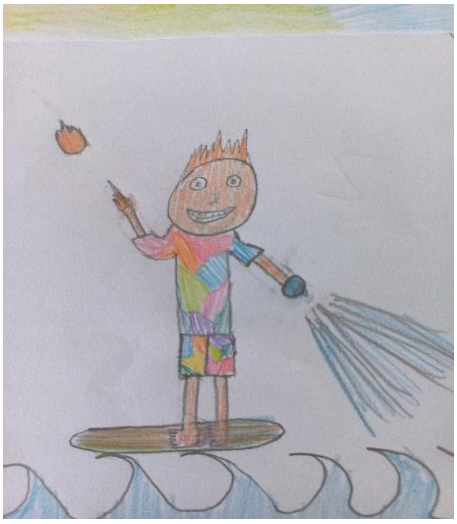
The change in the person was also true for Michael whose person changed from one who was helpless to one with magical powers surfing on the waves (see Figure 26).

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Figure 26

Michael's person in his first and second drawing





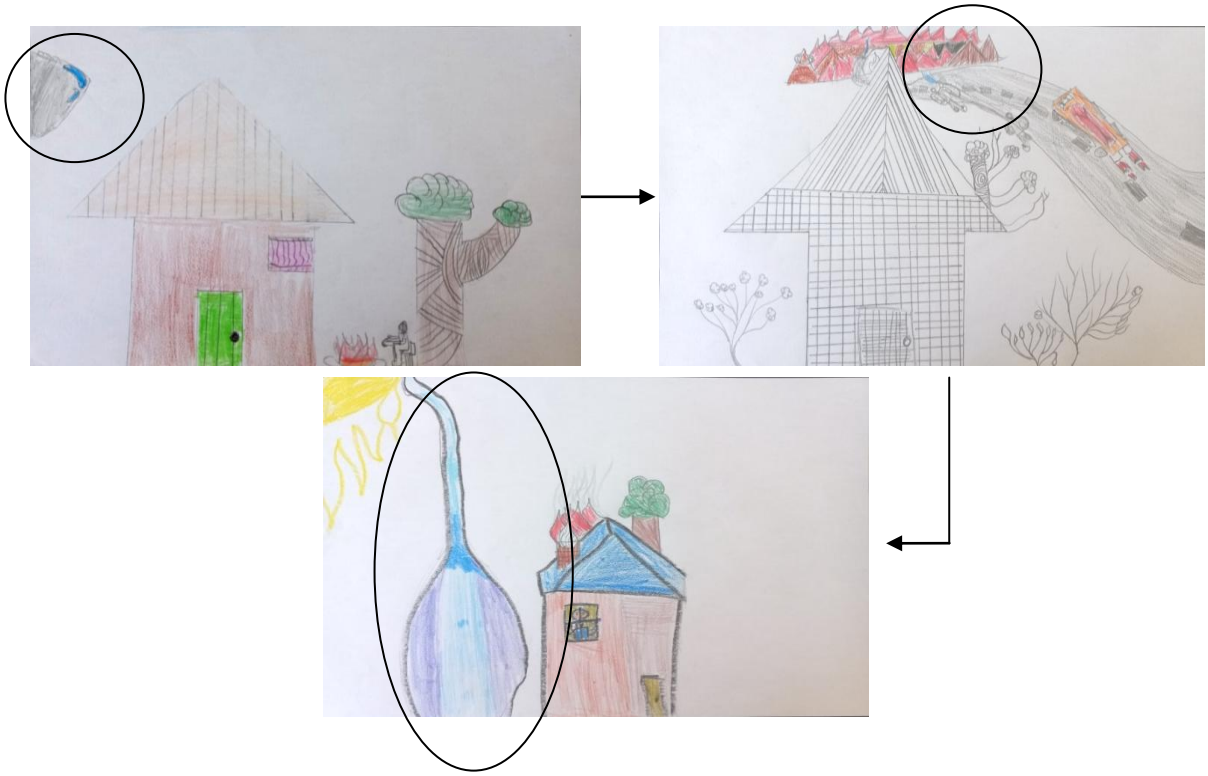
In Michael's first drawing his depiction of a person with its short limbs and big head, did not seem developmentally age appropriate but much younger than Michael. Even the colours in the clothing changed from just one colour to multiple colours. The change in the way he drew the person suggested a move from feelings of helplessness and being dependant on adults to one of being empowered and self-sufficient.

The water in Clint's series (encircled in Figure 27) starts out as a tiny stagnant puddle. It progresses to a suggestion of water being doused on a fire in the second drawing in his series to a flowing river that collects into a dammed area where (according to Clint's narrative), the owner is able to pan for gold. Initially, the water is rather sparse, which could be pointing to some lack in Clint's life. It also does not move. Then the movement starts, but there is very little evidence in his drawing and it is more an assumption, which could be pointing to potential. Finally, the water not only flows but is also a source of wealth, which possibly suggests that development has taken place in therapy.

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Figure 27

Clint's HTFWP drawings



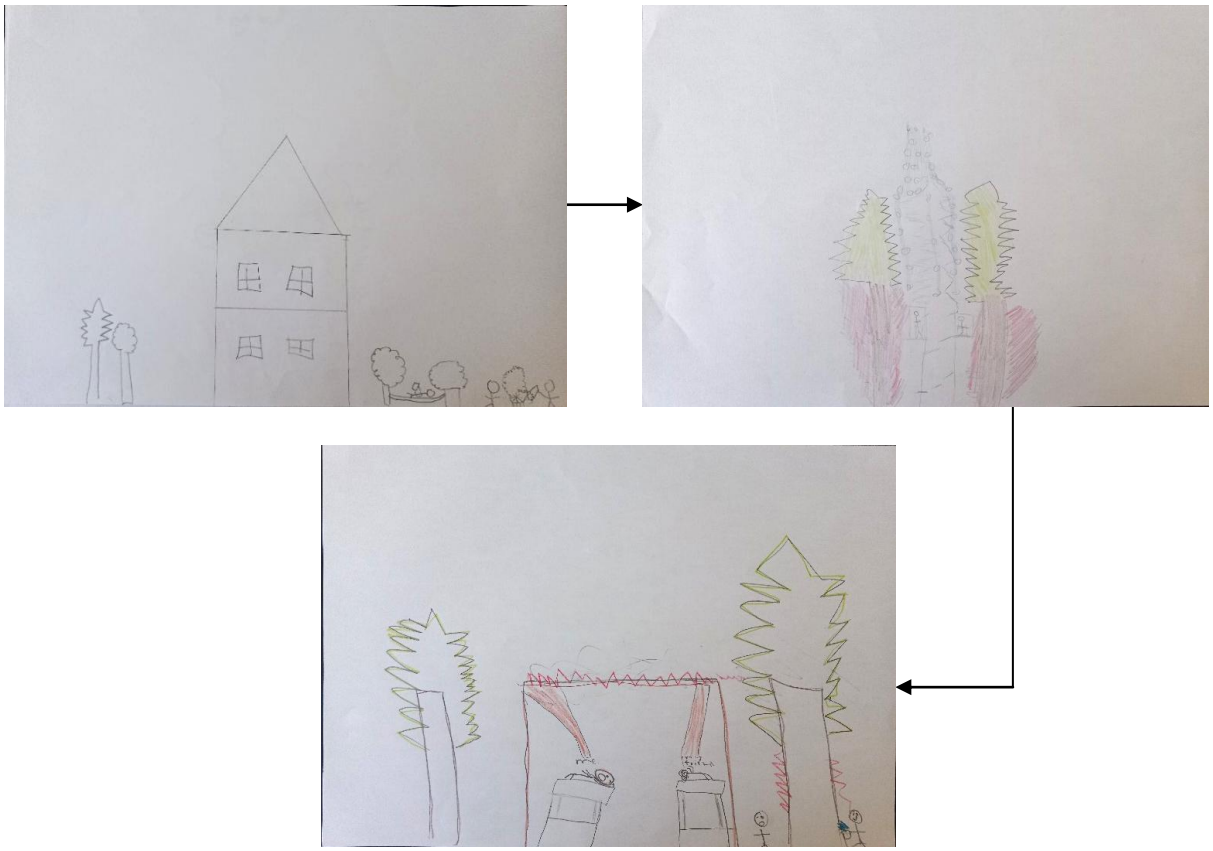
According to Clint, the owner of this dam (which appears 'pregnant' with treasure), pans for gold and his wealth is displayed in his house, which has golden walls inside and a golden door. This change in Clint's depiction of water also made me wonder about the changing relationship with his mother as she was pregnant during this time of my study and in the course of our HTFWP-drawing elicitation conversatons she reflected on her parenting style, deciding that she was not showing Clint enough warmth. She changed her parenting style and started showing him warmth following the insights she developed about her parenting via the HTFWP drawing-facilitated discussions. Could the treasure-filled, pregnant-looking dam be reflecting the warmth he now receives from his mother, which is warming/nurturing him on the inside (the golden walls of his final drawing)?

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In some cases, the change was more about how children explained their drawing than in the visual content. For example, Kurt's narrative of his drawings carried significant weight for me in illustrating progress (see Figure 28). This was largely due to his struggle with handwriting, as explained by his mother, and manifested in his drawings.

Figure 28

Kurt's HTFWP drawings



Kurt initially exhibited an excessive reliance on his mother and she did more for him than necessary for a child of his age, like fetching him something to drink when they were both watching television. He could not sleep without his three teddy bears, which travelled with him to sleepovers at his father's house and his grandmother. He also needed both dogs on the bed with him at bedtime. Kurt was

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scared of the dark and had a night light. He did not like a change in his routine and got overwhelmed when there were too many people around him (i.e., more than five people were problematic). Kurt was unable to spend nights at his father's house without tears, which often led to his mother fetching him prematurely. When he joined my study, his anxiety was also interfering with regular, everyday activities like his Grade 5 class going to the school camp, which happened during our time together.

Despite his struggle with fine motor skills, with each subsequent drawing, Kurt's narrative vividly conveyed his intended message. The representation of a passive boy lying in a hammock between two trees gradually evolved into two stick figures battling a fire to protect the tree-house nestled amidst the trees. According to Kurt, the boys would not be successful and the trees would burn, destroying the tree house. In the third drawing, two boys at a school campsite escape a fire that encroaches upon their bungalow, taking matters into their own hands to extinguish it. According to Kurt, they are successful and become the heroes of the camp. Although it was difficult to decipher his drawings, I was able to make out some details as he shared the narrative of each drawing with me. This shift in his drawings and narrative reflected Kurt's transition from a disengaged, passive and scared child, dependent on parental intervention or external factors like a nightlight, teddy bears or dogs, to an active, heroic individual, who ventured out on a school camp (literally as well as in his drawing), and assumed responsibility.

While the drawings often indicated progress, they also shed light on the need for further therapy, as exemplified by Eliana's artwork (see Figure 29). Each of her drawings conveyed a sense of disturbance. The initial drawing depicted a house engulfed in flames, followed by a sombre-looking male figure barbecuing in the rain.

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In her final illustration, a frightened stick figure sought refuge inside a house while arrows rained down on their village. Notably, all of Eliana's drawings, which conveyed some unsettling element, also featured male characters, potentially suggesting a recurring theme worthy of exploration in therapy. In the course of our collaborative discussions about her drawings, I advised her mother that therapy continue.

Figure 29

Eliana's HTFWP drawings



In summary, through the transformation of the drawings and the stories related to them that I shared above, these examples illustrate both progress and ongoing challenges. This was a win for me as the treating psychologist but also a win for the parent as they could better understand their child's progress in therapy

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(or lack thereof), thereby highlighting the benefits of sharing the child-client's HTFWP drawing series with their parents during HTFWP-drawing elicitation conversations when the child is in therapy for anxiety. Witnessing and acknowledging the progress of the child, as evidenced in the drawings, likely played a significant role in shaping my relationship with the parents. My recognition and acknowledgement of these positive changes in their child's drawings demonstrated my appreciation for their efforts in parenting and the emotional and psychological growth of the child. This validation contributed to a sense of encouragement and collaboration between myself and the parents; it strengthened our rapport. In this drawing-faciliated way, the parent's efforts to work with me to support their child according to that child's specific need was validated. The changes we observed in the child's HTFWP drawings contributed to a constructive and hopeful feeling that bolstered our alliance.

In addition, the visible progress in the drawings could have contributed to building trust between myself and the parents. As they observed tangible improvements in their child's expression and emotional well-being through their HTFWP drawings, they might have developed a greater sense of trust in my expertise and the effectiveness of the therapy process. This was a big win for me because it kept parents committed to the therapeutic process. Furthermore, sharing the drawings and witnessing the progress seen in them created a shared goal between myself and the parents – the well-being and development of their child. This shared objective fostered a sense of unity and collaboration as we worked together to support their child's emotional and psychological growth; I experienced this as us being parnters in the child's growing resilience. As parents witnessed their child's progress and began to recognise their child's resilience, they felt more empowered

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and capable in their parenting roles. This brought a sense of gratitude for my role in co-facilitating this progress, which enhanced my relationship with them.

5.2.3 A Win for the Child

I chose my final metaphor (see Figure 30) of a passion fruit plant bearing fruit, to symbolise the positive outcomes and benefits for the child as a result of the HTFWP drawing-facilitated collaborative relationship between myself and the parents – similar to a tree bearing fruit after being nurtured and cared for in an appropriate way. As I reflected on my experience as a novice gardener, I realised that for the passion fruit to thrive, it needed the trellis as well as the warmth of the sun, just as children who struggle with anxiety need supporting relationships and the warmth from these relationships to foster their resilience against anxiety. In particular, as I will report next, the HTFWP drawing-facilitated conversations encouraged child-psychologist and child-parent relationships that could potentially sustain the progress they had made in therapy.

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Figure 30

A collaborative relationship bears fruit



Note. Shiny Green Unripe Granadilla Fruit (https://www.publicdomainpictures.net/en/view-image.php?image=306906&picture=shiny-green-unripe-granadilla-fruit). In the public domain.

5.2.3.1 Sustaining Therapy Gains

In the preceding sub-themes, I showed that all nine primary (parent) informants benefitted from our collaborative relationship. In all cases, the sharing of the HTFWP drawing and related exploration of its meaning was key to this collaboration between the parent(s) and me and our shared commitment to supporting the child's progress in therapy. This included a commitment to sustaining that progress once the therapeutic process was completed (e.g., through the deepened insight gained into their child's anxiety as well as by helping their child to continue practising strategies and techniques to manage anxiety at home). For instance, Kimberley said, "it's not just you and her, all of us have to be working

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together to figure this out, because she'll only, you know, one would only see the therapist for a period of time, and then it still needs to be managed at home".

Supporting gains in therapy and sustaining them is a win for the child. Parents expressed their appreciation for being included in the therapeutic process via the HTFWP-drawing elicitation conversations; they felt like they were part of a team working towards the common goal of therapeutic progress and sustaining that progress. They appreciated that this would enable them to better help their child through future anxious times. As Winnie put it:

> It wasn't just you, it wasn't just me, it wasn't just her, it was all three of us... So, I knew she now learnt something, and now I know I can use it for her next time when she can't remember about it, I can then remind her. So, it becomes team work because ultimately she's not alone in this.

5.2.3.2 Shared HTFWP Drawings Foster Understanding and Connection

Sharing the drawing with the parents led to a deeper understanding of their child and their child's anxiety (see Section 5.2.1). Not only did the parents gain insights that potentially positively influenced their relationship with their child, but the children also felt a heightened level of understanding from me as we explored their drawings together and they shared the story of their drawings with me. Furthermore, the act of creating the drawings enabled the children to spontaneously engage in conversations with their parents, opening up new avenues of communication. The children therefore experienced an enhanced sense of being understood. This was a win for the child.

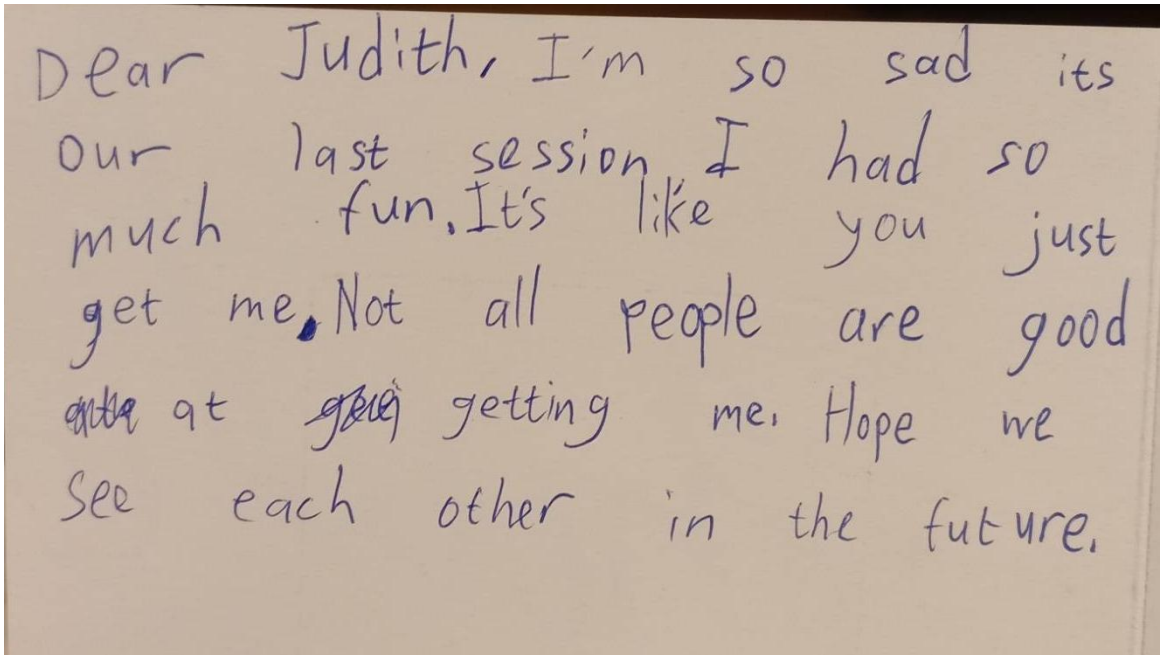
An example of feeling understood by me, was a sentiment echoed by Michael in his heartfelt, thank-you note at the culmination of my study (see

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Figure 31).

Figure 31

Michael's thank-you note



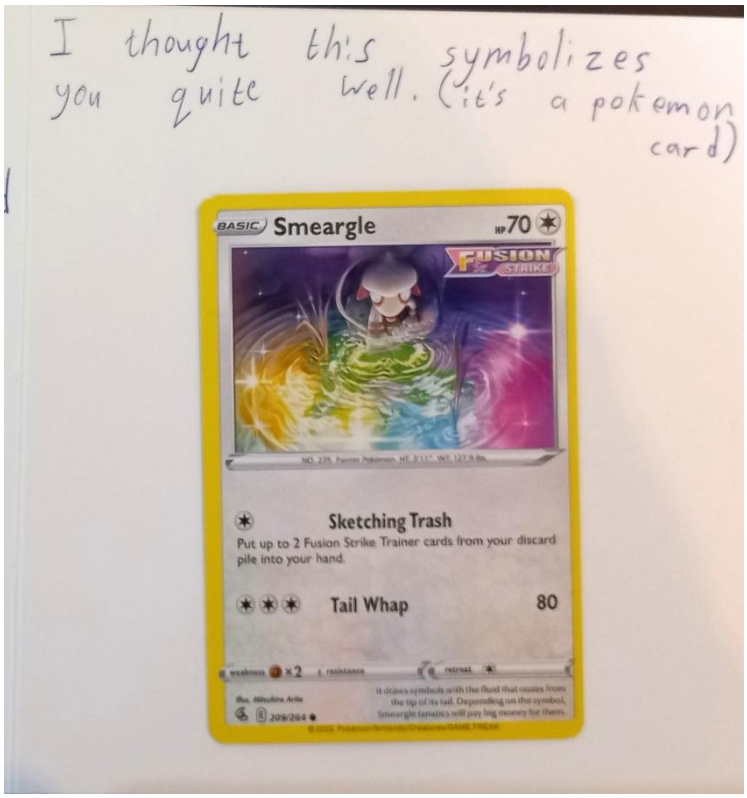
Although Michael does not refer to the drawings in his thank-you note, he does imply that the drawings were valuable to him by including a special gift in the card in the form of one of his Pokémon cards (containing a figure drawing with its tail) with a little note above it (see Figure 32). At the bottom of the Pokémon card it explains that Smeargle (the name of this Pokémon) draws symbols with the fluid that oozes from its tail. This Pokémon card studies its opponents and then mimics their moves through a drawing. To me, Michael selecting a Pokémon card that specifically highlights drawing abilities and mirrors the person in front of them and including it as a special gift reflected an understanding and appreciation of the creative process

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that the HTFWP drawings facilitated, and the resultant feeling of being better understood.

Figure 32

Michael's Pokémon card



Note. "Smeargle draws symbols with the fluid that oozes from the tip of his tail" (Pokémon/Nintendo/Creatures/Game Freak, 2022)

A similar sentiment was shared between Eliana (daughter to Winnie) and myself during her first HTFWP drawing session. During her story of the drawing, Eliana explained that the house would be saved eventually, but that everything inside would be "wrecked" (see Figure 33). We used this as an analogy for her anxiety. When I suggested the following: "So I wonder if that's how it is when you're anxious. You still look like you're fine, like in class. But inside you're a little bit

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wrecked?" Eliana agreed wholeheartedly. She then relayed this HTFWP drawing-facilitated discussion to her mother (Winnie), who in turn relayed it to me:

> Well, I know what she [Eliana] said, that you [Judith] are a genius, because you really know your stuff, because when she drew it [Eliana's first HTFWP drawing], I don't think she knew what she was drawing until you discussed it with her and then it made all this sense in the world to her, then you were a genius. ... It helped in the sense that I [Winnie] could change things as well. I could change, go home and look at the situation there and change things there.

Winnie's comments helped me understand an important benefit of using the HTFWP drawings. Through the discussion of the drawing with Eliana, she felt understood; this was a win for her. She was then able to spontaneously discuss this drawing with her mother when she was fetched from the session; another win for her. Finally, Eliana's mother relayed her discussion with me. This discussion about the drawing is an example of how a HTFWP drawing-prompted discussion between myself and the child, then parent and child and finally myself and parent, allows parent, psychologist and child to work together as a team and support the gains made in therapy. Sharing the drawing allowed for open communication and collaboration towards the common goal of improving the child's well-being.

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Figure 33

Eliana's first HTFWP drawing



5.3 Conclusion

In conclusion, this chapter has presented the theme and three related sub-themes that I developed during the data analysis to answer my primary research question regarding the benefits to the therapeutic process, if any, of sharing the series of the child-client's HTFWP drawings in parent feedback sessions when a child is in psychotherapy for GAD. Collectively, these findings point to an unequivocal answer: there are benefits to sharing the HTFWP drawings of child-clients with their parents during HTFWP-drawing elicitation conversations in that the parents win, the psychologist wins, and the child wins. The chapter that follows will discuss these wins by considering how they fit with the literature I reviewed in Chapters 2 and 3, and how they extend that literature.

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Chapter 6

Discussion

6.1 Introduction

The primary research question that guided my instrumental multiple case study was: How does sharing the series of the child-client's HTFWP drawings in parent feedback sessions benefit the therapeutic process, if at all, when a child is in psychotherapy for GAD? Using Braun and Clarke's (2013; 2021a; 2021b; 2022) reflexive thematic analysis, I identified one overarching theme along with three subthemes, which were reported on in detail in the preceding chapter (see Figure 12 and Figure 34). In Chapter 6, I first discuss the benefit of sharing the child-client's series of HTFWP drawings for the creation of a strong parent-psychologist alliance thereby contributing to an understanding of how best to enable such alliances. Thereafter, I discuss the cascading benefits a drawing-facilitated parent-psychologist alliance has for the stakeholders (parent, child, and psychologist) in a child's psychotherapy. Furthermore, I discuss how these drawings serve as a catalyst for insight. Specifically, how parents gain insight into their child's anxiety through their understanding of their child's HTFWP drawings, while the drawings provide me, as treating psychologist, insightful cues for tracking progress in therapy.

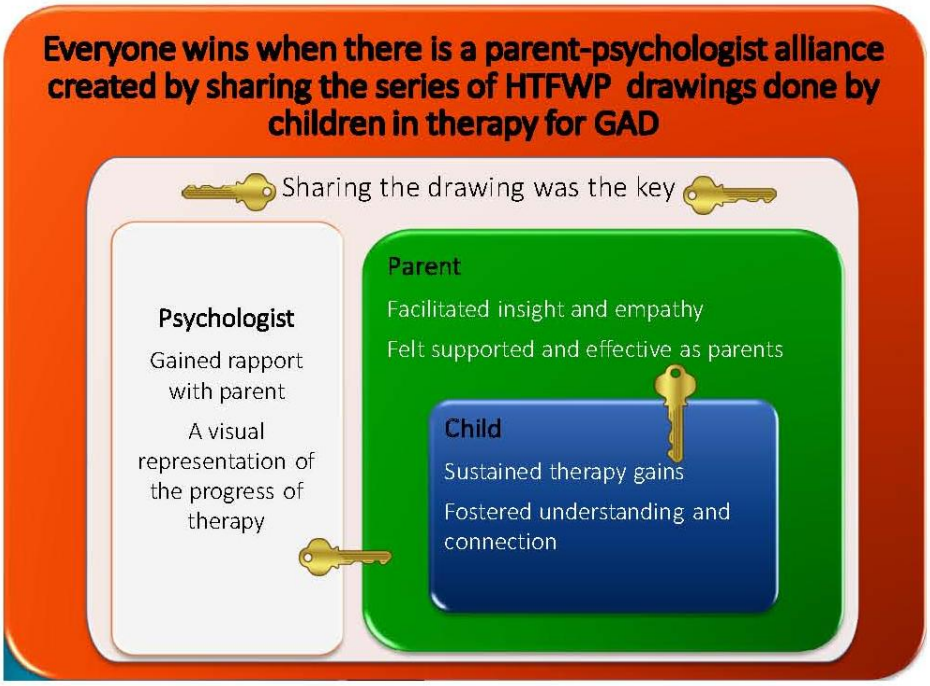
Through these discussions, I situate my research findings in the current understandings of the multisystemic resources that support children's resilience to mental health challenges, like GAD (Masten, 2014, Masten et al., 2021; Pillay et al., 2023; Theron & Van Breda, 2021; Ungar & Theron, 2020; Wu & Ou, 2021). In addition, I show how my study expands what was already known about using children's drawings to communicate with parents when the child is in therapy, the

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benefits of a parent-psychologist alliance, and the inclusion of parents in the child's therapy process when a child is in sandplay therapy.

Figure 34

The benefits of the sharing the HTFWP drawing with parents when their child is in therapy for GAD



Note. I developed Figure 34.

6.2 Sharing a Series of HTFWP Drawings Facilitated a Parent-Psychologist Alliance

Research on child psychotherapy underscores the significance of fostering a robust alliance between parents and the treating psychologist, as it has been shown to significantly contribute to positive therapeutic outcomes for the child (de Greef et al., 2017; Diamond et al., 2000; Feinstein et al., 2009; Fox, 2012; Gvion & Bar, 2014; Kazdin & Whitley, 2006; Nevas & Farber, 2001; Ruberman, 2009; Zemmelman, 2018). As mentioned in Chapter 3 (see Section 3.2.4), there are few guidelines on

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how best to achieve this alliance. With regard to sandplay therapy (the modality I used), parents have typically been included in the sandplay therapy of their child by having combined sessions with their child, either building in the same tray as their child or building a sandplay scene alongside their child (Green & Connelly, 2009; Homeyer, 2015; Kaduson & Schaefer, 2006; Liu et al., 2023). However, including parents in this manner has its limitations, particularly concerning the potential for parents to become overly involved in their child's therapy. This over involvement can impede the relationship between the child and psychologist (Chandler, 2018). Possible controlling behaviours from parents can also hinder the child's development of healthy coping strategies (Butterfield et al., 2021; Pinquart & Gerke, 2019). In addition, research has shown that parents of anxious children are often experiencing their own mental health challenges (Bilsky & Friedman, 2022, Ginsberg & Schlossberg, 2002; Marzilli et al., 2021; McLaughlin et al., 2011; Suveg & Zeman, 2004). When parents have their own mental health challenges, this could potentially have a negative emotional influence on the child during the therapy session. Finally, one sandplay therapy study included parents in the child's therapy process by following individual sessions for the child with two family sandplay therapy sessions (Tan et al., 2021). However, as previously noted (Chapter 3, Section 3.2.4), this approach proved to have limited effectiveness in fostering a collaborative, supportive, and meaningful parent-psychologist alliance, which is why I opted not to pursue this approach.

Unlike Green and Connelly (2009), Homeyer (2015), Kaduson and Schaefer (2006) and Liu et al., (2023) mentioned earlier, who involved parents in the sandplay process with their child, my sessions with parents were conducted separately from those with the child. Additionally, I utilized the child-client's HTFWP drawing series

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with parents to include them in the child's therapy process, instead of having parents build sandplay scenes alongside or with their child, as utilized by these authors. My strategy to building a strong alliance with parents when their child was in sandplay therapy, involved sharing a series of the child-client's HTFWP drawings with their parents during HTFWP-drawing elicitation conversations. I found that these HTFWP-drawing elicitation conversations established a strong connection with the parents. According to Wienand (2016), the HTFWP drawing has distinctive features (i.e., the symbolic significance of the five elements – house, tree, fire, water and person; the interaction between these elements, the placement on the page of these elements, the line structure, and the use of colour). I theorize that the strong connection with parents occurred as follows: with their distinctive features, the HTFWP drawings provided a tangible, visual medium my primary informants could explore in interaction with me. In essence, with the framework of Symbolic Interactionism (Gallin, 2022; Quist-Adade, 2019; Salvini, 2019; Segre, 2019; Totkova, 2019; van der Vaart et al., 2018; Willis Hepp et al., 2019; Yazan, 2015), I postulated that these distinctive features, combined with conversational interaction regarding their potential meaning for that particular child, likely facilitated opportunities for connection between the parents and me.

The manner in which I shared the child-client's drawing series with parents in my study was akin to the concept of attunement. As discussed in Chapter 3 (see Section 3.2.4), attunement involves a cognitive connection as well as a deeply felt embodied connection (Biddle et al., 2023). It occurs through establishing a meaningful connection with someone by empathizing with their emotions, mirroring their internal states (like imitating their breathing) and providing a safe space for emotional expression (Markman, 2020; Monticelli & Liotti, 2021; Talia et al., 2020).

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My study contributes a drawing-facilitated pathway to attunement. Through my HTFWP-drawing elicitation conversations I created a safe space for parents to express their concerns regarding their child's anxiety, empathizing with these concerns. By using open-ended questions (e.g., what thoughts or associations come to mind when you look at the different elements of the drawing?; see Table 5), I encouraged open dialogue and collaboration, steering away from imposing my expertise in a top-down manner. Instead, I valued and honoured the parents' perspectives, fostering a sense of partnership and equality in the feedback process. Instead of a one-sided delivery of feedback, the sessions involved interactive dialogue where parents were encouraged to express their thoughts, observations, and concerns regarding their child's HTFWP drawings. This open exchange of ideas facilitated a safe discursive space and cognitive connection that encouraged communication and trust between us, strengthening the parent-psychologist alliance. Aligning with the assertion of Zalaznik et al. (2021) regarding the attainment of attunement, my attuned connection allowed parents to feel accepted, understood and supported. Similarly, I concurred with Biddle et al. (2023) regarding the understanding of attunement through harmony; I attempted to create a harmonious working relationship with the parents by actively involving them in the process of trying to understand their child's message in their drawings. Our working together was based on mutual respect for each other's opinions and insights. This creation of a robust parent-psychologist alliance aligns with Bram (2021) who highlights that when parents felt valued, respected, and understood by the psychologist, their investment in their child's therapeutic process deepens.

Most of the reports on involving parents in their child's psychotherapy emphasised the importance of including parents, but did not mention the frequency

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required to do this effectively (de Greef et al., 2017; Diamond et al., 2000; Feinstein et al., 2009; Fox, 2012; Gvion & Bar, 2014; Kazdin & Whitley, 2006; Nevas & Farber, 2001; Ruberman, 2009; Zemmelman, 2018). Ruberman (2009) suggests that feedback frequency may vary depending on the individual case, but provides no further guidelines. I engaged parents in feedback on three separate occasions, using the HTFWP-drawing elicitation conversations, i.e., at the beginning, more or less in the middle and at the end of the child's therapy process (see Chapter 4, Table 3). My study therefore draws attention to the value of more frequent, drawing-facilitated parent feedback sessions. I believe that this iterative approach strengthened the parent-psychologist alliance as the repeated time we spent together, increased our familiarity, built our trust and rapport and allowed for in-depth exploration.

In summary, while reports exist regarding the advantages of a parent-psychologist alliance (Bonanno et al., 2024; Bram, 2021), these reports lack guidance on how to establish such a vital connection. Thus, my study points to a comprehensive, step-by-step, drawing-facilitated approach to fostering this crucial parent-psychologist alliance. It draws attention to the value of creating a safe discursive space through sharing the child-client's HTFWP drawing series with their parents in HTFWP-drawing elicitation conversations, which will form the basis of my recommendations for psychologists in Chapter 7. As discussed in the next section, the creation of the drawing-facilitated parent-psychologist alliance had spill-over benefits for the stakeholders (i.e., parents and psychologist) connected to the child's psychotherapy for GAD.

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6.2.1 Spillover Benefits of the Drawing-Facilitated Parent-Psychologist Alliance for the Stakeholders

6.2.1.1 Benefits for Parents

6.2.1.1.1 Enhanced Parenting Skills

Studies have shown that parents face challenges in co-managing their children's difficulties arising from their GAD symptoms (Beesdo et al., 2009; Bilsky & Friedman, 2022). As reviewed in Chapter 2, (see Section 2.2.2), these GAD-related difficulties include those related to physical symptoms (for example, rapid breathing, headaches, trembling) as stated by Garcia-Adasme et al., (2021), Meers et al., (2020) and Theuring et al., (2023). In addition, as noted by Sonmez et al. (2020), co morbidity (for example, depression), can also be included in the list of GAD-related difficulties. Furthermore, according to Meers et al. (2020), Hanna et al. (2020) and Driscoll et al. (2020), GAD-related difficulties include academic difficulties (for example, general underachievement at school). Bilsky & Friedman (2022) take impaired family functioning (for example, increased stress and conflict in the family unity) into account. Finally, Garcia-Adasme et al. (2021) includes impaired social relationships (for example, avoidance of activities) to the list of GAD-related difficulties.

In my study, my primary informants spoke about their child's GAD challenges of excessive trembling and crying, increased stress in the family, excessive fears, avoidance of typical, everyday activities, impaired social and sibling relationships. The parents in my study expressed their need for practical ideas relating to how to respond to and manage these challenges. Their expressed need for coping skills and guidance concurs with that of several authors who emphasise the importance of establishing strong parent-psychologist (Accurso & Garland, 2015; Kaduson & Schaefer, 2006; Vigdal & Brønnick, 2022; Yamamoto et al., 2023). Ruberman (2009)

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highlights that feedback sessions are ideal opportunities for parental guidance. My study highlights the use of drawing-facilitated feedback sessions, which I refer to as 'HTFWP-drawing elicitation conversations', to facilitate a parent-psychologist alliance and parental guidance. As also noted in Chapter 5, these conversations provided a safe space for parents to make their need for guidance known.

Previous studies have explored the therapeutic usefulness of drawings to communicate with parents (Broecher, 2012; Baghdadi et al., 2020; Kissos et al., 2020; Lev-Wiesel et al., 2021; Sheikh et al., 2019). However, these studies focus on the child's experiences of sexual abuse, dental treatments, peer rejection, family functioning, attachment disorders and parenting styles. These aforementioned studies (Broecher, 2012; Baghdadi et al., 2020; Kissos et al., 2020; Lev-Wiesel et al., 2021; Sheikh et al., 2019) do not focus on the challenges of children exhibiting symptoms of GAD. My study extends this previous literature to include the therapeutic usefulness of drawings to communicate with parents whose child is in therapy for GAD. In specific, the act of sharing the child-client's HTFWP drawing series opened up avenues for discussion and aided parents in addressing their child's struggles with anxiety.

The HTFWP drawing was developed initially, for diagnostic purposes (Groschwitz, 2016; Kreuter-Hafer et al., 2016; Lutz, 2007; Wienand, 2016, 2020). Clinical analysis of the drawing has therefore been noted by various authors (Kreuter-Hafer et al., 2016; Lutz, 2007; Wienand, 2016). Unlike these aforementioned reports, I did not share any clinical analysis made of the drawings for the purpose of my study. Instead, I was interested in the child's explanations of their drawing and the parent's understanding of the drawings. I elicited the parents' emotional responses to prevent an excessive intellectualization of their thoughts

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regarding their child's drawing. I did this by asking for their first emotional reaction when they were exposed to their child's HTFWP drawing (see Chapter 4, Section 4.7.1.3).

We then explored the different symbols in the drawings and elements like the use of colour, how their child created the drawing and what aspects of the drawing jumped out at them (e.g. the way their child drew the house). This conversation inevitably allowed an exploration of parenting and gave me the opportunity to guide parents to adopt methods that would better support their child. As we grappled with different ways of approaching their parenting challenges and started seeing positive changes in their children's behaviours (which were also reflected in their subsequent HTFWP drawings), parents started gaining confidence in their abilities to cope better with their child's anxiety.

Their sense of empowerment grew as they felt better able to cope with their child's anxiety by the end of the therapy process. At the end of the therapy process, parents indicated that they valued and appreciated the guidance offered during the HTFWP-drawing elicitation conversations. Using drawing-facilitated discussions to build rapport and empower the parents (i.e., advance parenting skills) aligns with the pre-existing understanding of the importance of empowering parents as active partners in the therapeutic process, as doing so contributes to the child's resilience and well-being (Bratton et al., 2005; Diamond et al., 2000). However, no previous study has suggested using a series of child-client generated HTFWP drawings to achieve this.

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6.2.1.1.2 Parents Felt Supported

My study was conducted at the end of the COVID-19 pandemic period during which many parents felt particularly unsupported as it was difficult for them to access mental health services or parenting programs (Munir, 2021). Furthermore, like many other parents raising children who are anxious, as highlighted in studies by Bilsky and Friedman (2022), Driscoll et al. (2020), and Sonmez et al. (2020), the parents in my study felt overwhelmed by their children's anxious behaviours, also because these behaviours were often unpredictable. They were also overwhelmed by personal stresses related to their job, marriage or their own mental health challenges, including anxiety (Bilsky & Friedman, 2022, Ginsberg & Schlossberg, 2002; Marzilli et al., 2021; McLaughlin et al., 2011; Suveg & Zeman, 2004; Troller-Renfree et al., 2019).

Parents were unsure about how to manage their child's anxiety and felt alone. The regular contact we had via the HTFWP-drawing elicitation conversations helped them feel less isolated. They felt that they no longer had to try to figure things out by themselves. In this study, it was important for the parents to know that someone was listening to their parenting challenges without being judgemental. This finding of parents feeling less isolated as fostered by the parent-psychologist alliance, aligns with previous studies on the benefits of the parent-psychologist alliance (Bram, 2021; Fox, 2012). However, to date, studies have not proposed employing a series of drawings, particularly HTFWP drawings, to achieve this outcome.

6.2.1.1.3 Improved Affect Regulation

As I observed the parents over time, I noticed a shift towards greater self-awareness. At first, parents would explain how impatient they were with their children, but as we continued our discursive process of sharing the series of their child's drawings and as the alliance between us grew, parents became more tolerant

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and patient. The parents in my study recounted instances where they struggled to maintain control but actively sought ways to regulate their own reactions. Parents' improved regulatory capacity and heightened frustration tolerance resonate with prior studies on the benefits of a parent-psychologist alliance (Bonanno et al., 2024; Fox, 2012). However, neither of these prior studies explore the use of drawings to enhance the regulatory capacity of parents. The parents in my study gained a deeper understanding of their child's challenges with regard to anxiety when seeing and discussing their child's drawings during the HTFWP-drawing elicitation conversations. This enhanced understanding may have allowed them to respond to their child's challenges with empathy instead of reactively.

6.2.1.1.4 Self-compassion was fostered

In addition, parent's self-compassion grew. They seemed more forgiving of themselves when their attempts at managing their child's anxious behaviour did not have the desired results. I was surprised by the development of self-compassion in parents. For this reason, I went in search of literature to support this surprising finding. Despite conducting an extensive search, I could not find this particular benefit mentioned in previous studies regarding the advantages of parent-psychologist alliances (although it is reported in association with more supportive or enabling parenting; see Chapter 2, Section 2.4.2). It is noteworthy, however that there is attention given in studies to self-compassion and resilience, which posits that nurturing people's capacity for self-compassion can also nurture resilience (Bag et al., 2022; Belfi et al., 2024; Egan et al., 2022; Haldorai et al., 2023; Kotera et al., 2021; Kotera & Sheffield, 2020; Pérez-Aranda et al., 2021; Yu et al., 2023). Reflecting on this finding, I believe that it was possible that the empowerment and support provided through the drawing-facilitated parent-psychologist alliance

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encouraged parents to adopt a more forgiving and understanding attitude towards their own challenges. This empowerment could be associated with the strengthening of parents' confidence in their parenting abilities. The discursive context created when sharing the child's drawings with their parent likely played a significant role in facilitating this process, as it provided an opportunity for reflection and dialogue that could lead to increased self-compassion.

This growth in their self-compassion could also have been as a result of parents seeing that their child's drawings placed no blame on them as parents. I had not anticipated this as a benefit. Also, through my discursive process of sharing the child-client's series of HTFWP drawings, the respect parents experienced from me could have reduced any guilt or shame they may have carried regarding the co-management of their child's anxiety. Furthermore, through the repeated discursive space when exploring their child's HTFWP drawing series, parents may have come to see the challenges they and their children faced because of anxiety, as opportunities for growth instead of a reflection of their worth as parents.

6.2.1.2 Benefits for the child

6.2.1.2.1 Authoritative parenting

Authoritative parenting, as discussed in Chapter 2 (see Section 2.4.3), is the parenting style that balances high levels of warmth with moderate control (Baumrind, 1973; Rothenberg et al., 2020a; Sahithya & Raman, 2021). In addition, an authoritative parenting style is considered a protective factor for a child's resilience to anxiety (Masten et al., 2021). As highlighted by numerous authors, authoritative parenting nurtures several positive attributes in children as well as fostering a supportive home environment, thereby mitigating the effects of anxiety in children and potentially sustaining gains made in therapy (Abed et al., 2023; Butterfield et al., 2021; Creveling-Benefield & Varela, 2019; Lunetti et al., 2021; Rakhshani et al.

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2022; Roman et al., 2016; Sahithya & Raman, 2021). Bram (2021), Diamond et al. (2000), Fox (2012) and Kazdin and Whitley (2006) underscored that the parent-psychologist alliance helps foster an authoritative parenting style.

In my study, parents grappled with finding a sense of balance in their parenting approach, often questioning whether they were being too permissive or too authoritarian (i.e., strict). Through the discursive style of the regular HTFWP-drawing elicitation conversations, they had the opportunity to achieve a balance between warmth and appropriate control. Parents who recognised tendencies towards being overly strict, adjusted their approach, becoming warmer and less overbearing, thus allowing their children's autonomy and self-efficacy to develop. This adjustment not only fostered a healthier parent-child bond but also ensured that children's individual needs were met through their parent's parenting style. These findings resonate with previous findings on the benefits of the parent-psychologist alliance in promoting authoritative parenting and improving the parent-child relationship (Bram, 2021; Diamond et al., 2000; Fox, 2012; Kazdin et al., 2005). The distinction lies in the fact that these aforementioned studies did not include the use of drawings to achieve these outcomes.

6.2.1.2.2 Feeling understood and connected

When exploring the benefits of sharing the child's drawings during regular HTFWP-drawing elicitation conversations I found that it helped the child feel better understood by, and connected to, their parents (see Chapter 5 Section 5.2.3.2). The child's experience of feeling understood aligns with previous studies emphasizing the significance of supportive relationships, particularly for children, as a critical protective resource in fostering resilience against anxiety (Bailey et al., 2020; Clayborne et al., 2021; Luthar, 2006; Masten, 2014; Vigdal & Brønnick, 2022; Yoon

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et al., 2021). The value of the child feeling supported by the parent aligns with the broader literature on the importance of secure attachment and emotional connection in promoting positive child development (Abed et al., 2023; Bailey et al., 2020; Gouze et al., 2021). However, these studies on the value of supportive relationships for children did not use drawings as a means of achieving this goal.

Diamond et al. (2000), states that enhanced empathy in parents due to involvement in their child's therapy process, enables parents to support their children emotionally. While Freeze et al. (2014), asserts that a supportive, nurturing environment correlates with lower levels of anxiety in children. When the parents in my study engaged with their children's drawings during HTFWP-drawing elicitation conversations, they experienced heightened levels of empathy for the challenges faced by their children. An enhanced nurturing environment for their children was also observed in their responses during the HTFWP-drawing elicitation conversations. However, neither of the aforementioned studies used drawings to achieve the outcomes of enhanced empathy and a nurturing environment.

Aligning with the seminal work of Fonagy et al. (1991) on reflective functioning, and the work of Borelli et al. (2015), Camoirano (2017) and Stevenson-Hinde et al. (2013), on the empathic attunement of parents, the development of reflective functioning in parents has a positive influence on the development of parental empathic attunement for their child's emotional challenges (see Chapter 3, Section 3.2.4.1.3). This psychological growth in parents allows them to better understand the emotions and anxious behaviours of their children. Various studies also support the notion that the fostering of reflective functioning in parents is dependent on parents continuously engaging in attempting to understand their own and their child's emotions, behaviours and intentions (Arabadzhiev & Paunova,

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2024; Camoirano, 2017; Tollenaar & Overgaauw, 2020). As the parents in my study experienced continuous engagement (three HTFWP-drawing elicitation conversations) of trying to understand their child's anxiety and their role in allowing this anxiety to flourish, their reflective functioning potentially developed. At times, the parents in my study showed their vulnerabilities when speaking about their perceived inadequacies in parenting their child with anxiety. Although this engagement is difficult, sensitive and emotional, the drawing-facilitated safe space enabled them to express themselves and practise regulating their own emotions concurring with the ideas of Luyten et al. (2020). Being more aware of and in better control of their own emotions allowed them to better relate to the emotions, behaviours and intentions of their children (Arabadzhiev & Paunova, 2024; Camoirano, 2017; Slade, 2005). The discursive environment of the HTFWP-drawing elicitation sessions and the resultant parent-psychologist alliance therefore provided the vehicle towards warmer, more empathetic parenting. The literature cited regarding mentalizing or reflective functioning did not make use of drawings to facilitate this type of parenting.

6.2.1.3 Benefits for the Psychologist

6.2.1.3.1 Bolstered My Connection with the Child

Through the discursive environment nurtured with parents during the regular HTFWP-drawing elicitation conversations, I got a deeper understanding of their child's background and family situation. It enhanced my understanding of the child's experiences with anxiety. In addition, after each session in which the child completed their HTFWP drawing, I would ask for an explanation of their drawing as well as their permission to share the drawing and explanation with their parents. This practice helped the child understand that their parents and I were collaborating as a team to support them and that they also had a role in this team. The child's sense of inclusion within a supportive team, which included their parents and me, fostered an

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environment of openness that contributed to progress in therapy. Seeing the child actively participating in the collaborative process and them feeling empowered to share their thoughts and feelings validated the efficacy of my therapeutic framework. My deepened relationship with the child reaffirmed the importance of fostering trust and collaboration in therapeutic practice and aligned with authors emphasizing the importance of a robust therapeutic working alliance to further the positive outcomes of therapy (Bordin, 1979; 1994; Chandler, 2018; Grosberg, 2019; Halfon, 2021; Johnson & Wright, 2002; Zilcha-Mano, 2017). However, none of the literature regarding therapeutic working alliance suggests sharing a child-client's drawings, following the child's permission and with their knowledge, with parents in order to achieve this connection.

6.3 Sharing the Drawing Series Fostered Insight

6.3.1 Parental Insight into the Child's Anxiety

My finding that the series of child-client generated HTFWP drawings is an effective therapeutic tool for communication with parents aligns with previous reports on the efficacy of drawings as a therapeutic tool (Broecher, 2012; Molinari, 2013; Rand, 2020). These aforementioned studies have shown that children's drawings effectively convey the child's experiences and concerns to their parents. However, none of the aforementioned studies use a series of the child-client's drawings to communicate with parents, nor do they use the HTFWP drawing to achieve this outcome.

One of my findings when using HTFWP-drawing elicitation conversations, is that parents developed a deeper and more nuanced understanding of their child's anxiety. At times, parents also gained insights into their child's anxiety experiences, which they were previously unaware of. For example, one child was seen by her parents as so self-assured and they were surprised by the vulnerability expressed in

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her drawings. Another parent was unaware of her son's longing for his parents to reunite after their divorce, which happened when he was two years old.

This finding of new and/or heightened insight underscores previous reports on the benefits of sharing children's drawings with parents. Several researchers illustrate how sharing children's drawings contributed to parental insight into the thoughts and emotions of their children (Allan, 1988; Amod et al., 2013; Baghdadi et al., 2020; Broecher, 2012; Çetin & Güneş, 2021; Goodman et al., 2022; Kissos et al., 2020; Maloney, 1981; Molinari, 2013). However, none of the aforementioned studies used a series of HTFWP drawings.

According to the literature (albeit limited) on the HTFWP drawing, the drawings represent the child's psyche (which might not always be readily apparent to others, including parents), encompassing conscious and unconscious themes, conflicts, and psychodynamics – all of which are sensitive to the dynamics of the developmental phase of childhood and their environment (Groschwitz, 2016; Kreuter-Hafer et al, 2016; Wienand, 2016; 2020). Sharing the drawings with parents allowed them to gain insights into their child's inner world, fostering a deeper understanding of their emotions, thoughts and experiences. Their ongoing engagement with the drawings, as they were presented with a series of their child's HTFWP drawings, enabled parents to recognise patterns, changes and emerging themes. The sharing of the series of drawings promoted a more nuanced understanding and informed their responses to their child's needs and challenges.

6.3.2 Psychologist Insight into Progress in Therapy

By tracking progress over time, clinicians can better understand the child's development in their therapeutic journey (Bain et al., 2013). For instance, it potentially helps the psychologist understand if progress has been made in resolving

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conflicts and/or developing coping strategies. Being able to track the child-clients progress over time therefore allows clinicians to make informed decisions about the effectiveness of the treatment they are providing (Amod, 2013; Çetin & Güneş, 2021; Girish et al., 2023). It also helps the clinician identify areas that need further attention and make informed decisions about treatment plans (Bisagni, 2022; Jue & Ha, 2019) and can support a recommendation for continued therapy (see Section 5.2.2.3).

I found that the series of HTFWP drawings created by the child, facilitated my (i.e., the psychologist's) understanding of the child's therapy progress (or lack thereof). The child client's first HTFWP drawing often portrayed a struggle, which was resolved over the course of the series of HTFWP drawings, implying that the child was able to overcome their struggle. Often, over the course of therapy, elements in the child-participant's drawings transitioned from a sense of seeming uncontrollable and destructive (e.g., the overwhelming, destructive fire in Tessa's first drawing (see Section 5.1.1.1)) to a sense of seeming contained and more in control (e.g., the warmth of the sun representing fire in Tessa's final drawing (see Section 5.1.1.1). There was sometimes a shift from a sense of helplessness and feeling limited in the ability to act, to a sense of self-confidence, empowerment, and self-sufficiency. With some child-clients, the drawings reflected a change from loneliness to feeling less lonely and more supported, and from perfectionism to being less self-critical. This benefit of the HTFWP drawing series providing a visual representation of therapeutic progress aligns with the literature on the use of drawings for mental health professionals (Girish et al., 2023; Lev-Wiesel et al., 2021; Pivnick, 2023; Rashid et al., 2020; Sheikh et al., 2019; Søndergaard & Reventlow, 2019; Truneckova, 2021; Willer et al., 2018). These researchers highlighted the

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capacity of children's drawings to capture changes in both the structural aspects (visual elements) and conceptual depth (symbolism representing the child's emotions) of the drawings. This makes drawings a valuable tool for monitoring changes in children's perceptions and experiences over time, thereby aiding psychologists in assessing therapeutic progress. Çetin and Güneş, (2021) asserted that drawings allowed psychologists insight into the child's inner world so that they can provide the necessary intervention. However, none of the aforementioned studies on the usefulness of drawings for psychologists used the HTFWP drawing. Using the experience of my research, I believe that the distinguishing elements of the HTFWP drawing differentiate its use from other projective drawings like the Goodenough Draw-a-Person which is referred to by Springer et al. (2020), These elements include the specific elements and symbolism of the house, tree, fire, water, and person, as well as observations regarding how the child draws these elements, their placement on the page, and the child's use of colour (Wienand, 2016). Additionally, the child's verbal explanation of their HTFWP drawing provides valuable context aligning with reports emphasizing the usefulness of the child's accompanying narrative (Amod et al., 2013; Bisagnie, 2022; Çetin & Güneş, 2021; Or & Shalev, 2022). This differentiation of the HTFWP drawing enhanced my ability to glean therapy progress cues.

6.4 Conclusion

In this chapter, I have explored two key benefits of sharing the series of the child-client's HTFWP drawings during HTFWP-drawing elicitation conversations within the context of psychotherapy for GAD. Firstly, I have demonstrated how this practice of sharing the child-client's HTFWP drawing series with parents contributes to the creation of a robust parent-psychologist alliance (with spill-over benefits for

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parents, the child in therapy and the treating psychologist). Secondly, I showed how these child-client HTFWP drawing series served as catalysts for insight – offering parents invaluable glimpses into their child's anxiety and serving as tangible cues of progress in therapy for me as treating psychologist. By situating my findings in the literature, I demonstrated that my study not only confirms the importance of the parent-psychologist alliance but also the usefulness of drawings in the child's therapy process. Aligning with Merriam and Tisdell's (2016) assertion that the advancement of the knowledge base is a fundamental goal of scholarly inquiry, I have shown that my study also makes a contribution to the means of creating a parent-psychologist alliance with emphasis on the particular usefulness of sharing the series of the child's HTFWP drawing as a means to include parents in their child's sandplay therapy process.

Approaching the next chapter of my research report, I acknowledge the potential impact of my findings on both academic discourse and practical applications within child psychotherapy. Creswell and Creswell (2023) stress the importance of translating research into actionable practice recommendations, while Merriam and Grenier (2019) highlight the need to bridge theory and practice. In Chapter 7, I aim to address these goals by exploring the real-world implications of my study and its potential to inform both theoretical frameworks and practical approaches in child psychotherapy.

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Chapter 7

Recommendations for Sharing the HTFWP Drawing Series

7.1 Introduction

In Chapter 5 I delineated my findings in response to my primary research question. This primary research question asked how sharing the series of the child-client's HTFWP drawings in parent feedback sessions benefitted the therapeutic process, if at all, when a child is in psychotherapy for GAD. However, my study was also based on a secondary question that relied on the outcomes of my primary question. In the event that I identified benefits, this secondary question asked what guidelines psychologists can follow to effectively incorporate the child-client's HTFWP drawing series into parent feedback sessions to optimize the therapeutic process for children undergoing psychotherapy for GAD. As my findings showed there were benefits to sharing the child-client's HTFWP drawing series with parents, my secondary question can now be answered. Delineating the guidelines that psychologists can follow is therefore my purpose for this chapter. I start by explaining the mechanics of using the HTFWP drawing as a way of providing guidelines of how I achieved my outcomes. These outcomes related to the benefit of using the HTFWP drawing series to foster a parent-psychologist alliance with its cascading effects, to bolster insight and to track therapy progress so that my study is useful for fellow psychologists working with children in similar settings.

7.2 The Mechanics of Using the HTFWP Drawing in Child Psychotherapy

7.2.1 Informed Assent and Consent

Ethically it was important that both the child and the parents understood what they were consenting to. It allowed for transparency regarding the process and goals of my study (Arifin, 2018; Billups, 2020; Price, 2015). This openness helped foster a

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sense of trust. Asking children for assent and their parents for consent indicated that I respected their autonomy and that I was committed to ethical practice, which strengthened their trust in me. Asking for consent and assent empowered the child and parent giving them a valued voice in my study. Being active instead of passive informants, boosted their confidence and helped foster their sense of self-worth.

Initially, before my study started, I sent prospective child and parent informants letters of consent and assent, which they each needed to sign to participate in my study (see Appendix E and F). However, after each drawing that the child did, I again verbally asked their permission to share their drawings with their parents. Psychologists, who would like to share the child's drawings with their parents, could use the following script to obtain assent of their child-clients. The script is as follows:

> Right at the beginning I asked you to sign a piece of paper giving me permission to share your drawings with your parents. You said yes then, but you are allowed to change your mind at any time and that is why I am asking you again. I will not be upset with you if you say no. Or you may have questions before you decide if it's okay for me to share your drawing with them. Next week (or whenever the meeting with parents will take place), I meet with your parents again and I would like to share your drawing with them so that your parents and I can have a conversation about your drawing, just like the chat you and I just had. Will you be okay with me showing them your drawing so that I can have that conversation with your parents?

7.2.2 Setting Up the Drawing Session

In preparation for the drawing of the HTFWP picture the child-client and I are seated at the drawing table. This table is covered with a blue plastic cloth as often

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children are concerned about messing, or colouring in onto the table. My plastic table cloth helps put children at ease. The tiled floor also helps if they drop any pencil shavings. Sometimes messing on the floor makes children nervous but I would just casually say, “Oh that happens sometimes, but luckily the floor is tiled so it is easy to clean”. My table is also big enough to give children enough personal space to work without feeling crowded in.

In addition the child-clients are given several blank sheets of A4-size paper. This adds to the child’s sense of ease as they can start again on a clean sheet if they wish to do so. I also always place the page in the landscape position as experience has taught me that this is the best way to complete the drawing especially when some children struggle to organise their space. There are also several options in terms of pencils, eraser, pencil crayons and retractable wax crayons indicating that they can use any and everything (see

Figure 35). Just before children start drawing I let them know that there is ample time to complete so that there is no time pressure.

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Figure 35

Stationery for each drawing



7.2.3 Drawing Instructions to the Child

When the child has settled at the drawing table, my instruction to the child, aligning with several authors regarding the HTFWP drawing, is that I would like them to do a drawing that has five elements in it: a house, tree, fire, water and a person

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(Groschwitz, 2016; Kreuter-Hafer et al., 2016; Lutz, 2007; Wienand, 2016, 2020). As I give this instruction I write the first letter of each element in big capitals on a blank piece of paper so that the child also sees what is required. Using both verbal instructions and written cues reinforces the instructions and gives the child a visual reminder of what is required while they are drawing. My experience as an Educational Psychologist has also shown me that children take in information differently. Some children are able to retain auditory information well while others retain visual information better. According to Pellicer-Sánchez et al. (2020), presenting verbal with visual elements simultaneously enhances understanding and improves retention of information with children. By providing both, I helped the child feel comfortable and capable, thereby enhancing their interest and engagement. Giving verbal instructions and visual cues also helped to break the task down into smaller steps. It provided the child with a checklist. However, the child could start with any element first.

I also explained to the child that how well they draw is not important as I am really interested in the story their drawing is telling me, so their best drawing will always be good enough. While this is my standard approach as a practitioner, this is also a typical part of the instruction when researchers use drawings as a methodology (Angell et al., 2015; Mitchell et al., 2011). This concept of the child's narrative revealing more about the child's inner world is highlighted by authors who noted their experiences in using the HTFWP drawing (Groschwitz, 2016; Kreuter-Hafer et al., 2016; Lutz, 2007; Wienand, 2016, 2020).

Some children may seem confused by the concept of a drawing being able to tell a story. That is when we would look around my therapy room at the paintings on

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the wall and I use these to illustrate what I mean. These paintings were done by a professional artist (Portchie, see

Figure 36), by my daughter at the age of six (see

Figure 37), and by myself (see Figure 38). To use the painting by Portchie (see

Figure 36) as an example, I would say something like: “I imagine that this person was asked to draw children, a house, trees and a windmill and maybe their story would be that the children lived on a farm and were happily playing hopscotch in the front garden. Some of them may be brothers and sisters. Or do you think they are friends?” I have found that the different levels of artistic skill are also important for children to see as it helps them understand that I do not have expectations with regard to their level of expertise.

Figure 36

Painting done by Portchie

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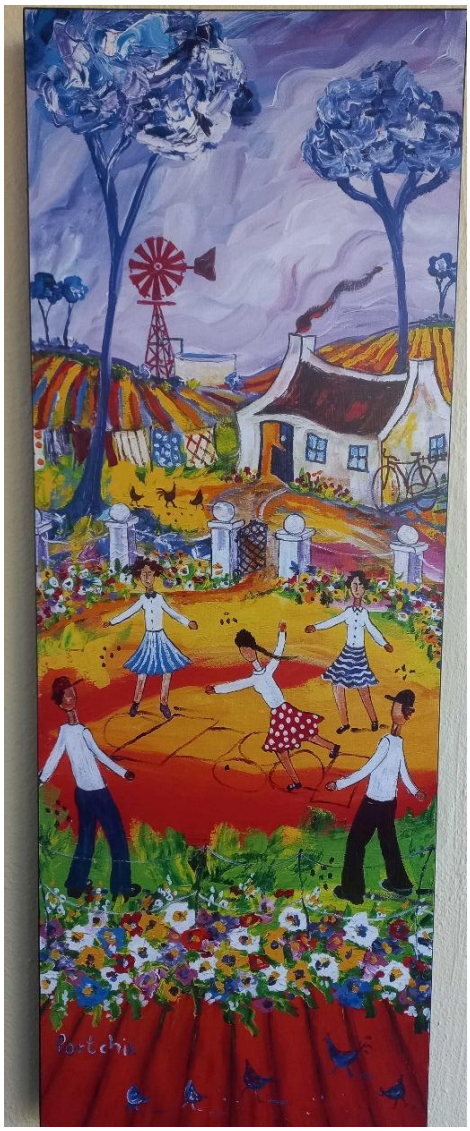


Figure 37

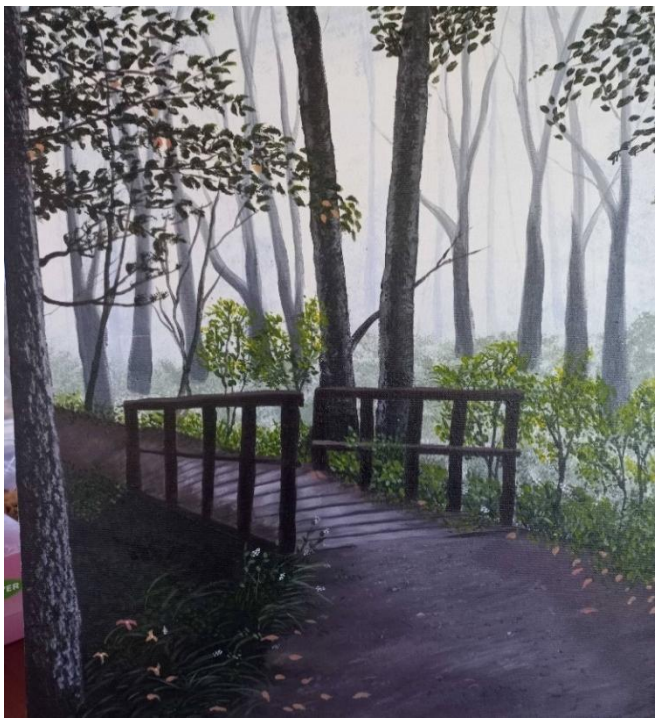
Painting done by my daughter at the age of six

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Figure 38

Painting done by me



7.2.4 Observation and Interaction

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On receiving instructions, children would often ask if they can draw a stick man or if they have to colour in. At this point I would tell them that the choice was theirs, but that I would like them to do the best drawing they can. I would also have a notepad ready to jot down any observations regarding the manner in which they tackle the task of drawing. I would tell the child that what they are doing is important and sometimes I would write things down to help me remember how they did the drawing. I would then jot down my observations of pencil pressure, colouring in style, drawing style and erasures. For example, when doing his drawing, Clint's person (see

Figure 16) was half the size before he redrew him. This initial tiny figure and the erasure raised questions for me regarding Clint's self-esteem.

7.2.5 Child's Story of Their Drawing

When the child finishes the drawing, I would often make some type of affirming comment like; "Wow! You really worked hard at that", or, "you were concentrating so well when you did that drawing," making sure not to comment on the quality of the drawing. I would follow this up with, "I am so interested to hear the story that goes with your drawing. Can you tell me what's happening in this drawing?"

I would then write down the child's story in my observation notes, asking clarifying questions to make sure that I have understood them well.

7.2.6 Preparing for Meeting with Parents

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When preparing for the first HTFWP-drawing elicitation conversation with parents, part of my preparation was to look at the child's drawings to have a sense of how I understood them. This meaning making for myself was not shared as a formal analysis during the meeting with the parents, but rather kept in mind during our discussion (see Section 6.2.1.1). To explain this, I use the examples of Michael's drawing and Kurt's sandplay; I explain how I made meaning for myself them and then comment on how I kept these understandings in mind.

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7.2.6.1 Making meaning of Michael's drawing

Michael drew a house that was on fire (see Figure 39). Michael's explanation of his drawing was that the roof was on fire and the fire was coming out of the windows. One of the windows had broken as a result of the heat. The tree had also caught alight. The person was standing just outside the house crying for help because coming towards him and the house was a tsunami. When using the interpretations of the different symbols as offered by, Groschwitz, (2016), Kreuter-Hafer et al., (2016), Lutz, (2007), and Wienand, (2016, 2020) I first considered the symbolism of the house. According to these authors the house could symbolise the body and self with the roof representing intellect (Lutz, 2007). The house could also represent home and security with experiences of safety, comfort and stability (Kreuter-Hafer et al., 2016; Wienand, 2016; 2020). The house is reminiscent of the maternal womb (Kreuter-Hafer et al., 2016). It represents emotional stability and is a complex interplay of emotional needs and personal experiences (Kreuter-Hafer et al., 2016; Wienand, 2016; 2020). The flames in Michael's drawing could represent strong emotions of anger and/or anxiety. Michael's burning house did not seem to represent emotional stability. It gave the appearance of emotions that are not contained and that were destructive. Michael's drawing of the house did not depict a safe place. The house in its current representation reflects Michael's inner world as well as his relationship with the external world, which was tumultuous. It made me wonder about the stability in his home and also in himself.

The symbolism of the tree is also multifaceted. The trunk of the tree often represents the male principle while the nurturing, protective crown of the tree is considered to symbolize the feminine, creative principle (Kreuter-Hafer et al., 2016; Lutz, 2007). In addition, the strength of the trunk of the tree reflects resilience in the

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face of threat with the capacity to weather storms and provide shelter and nourishment (Kreuter-Hafer et al., 2016). Michael's tree trunk had grown tall in comparison to the house, but it was thin and rigid and the crown was small in comparison to the trunk. The crown was also on fire. It made me wonder about Michael's ability to weather storms at this time in his life. I also wondered about the small crown – its ability to provide protection and shelter and its ability to nurture him.

Figure 39

Michael's first drawing



The symbolism of the person in the drawing reflects the child's self-image and emotional state (Kreuter-Hafer et al., 2016). The posture of the person in the drawing, the way it is depicted, proportion of body parts, the facial expression and the way the person relates to the other elements in the drawing, all depict the child's inner world and relationships with others (Groschwitz, 2016; Kreuter-Hafer et al., 2016, Lutz, 2007; Wienand, 2016, 2020). These elements of the person in the

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drawing could depict self-sufficiency, helplessness and an inability to act (Groschwitz, 2016; Wienand, 2016). It provides insights into self-esteem, self-confidence, autonomy development, identity formation and, balanced or damaged self-perception (Wienand, 2016, 2020). Proximity to the house may indicate potential separation anxiety and feelings of alienation (Groschwitz, 2016; Wienand, 2020).

One of the first things I noticed about Michael's person was the sense of helplessness, which he made very clear by adding his speech bubble. His person also has a big head and short plump arms, giving me the association with that of a baby and possibly a sense of Michael's limited autonomy development. The use of colour is also symbolic as the choice of colour, intensity and combination in the drawing can reflect the child's mood and coping mechanisms (Kreuter-Hafer et al., 2016). When comparing the colour in Michael's drawing to Tessa's (see Figure 19) and the lack of colour in Kurt's (see Figure 21) drawing, I get a sense of the mood of each child. As Kurt mentioned, a drawing with no colour conveys a feeling of sadness as opposed to the intensity in Tessa's drawings whom I experienced as a passionate, expressive child.

7.2.6.2 Keeping my meaning-making in mind

There was a lot of symbolism to keep in mind as I entered the HTFWP-drawing elicitation conversations with the parents. However, as it was important to create a non-judgemental, safe, discursive space, it was important that I bracketed these 'insights'. Bracketing, a standard procedure in phenomenology, refers to the researcher setting aside assumptions and preconceptions to instead allow a stance of openness and receptivity in order to explore the lived experience of research informants (Thomas & Sohn, 2023). One way I did this was realising that my 'insights' were not conclusions, they were merely possibilities. I also remembered the

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saying taught to me by one of my lecturers. The saying is: “een veer maak nie ‘n voël nie” (the English equivalent is “one swallow does not make a summer”), which to me meant that I could not make judgements based on one drawing or one sandplay scene. In addition, one of the principles of sandplay therapy is delayed interpretation by the clinician in order to allow for spontaneous, non-directed exploration by the child (Zappacosta, 2012). Delayed interpretation is also important as it takes time to make connections between different sandplay scenes in the sequence created by the child (Ammann, 2020).

In addition, my experience as an educator taught me that children bring several stories about their parents. I listened to, and empathised with these stories, but did not necessarily act on them (unless the child was in danger of being hurt), as it was often a child just needing to vent, trying to process different incidents in their lives or create a connection with me. Similarly, the child’s HTFWP drawing and sandplay scene was an important perspective that had a significant effect on the child and was important for parents to eventually see, but it was not necessarily the entire picture. I would therefore say to parents that the drawing was their child’s perspective, which they may think was not true, but it was true for their child and what we had to work with. In addition, I would keep Bettelheim’s (1987) concept of the good-enough parent in mind, which he derived from Winnicott’s (1965) concept of the good-enough mother. The good-enough parent is one who realises that the inevitable mistakes made by parents need to be outweighed by the positive, nurturing, loving environment they provide. Therefore, another way I bracketed my insights from the drawing and sandplay scenes was to acknowledge this belief.

The parents in my study also voluntarily brought their child and my belief was that parents did this because they wanted things to be better. My role was therefore

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to support this idea, which could not be done with a judgemental stance but rather through establishing a supportive environment.

7.2.7 Setting the Tone

Establishing a supportive and open environment for every meeting with the parents, whether it was for the semi-structured interviews or for the HTFWP-drawing elicitation conversations, started with a warm greeting, exhibiting a genuine interest in the parents and their child. I also ensured that I was fully present by making sure that everything we needed for the meeting (e.g., the drawing, my video camera and dictaphone – specifically needed for my study) was set out before the parents arrived. This preparation allowed me to be attentive and mindful of their emotions during the meeting.

In addition, sitting in a quiet space where there were no interruptions was one way I created a safe space. I realised that the seating arrangements were also important. Typically, when I meet with parents I would sit diagonally across from the couch where parents would sit (see Figure 4). I felt that this was important during intake interviews when parents are explaining their concerns and family dynamics. As this meeting (intake interviews) is typically the first time I would meet the parents in person, this seating arrangement allows a sense of separation and distance that makes it easier for parents to share sensitive information. It is also a conducive setting for feedback meetings, after an assessment, as it helps maintain a professional boundary while discussing the findings of an assessment. However, in the semi-structured interviews and HTFWP-drawing elicitation conversations, I did not want parents to feel separate or to have a power dynamic introduced in our relationship. We therefore sat around a table to create a sense of equality and collaboration. This seating arrangement helped to minimise physical barriers

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between myself and the parents and introduced an equal partnership in the discussion of the child's anxiety.

Another way in which I created a supportive environment for parents was to manage their expectations. I did this by explaining the process of the session and how long it would take. I also ensured parents again that our discussion was confidential and that any use of our transcription would be done anonymously.

In addition, using the standard techniques for building rapport, my tone of voice, language usage and active listening were important (de Greef et al., 2017; Kottler, 2016). I used active listening, which included not interrupting parents when they were speaking or using probing questions to try to understand what they were saying (Billups, 2020), to demonstrate that I valued the parents' input and perspective. My tone of voice was important to help parents feel respected and validated. My tone was therefore often empathetic and I tried to keep my language free from jargon and my communication as clear as possible.

Expressive ways of speaking or prosodic vocalization, which helped me emphasise the emotional intent of my message, were important throughout my interactions with the children and their parents. Sometimes my emotional intent was to convey excitement, while at other times comfort and reassurance. This idea of the use of prosodic vocalization was emphasised by Porges (2022, 2023) who stated that the tone of one's voice can influence the physiological state of the other in social interactions – promoting feelings of safety, connection and fostering well-being. Often in my interaction with the child and parent informants, prosodic vocalization helped with the co-regulation of their emotions.

7.2.8 Presentation of Drawings

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Parents require sensitivity when they are presented with their children's HTFWP drawing series as the purpose is not to reinforce any possible feelings of guilt or failure they may have about their parenting. Before presenting their child's drawing, I would first give them the following instruction:

> "I am about to show you a drawing done by your child that they have given permission for me to share with you. I am showing you this drawing so that we can better understand your child's challenges and gain a glimpse of the way they view life. It may be your natural response to focus on what you see rather than how it makes you feel, but the first thing I would be interested in are the feelings the drawing evokes and then what the various aspects of the drawing make you think of with regard to your child, your family, or yourself. You could start with your immediate emotional reaction to the drawing."

This instruction helps provide some sense of structure to the processing of information starting from emotion. It aligns with the ideas of Siegel (2004, 2006) and Siegel and Hartzell (2013, 2023) who stated that parents who are aware of their own emotions are more likely to respond to their children in an empathetic, sensitive manner.

As, at this point, I have already considered their child's perspective through their drawings and the narratives of their drawings, I have a sense if exposure to this drawing is going to be shocking for parents. In those cases, I would say something like, "it is amazing how well children can show us how they feel through their drawings, but it can sometimes be hard to bear. But we can now do something to change things". In this way I acknowledge and empathise with the feelings of the parents and the child as well as validate that the drawing can reflect their child's

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inner world. I also offer a sense of hope, so parents start shifting their thinking in the direction of how to make things better.

When parents spoke about positive change in their children, I would often respond with an exclamation, acknowledging their feelings related to the event and question them about how they managed to make that change. My response would therefore be something like; “Wow! That must make you feel so good. How did you manage to do that?” Or “What did you do differently so that you were able to get that change?” The reason I respond in this manner is to make the positive moments bigger, to help parents see that the changes they are making are having a positive effect and to raise their awareness of their agency in the change. This helps parents feel supported and empowered, further enhancing their parenting skills.

7.3 Step-By-Step Recommendations for Fellow Psychologists

The above explanations of the mechanics of sharing the child-client’s HTFWP drawing series with their parents illustrates the professional skills and resources (e.g., stationery, furniture, quiet space) that are implicit in achieving benefits when sharing the child-clients HTFWP drawing series with their parents. As detailed in Chapter 5, these benefits included fostering the parent-psychologist alliance, enhancing parenting skills, helping parents feel supported, helping to improve affect regulation in parents, fostering self-compassion, fostering authoritative parenting, helping children feel supported and connected, facilitating the enhancement of the parent’s insight into their child’s anxiety and tracking therapeutic progress. However, literature on the parent-psychologist alliance does not explicate a step-by-step approach for health practitioners on how to actualise this important part of child psychotherapy. My secondary research question stated the following: What pointers can psychologists follow to effectively incorporate the child-client’s HTFWP drawing

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series into parent feedback sessions to optimize the therapeutic process for children undergoing psychotherapy for GAD? As the findings of my study and the answer to my primary research question showed benefits to sharing the child-client's HTFWP drawing series with their parents I am now able to provide my fellow mental health practitioners step-by-step recommendations for creating the series of drawings and using them to derive benefits to the therapeutic process. These recommendations are detailed below. A print-friendly version is attached as Appendix M.

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Recommendations for Creating the Series of HTFWP Drawings and Sharing Them with Parents



SETTING THE SCENE





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Obtain informed consent and assent at the beginning and assent after each drawing. Essentially the assent has to be in child friendly language. For example:

> Right at the beginning I asked you to sign a piece of paper giving me permission to share your drawings with your parents. You said yes then, but you are allowed to change your mind at any time and that is why I am asking you again. I will not be upset with you if you say no. Or you may have questions before you decide if it's okay for me to share your drawing with them. Next week (or whenever the meeting with parents will take place), I meet with your parents again and I would like to share your drawing with them so that your parents and I can have a conversation about your drawing, just like the chat you and I just had. Will you be okay with me showing them your drawing so that I can have that conversation with your parents?



Provide several sheets of blank white A4 paper and a variety of coloured pencils, an HB pencil, sharpener and eraser.



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Pre-empt pitfalls that can lead to a child feeling anxious when considering the setting for the drawing. For example:

- Use a table that is big enough for the stationery while still allowing for enough space for the drawing activity
- Use a plastic table cloth to allow for easy cleaning
- Put the child's mind at peace if there is a spill by saying something like, "Oh that happens sometimes, but luckily the floor is tiled so it is easy to clean."
- Enough sheets of paper in case the child makes what they consider a mistake.

THE HTFWP DRAWING





Drawing Instruction

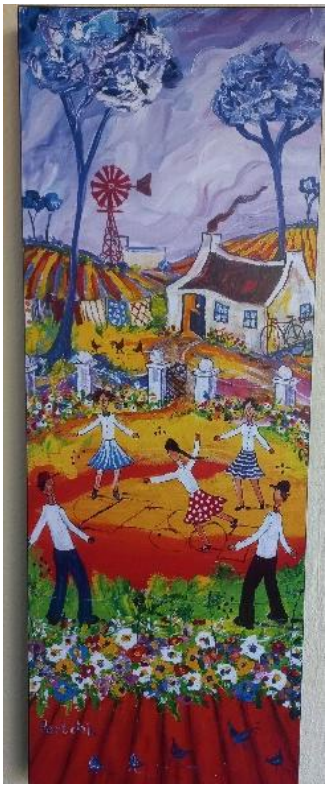
I would like you to draw a picture of a house, tree, fire, water and person. You can do it in any order. It is not about how well you draw, but more about the story your drawing is telling me.

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Have other artworks in your room to help you illustrate the drawing instructions.

E.g. drawings by an established artist like Portchie that tells a story, and drawings by a child.





WHAT DO YOU DO?

Observe the child when drawing, writing down your observations. Explain to the child why you are writing by saying something like:

What you are doing is important and sometimes I need to write things down to help me remember how you did the drawing.





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After the child completes their drawing, say something affirming like; “Wow! You really worked hard at that” or “you were concentrating so well when you did that drawing,” making sure not to comment on the quality of the drawing.

Ask the child for their story/explanation of their drawing after they have completed their drawing.
Remind the child that their story is important.

Follow-up open-ended questions	
1	How has the way you have drawn the house/tree/fire/water/person helped you tell that story?
2	Can you tell me more about the characters/objects in your drawing?
3	What emotions/feelings do you think the drawing represents?
4	Are there any specific details in the drawing that stand out to you? What about that detail makes it stand out?
5	How does the drawing relate to your experiences/thoughts about anxiety?
6	In which way have the colours you used helped convey that story?

Try to understand the child’s perspective in their drawing, sandplay scenes and drawing narratives before meeting with their parents; then bracket your understanding (i.e., put aside your preconceptions).



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THE HTFWP-DRAWING ELICITATION CONVERSATIONS





Make parents feel welcome in your therapy space – being careful with regard to seating and creating rapport.

Instructions before showing parents the drawing:

I am about to show you a drawing done by your child that they have given permission for me to share with you. I am showing you this drawing so that we can better understand your child's challenges and gain a glimpse of the way they view life. It may be your natural response to focus on what you see rather than how it makes you feel, but the first thing I would be interested in are the feelings the drawing evokes and then what the various aspects of the drawing make you think of with regard to your child, your family, or yourself. You could start with your immediate emotional reaction to the drawing.

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If the child's drawing is particularly upsetting say something like:

"it is amazing how well children can show us how they feel through their drawings, but it can sometimes be hard to bear. But we can now do something to change things".



Follow-up open-ended questions	
1	What emotions or feelings arise for you as you look at this drawing?
2	What thoughts or associations come to mind when you look at the different elements of the drawing?
3	How do you understand the use of colours and symbols in the drawing?
4	What aspect of the drawing resonates with your child's experiences, your family dynamics or your own reflections?
5	Are there any particular details or patterns in the drawing that stand out to you? If so, what do you think they might represent?
6	Which part of this drawing tells you about your child's anxiety?
7	Which part of the drawing speaks about your child's autonomy/self-sufficiency or dependency?
8	Just looking at the elements of the drawing, which parts do you wish were different?
9	Which aspects speak about resources and resilience in your child?
10	What gives you a sense of hope?

Respond to parents' comments about positive changes at home with emotionally charged language. E.g., "Wow! That must make you feel so good. How did you manage to do that?" Or "What did you do differently so that you were able to get that change?"

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7.4 Conclusion

In Chapter 7 I detailed the mechanics of sharing the child-client's HTFWP drawing series with their parents during HTFWP-drawing elicitation conversations and added a step-by-step how to guide for other mental health practitioners to use. The purpose was to answer my secondary research question, providing fellow psychologists with a guide on how to achieve the beneficial outcomes I did when I shared this drawing series. I used excerpts from my cases to illustrate where this was possible. I ended this chapter with a step-by-step summary of my detailed explanations and a print-friendly version in Appendix M, which fellow psychologists can print if necessary and easily follow.

Given that my research questions are answered, I now move to conclude my study. To that end, Chapter 8 will provide an opportunity for me to reflect on my study, and provide suggestions for future research in this area of child psychotherapy. Drawing on Braun and Clarke's (2013) framework for reflexivity, I will critically reflect on the interpretations and assumptions underlying my study. This process of introspection aims to offer a comprehensive exploration of the implications of my research, potentially fostering further inquiry and innovation in the field of child psychotherapy.

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Chapter 8

My Reflections on My Study

8.1 Introduction

This final chapter concludes my study. To conclude I discuss the contributions I think my study has made. I follow this discussion to critically reflect on the methodological strengths and limitations of my study. This is followed by my suggestions for future research in the area of child psychotherapy based on the methodological limitations I identified, with the emphasis on creating a parent-psychologist alliance during the therapy process of the child through sharing the client's HTFWP drawing series with their parents via HTFWP-drawing elicitation conversations.

8.2 Study Contributions

The purpose of my study was to explore the benefits, if any, to the therapeutic process of sharing the child-client's series of HTFWP-drawings with their parent(s) during parent-feedback sessions when this child was in sandplay therapy for GAD. In the event that I determined that sharing the child-client created HTFWP drawing series was beneficial, I also aimed to identify and set out recommendations for psychologists regarding the effective integration of the child-client's HTFWP drawing series into parent feedback sessions to enhance the therapeutic process for children in sandplay therapy for GAD. As I reflect on my findings, I believe that my study has provided novel insight into the benefits of the HTFWP-drawings to the therapeutic process of children in sandplay therapy for GAD. This is a complex topic, which had not been investigated prior to my study. By identifying (Chapter 5) and interpreting (Chapter 6) the benefits I offered a theoretical understanding of HTFWP-drawings'

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potential to aid the therapeutic process and bolster child and parent resilience when children are in therapy for GAD. Essentially, I found that the practice of sharing the child-client's HTFWP drawing series with their parents encouraged a robust parent-psychologist alliance that supported positive spill-over benefits for parents, the child in therapy, and the treating psychologist, along with insights that were valuable to supporting authoritative parenting and tracking therapeutic progress. This theoretical understanding also scaffolded a set of pointers (see Chapter 7) that I believe can make a practical contriution to the praxis of mental health professionals working with children with GAD.

In addition, I think the above have value for the field of child psychotherapy. I will first discuss the theoretical contributions before looking at praxis.

8.2.1 Theoretical Insights that My Study Contributes

8.2.1.1 A systemic understanding of the parent-psychologist alliance

One of the benefits of sharing the child-client's series of HTFWP-drawings with their parent(s) during parent-feedback sessions was the creation of a parent-psychologist alliance. The multisystemic understanding of resilience (Masten, 2024; Masten et al., 2021; Masten & Cicchetti, 2016; Masten et al., 2023; Ungar, 2018, 2021; Ungar & Theron, 2020), social-ecological model of human development (Bronfenbrenner, 1979, 1992), and the supporting alliance model (Baweja et al., 2024; Correa, 2020; Ekornes, 2015; Feinstein et al., 2009; Franklin et al., 2012; Gasparro et al., 2023; Gatta et al., 2019; Marinucci et al., 2023; Müller & Donley, 2019; Rilveria, 2022; Wingerden et al., 2021), all consider the multiple influences on a child's development through the child's relationships with systems like parents, psychologists and families. My combined use of these theories as a framework contributed to a theoretical understanding of the parent-psychologist alliance that was attentitive to systemic influences. Prior research on an alliance between parent

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and psychologist emphasised the positive impact of such an alliance in terms of contributing to treatment success (Accurso & Garland, 2015; Bram, 2021; de Greef et al., 2017; Diamond et al., 2000; Fox, 2012; Gvion & Bar, 2014; Kazdin & Whitley, 2006; Kazdin et al., 2005, Kottler, 2016; Marker et al., 2013; Nevas & Farber, 2001; Núñez et al., 2022; Ruberman, 2009; Safran, et al., 2011; Shirk et al., 2011; Zemmelman, 2018; Zorzella, et al., 2017). However, understanding the value of this alliance through the combined lenses of multisystemic resilience, the social-ecological model of human development and the supporting alliance model, provided an understanding of the value of the systems to which the child is connected, and the relationships between these systems as being co-responsible for the child's positive development in therapy. In other words, my study extended the previous fairly narrow focus on the therapeutic alliance (between client and psychologist (Bordin, 1979, 1994; Bram, 2021)), to include an emphasis on the relationships between the various systems to which the child is connected. These relationships were therefore not only between the child and psychologist (therapeutic alliance), or between the child and the parent, but also between the parent and the child's psychologist. This insight encourages a systemic mindfulness when theorising the stakeholders that matter for the resilience of children challenged by GAD and when theorising the roleplayers in child psychotherapy. Likewise, it encourages mental health practitioners to use the HTFWP drawing series to facilitate a multiystemic of triadic (parent-child-psychologist) alliance.

8.2.1.2 Insight into the benefits of drawings when children with GAD are in therapy

The research on drawings as a diagnostic and therapeutic tool when children are in therapy has been mentioned in several contexts such as family group therapy, to express a child's fear of surgery and to advance a parent's insight into their child's

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inner emotions (Broecher, 2012; Maloney, 1981; Molinari, 2013). Despite my extensive search of the available literature, I could not find publications that explored the usefulness of drawings for the therapeutic process when a child is in therapy for GAD or theorised that usefulness. My study brought attention to the use of drawings in this therapeutic context, adding GAD-related insight to the broad theoretical understanding that drawings function as therapeutic tools. Similar to the aforementioned studies (Broecher, 2012; Maloney, 1981; Molinari, 2013), I also found that the drawings provided insight into the child's challenges although in my study these challenges related specifically to GAD. In addition, in my study, the child's drawing series enhanced the parent's insight into the influence they had on their child's GAD-specific challenges. As I used a series of drawings, and there were repeated sessions where a drawing was shared with the parents, it enabled the growth of their reflective function (Fonagy et al., 1991), which enabled a better understanding of their emotional influence on their child's anxiety and a better understanding of their child's anxiety. This in turn helped them regulate their own emotions and enhanced their empathy for themselves and their child (Arabadzhiev & Paunova, 2024; Arioli et al., 2021; Borelli et al., 2015; Camoirano, 2017; Luyten et al., 2020; Schwarzer et al., 2021, Slade, 2005; Tollenaar & Overgaauw, 2020). Parents felt empowered to act on this insight and their confidence in their parenting ability grew. They acted by positively adjusting their parenting, which I believe, helped their child feel better supported with their GAD challenges. Using drawings in the way that I did therefore provided me with a framework in which to understand the processes occurring within the therapeutic space with the child and the HTFWP-drawing elicitation conversations with the parent. Relatedly, it encourages a theoretical understanding of drawings as an important vehicle for children with GAD

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to express GAD-related challenges concretely enough for their parents to understand and empathise. Warm, empathic parenting is an important facilitator of child resilience (Masten et al., 2021), but to the best of my knowledge no previous study has theorised that children's drawings can be instrumental to such parenting.

8.2.1.3 New understanding of the use and interpretation of HTFWP drawings

My study extended the theoretical understanding of the HTFWP, which was initially developed for diagnostic purposes (Groschwitz, 2016; Kreuter-Hafer et al., 2016; Lutz, 2007; Wienand, 2016, 2020; Usländer & Reitz, 2015). Elements in the drawing, like the house, tree, fire, water, person, colour, line structure and placement were used by the psychologist to understand the child's emotional world when the drawing was first developed (Groschwitz, 2016; Kreuter-Hafer et al., 2016; Lutz, 2007; Usländer & Reitz, 2015; Wienand, 2016, 2020). In my study, the interpretation of the psychologist (i.e., me) was not prioritised in a top-down approach. Through my epistemological lens of Symbolic Interactionism (Ali et al., 2022; Creswell, 2007; Creswell & Creswell, 2023; Galin, 2023; Quist-Adade, 2019; Salvini, 2019; Segre, 2019; Totkova, 2019; van der Vaart et al., 2018; Wang et al., 2019; Willis Hepp et al., 2019), my study drew attention to the value of a discursive space and parents' exploratory meaning-making through their interpretation of the HTFWP drawing symbols (i.e., house, tree, fire, water and person) and visual cues like colour and line structure. In this way my study contributed to the theory of how to interpret the HTFWP drawing and advanced attention to the importance of using a discursive space to facilitate parent (and child) co-constructed meaning of HTFWP drawings.

In addition, this discursive approach encouraged the alliance between the parents and myself. Originally, the HTFWP drawing was used to understand unconscious themes like intrapsychic conflicts and psychic energy to understand the

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child's emotional state (Usländer & Reitz, 2015). The psychologist's understanding of these unconscious themes and the symbolic representation of the symbols in the drawing were necessary in order to achieve diagnosis. In my study, instead of being a diagnostic tool, the HTFWP drawing facilitated a discursive space that enabled the elicitation of emotion, reflective function in parents, parental insight, parental empowerment and enhanced empathy, and a positive adaptation of their parenting style. I intentionally did not use a top-down approach, which parents seemed to expect when they started the process. They seemed to be asking for guidelines for managing their child's anxiety. To avoid this top-down approach, even though I made meaning for myself of their child's drawing and sandplay process, I bracketed these preconceptions (Thomas & Sohn, 2023). I believe that grappling with their own understanding of their child's drawing enabled the empowerment of these parents. The guidance that they were seeking therefore came through their understanding of their child's drawing in the discursive space of my HTFWP-drawing elicitation conversations, which included their child's explanations of their drawings. In using the drawing as an elicitation tool, my study offers a premise for rethinking a psychologist-led interpretation of the HTFWP drawing, thereby providing novel insight into the value of a co-constructed interpretation of the HTFWP drawing.

8.2.2 Contributions to Praxis

8.2.2.1 A tool for including parents in the child's sandplay therapy

As part of exploring the potential benefits of the HTFWP drawing to the therapeutic process of the child who is in therapy for GAD, my study explored how to use the HTFWP drawing to include parents when a child is in sandplay therapy for GAD. Research on sandplay therapy for children has shown that parents can be included in various ways (Cao et al., 2019; Green & Connelly, 2009; Homeyer, 2015; Kaduson & Schaefer, 2006; Liu et al., 2023; Punnett, 2015; Rousseau et al., 2009).

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This inclusion related to a parent sharing the therapeutic space with the child. Parents either simultaneously built a sandplay scene alongside their child or in the same tray as their child, psychologists had sessions with the parent after completing the child' sandplay process or had focus group sessions with parents (Cao et al., 2019; Homeyer, 2015; Kaduson & Schaefer, 2006; Liu et al., 2023; Punnett, 2015; Rousseau et al., 2009). The ethical concerns raised in the studies where parents built sandplay scenes either alongside their child or in the same sandtray as their child, related to consent and confidentiality (Kaduson & Schaefer, 2006; Liu et al., 2023). My added concerns with including parents in this way related to the research on what facilitates anxiety (see Chapter 2, Section 2.3). One of the risks for anxiety for children was the mental health challenges experienced by their parents (Beesdo et al., 2009; Mohammadi et al., 2020; Troller-Renfree et al., 2019), and their parenting styles (Bailey et al., 2020; Baker et al., 2021; Bilsky & Friedman, 2022; Clemens et al., 2019; Doyle, 2022; Gouze et al., 2021; Harrison et al.; 2021; Howard et al., 2017; Mohammadi et al., 2020). My concern was the influence these factors may have on a child's therapeutic progress. While acknowledging the importance of including parents in a child's therapy process, I wanted to avoid the potential influence of these risks, which may exacerbate the child's anxiety in the therapeutic space. I was also concerned about the delay of including parents only after a child's sandplay process was complete as indicated in the studies of Cao et al. (2019), Homeyer (2015), Kaduson and Schaefer (2006), Liu et al. (2023), Punnett (2015) and Rousseau et al. (2009).

My particular use of the HTFWP drawing was based on its roots in Jungian psychology, one of the foundations of sandplay therapy. The use of the HTFWP drawing was in answer to my challenge as a sandplay therapist of how to include

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parents in a child's sandplay process without this inclusion feeling like an intrusion into the child's safe and protected therapeutic space (Chandler, 2018; Troller-Renfree et al., 2019), or without adding to the parent's sense of overwhelm. As the HTFWP-drawing and sandplay therapy shared the roots of Jungian psychology I believed that it would be apposite for this purpose of including parents. My research shows that the HTFWP drawing series is an effective tool for including parents when their child is in sandplay therapy. In addition, my study shows that when this drawing is used in a discursive space (like my HTFWP-drawing elicitation conversations), it enables parents to be part of their child's therapeutic process in a non-intrusive, yet supportive manner. In this way my study has broadened the original diagnostic use of the HTFWP-drawing, thereby giving psychologists and other mental health practitioners a tool they can employ to include parents in the therapy of their child.

To bolster this contribution, I offered step-by-step recommendations (outlined in the previous chapter; see Section 7.3). In my recommendations I explained how one introduces the drawing to the child and how to prepare the setting. In addition, I explained the significance of the narrative that each child provides for each of their drawings. I included possible open-ended questions and the importance of the psychologist observing the process of the drawing activity. I explained how the psychologist can make meaning of the child's drawings and how the discursive space created by sharing the child's drawing series empowers the parents and facilitates their insight into their child.

8.2.2.2 A drawing-centered approach to creating a parent-psychologist alliance

My study advances the understanding on how to create the alliance between the parent and psychologist when a child is in therapy for GAD. The literature on the parent-psychologist alliance emphasised its importance to contributing to positive

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therapeutic outcomes when a child is in therapy (De Greef et al., 2017; Diamond et al., 2000; Feinstein et al., 2009; Fox, 2012; Gvion & Bar, 2014; Kazdin & Whitley, 2006; Nevas & Farber, 2001; Ruberman, 2009; Zemmelman, 2018). While several of my findings aligned with the aforementioned literature on the benefits of a parent-psychologist alliance, this literature did not explain how one could achieve this alliance. My study showed that sharing the HTFWP-drawing series in a discursive space with parents helped create an alliance between myself and the parents thereby filling the gap in parent-psychologist alliance literature regarding the how-to of creating alliances, and potentially advancing the practice of psychologists and mental health professionals working with children. I created a set of recommendations that detailed the interaction between the psychologist and parent during the HTFWP-drawing elicitation conversations (see Section 4.7.1.3). In my study, the instructions given to parents before sharing the drawing with them and the list of open-ended questions the psychologist could ask the parent to elicit more meaning-making with regard to the drawing, stimulated this alliance between parent and psychologist. I am hopeful that these pointers will support other psychologists to build a strong alliance with the parents of children whom they are treating.

My study also brought attention to the frequency of contact sessions to foster a robust parent-psychologist alliance. This was previously not a focus in the research on the parent-psychologist alliance (de Greef et al., 2017; Diamond et al., 2000; Feinstein et al., 2009; Fox, 2012; Gvion & Bar, 2014; Kazdin & Whitley, 2006; Nevas & Farber, 2001; Ruberman, 2009; Zemmelman, 2018). Ruberman (2009) alluded to the frequency of feedback being dependant on factors in each individual case but did not elaborate on this. In my study, I met with parents on three separate occasions to discuss their child's HTFWP-drawing series. Initially, we met at the beginning of the

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process, a few days after the first session with their child; we then also met after every fourth session. Our repeated sessions helped foster their reflective function, thereby raising their self-awareness (Arabadzhiev & Paunova, 2024; Camoirano, 2017; Tollenaar & Overgaauw, 2020). This in turn likely allowed for better self-regulation of their emotions. As parents were able to understand their parenting role better in the context of their child's anxiety, their self-compassion grew. I observed that this growth in parents had a positive influence on their relationship with their child. They became more empathetic, their insight into their child's anxiety increased, they were more supportive and their style of parenting leaned more toward authoritative parenting. This allowed their child to feel better understood and supported by their parents. In other words, my study shows that more frequent feedback yields multiple positive dividends for the parent, the child, and the parent-psychologist alliance. In so doing, my study promotes the practice of more frequent feedback sessions with parents.

8.3 Reflexivity

Researcher reflexivity involved continuous self-examination to grasp my beliefs, biases, and perspectives (Braun & Clarke, 2013; Creswell & Creswell, 2023; Kalu & Bwayla, 2017; Levitt et al., 2018; Merriam & Tisdell, 2016; van der Vaart et al., 2018). I was purposefully reflexive as my beliefs, biases, and perspectives potentially impacted my research process, my interactions with informants, and data interpretation (Durdella, 2019; Swaminathan & Mulvihill, 2018). Reflexivity promoted the transparency of my study (Braun & Clarke, 2013). Reflecting critically on my research process enabled me to identify the strengths and weaknesses of the methodological choices and the assumptions I had made at the start of my study; these choices are outlined in the next section.

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8.3.1 Reflecting on Methodological Strengths of My Study

As pointed out in Chapters 1 and 4, I used a qualitative paradigm. This paradigm facilitated nuanced insights into the experiences of my primary and secondary informants as we interacted in the real-life setting of therapy. Therapeutic settings are typically complex to navigate, but this complexity is embraced by qualitative approaches that are adept at exploring complex phenomena that resist straightforward measurement (Creswell, 2007; Flick, 2010; Yanow, 2014). In addition, my use of a qualitative paradigm allowed for an exploration into the potential benefits of sharing the HTFWP-drawing series with parents, a complex topic, which had not yet been investigated. My use of a qualitative paradigm allowed for methodological strengths, such as flexibility within my research, the variety of data from which to glean the benefits of the HTFWP drawing series, the use of Nvivo to initially manage my data, and managing my influence on my data. I detail my reflections on each of these next.

8.3.1.1 A Qualitative Approach is Flexible

I acknowledge the value of the flexibility of qualitative research as I reflect on data gathering, analysis and my research design. This flexibility was particularly important when drawing up the interview protocols for my semi-structured interviews and deciding on questions for eliciting more information from my primary (parent) informants during the HTFWP-drawing elicitation conversations and the post drawing sessions with my secondary (child) informants as they told the stories about their drawings. Firstly, in initially drawing up the interview protocols, including the open-ended probing questions, the nature of qualitative enquiry enabled me to draw upon my experience and what I had learnt in the literature to develop my questions rather

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than using a standardised protocol (Lamba et al., 2022). This added to the unique nature of my study.

As I reflect on the semi structured interviews, HTFWP-drawing elicitation conversations with my primary informants and drawing sessions with my secondary informants, I believe that my open-ended questions as well as prompts gave the opportunity for greater, more in-depth detail and a better understanding of what my informants were trying to express. For example a question like: “What is your understanding of your child’s anxiety?” was followed by a prompt like: “What is the cause?” Another example of an open-ended question in relation to the drawing was: “What does the colour in your drawing say about your anxiety?” My research showed that using this open-questioning style and the flexibility of the qualitative research, enabled me to be responsive to the trend of my informant’s thought processes in the different conversations, and to select the leads I wanted to be responsive to as my conversation with my informants unfolded (Willig, 2021). I was therefore able to explore the thoughts and feelings of each informant. This resulted in a different type of conversation for each of them aided by the diverse range of perspectives, as I had multiple cases comprising primary and secondary informants (Billups, 2021). The exploration of these diverse aspects of my informants, in turn, allowed for the development of rich data – a focus of qualitative research (Merriam & Grenier, 2019). The flexibility afforded me through qualitative research enabled me to modify the order of questions and details of how topics were covered (Billups, 2021). I believe the flexibility facilitated by my qualitative design encouraged the atmosphere of support and safety I was attempting to establish.

Due to the iterative nature of qualitative research I was also able to refine my research questions based on emerging findings (Creswell & Creswell, 2023; Merriam

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& Grenier, 2019). The emergent and recursive nature of qualitative research allowed me to adapt accordingly as new insights emerged (Billups, 2021; Creswell & Creswell, 2023; Willig, 2021). For example, as I analysed my data, I encountered the unexpected finding of HTFWP-fostered self-compassion felt by my primary informants. I had not reviewed literature in this regard, but the recursive, flexible nature of qualitative research enabled me to understand this finding by reviewing additional literature.

While I appreciated the flexibility that a qualitative approach afforded me and while I liked that it strengthened my methods and literature review, I did think that future PhD candidates need to be sure that they are comfortable with a flexible approach. For those who prefer certainty, also in terms of a standard set of protocols and a pre-defined literature review, a qualitative approach is probably not the best way forward for them.

8.3.1.2 Multiple Data Sources

My multiple case study design also allowed for multiple sources of data as mentioned in Chapter 4 (see Section 4.7). These sources included a demographic questionnaire, Child Behaviour Checklist for ages 6 to 18 years, two semi-structured interviews and three HTFWP-drawing elicitation conversations with primary informants. Sources from the secondary informants were their HTFWP drawings and the accompanying stories related to their drawings. I also had the opportunity to observe the non-verbal behaviour of my informants.

As I reflect on my demographic questionnaire (see Appendix J), which I based on my review of the literature regarding childhood anxiety and its impact on micro- and mesosystems as well as the risks related to anxiety, I believe that this questionnaire was valuable. It gave me an idea of precipitating factors like the

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struggle with academic achievement and the ACEs the children participating in my study experienced. I also got a sense of the impact of the child's anxiety on the family. This questionnaire gave me some insight into the family makeup and basic demographic details regarding the secondary informant, like gender and age. Information from the Child Behaviour Checklist for ages 6 to 18 years added to this profile by giving me an idea of the degree of the parent's concern regarding their child's anxiety. These two sources of data were therefore valuable in furthering my understanding of the context of each case and I would encourage their future use by other mental health professionals.

The sessions with my primary and secondary informants as well as the child's drawings and sandplay scenes provided a variety of valuable data sources that encompassed a holistic, comprehensive understanding of the perspectives of my informants (Merriam & Tisdell, 2016). It allowed for the triangulation of my data, enhancing the trustworthiness of my research (see Chapter 4, Section 4.10 (Creswell & Creswell, 2023; Korstjens & Moser, 2018; Schwandt et al., 2007).

8.3.1.3 Managing My Data

As I reflect on the value of the multiple sources of data I also recall a sense of overwhelm when trying to manage all these sources. My use of the data analysis software, Nvivo, was helpful in this regard. This software helped me streamline the process of managing large volumes of data generated by my research (Merriam & Grenier, 2019). As a data analysis software, Nvivo offered tools for facilitating coding and categorisation (Merriam & Tisdell, 2016). I was able to easily access different data sources and track patterns in the data leading to a more systematic and rigorous coding process (Merriam & Grenier, 2019; Morse, 2015). However, I only used Nvivo up to a certain point (see Section 4.9.1.3). While it was useful to manage

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the large amount of data and help me with coding, I needed to revert to a paper and pencil approach by printing my codes to develop my themes. This hands-on approach allowed me to physically move and group my codes as I developed my themes. This manual method allowed me to get an overview of all my codes and themes while electronically I would only have been able to view them one page at a time. As I looked back on my switch from electronic to manual methods, it helped me realise how important it was for me to find methods which supported my research process and I would encourage other researchers to do the same.

8.3.1.4 Managing my influence on my data

My ontological lens of social constructionism, which considers the existence of multiple realities within a social context, includes the researcher who comes with their own realities and context. I was mindful of my biases and their influence on my interaction with my primary informants by practicing researcher reflexivity and using the framework of my ontological lens which emphasised the influence of social contexts in creating reality (Creswell & Creswell, 2023; Lamba et al., 2022; Willig, 2021). For example, as I was a mother anxious for my children during our experiences of COVID-19 the potential for my over-identification with my primary informants existed. Thinking back to that anxious time, I realise the importance of my own personal therapy so that my own anxieties as a parent during COVID-19 did not unduly influence my data generation and analysis. Although my contact with my informants was for approximately four months, my influence on my data was much longer and therefore my personal therapy was for a year. Support for psychologists is typically encouraged, but I do not think I realised the importance of this step, especially for psychologist-researchers. Reflecting on it now, I am grateful that I engaged in my own therapy and would encourage aspiring students of academia to

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do the same, particularly those working in a therapeutic setting and more particularly those who straddle the identities of psychologist and researcher in the same study.

8.3.2 Reflecting on Methodological Limitations of My Study

While the exploratory nature of my study and the instrumental multiple-case study design were a fitting choice for my study, it held some limitations related to my sample, the parents involved in my study, the lack of longer term follow-up, the setting of my study, my singular focus on GAD and my use of one therapeutic modality.

8.3.2.1 My Sample

I limited my sample to primary school children aged 10 to 12 years exhibiting symptoms of GAD. I did this because children's anxiety including GAD was found to be on the increase during the COVID-19 pandemic (di Fazio et al., 2022; Harrison et al., 2022). In retrospect, when I reflected on this sample delimitation, I wondered how different parenting and parental involvement is in therapy when the client is an adolescent with a different diagnosis (e.g., Major Depressive Disorder (MDD), Post Traumatic Stress Disorder (PTSD) or Substance Use Disorder (SUD)). Like primary school children, adolescents also require warm, supportive responsive parenting to foster their well-being and resilience (Masten & Tellegen, 2012; Masten, 2024). Moderate monitoring and control as well as warm parenting positively influences internalising symptoms like MDD (Lunetti et al., 2021). Parenting styles and parent-adolescent relationships therefore need specific consideration in reference to balancing the adolescent's autonomy and the parent's authority (Abed et al., 2023). Literature on the type of parenting style required to support an adolescent with internalising and externalising challenges strongly suggests the importance of authoritative parenting (Freeze et al., 2014; Lunetti et al., 2021). A parent's ability for clear communication is important in the healthy emotion regulation of the adolescent

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(di Giunta et al., 2022). These are all the parental characteristics which were fostered when sharing the child-client's HTFWP drawings with their parents in my study (see 5.2.2.3). I wonder how well this sharing would work when the adolescent is in therapy for any internalising disorder (other than or including GAD) or any Disruptive, Impulse-Control and Conduct Disorders. I am assuming that the relationship between the psychologist and adolescent would need to be one based on trust in order for the adolescent to willingly give their assent for their drawings to be shared and discussed with their parents, but I cannot be sure given that my study focused on children.

8.3.2.2 Parents versus Caregivers

The parents in my study were coincidentally all biological parents. As I reflected on this occurrence, I wondered what the results would have been for other caregiver figures like foster parents, adoptive parents, step-parents, grandparents, other relatives or legal guardians taking on the role of support, care and guidance for the children in their care. The researchers involved in the Connect Programme, which aimed to foster the parent-adolescent relationship by focusing on secure attachment predominantly with the mother, considered the role of other caregivers (Moretti & Obsuth, 2009). Researchers in this area stated that the unique challenges faced by other caregivers, in terms of attachment, would need to be considered in order to apply this intervention to all caregivers (Barone et al., 2021).

Taking this research into account (Barone et al., 2021; Moretti & Obsuth, 2009), the needs and specific challenges of caregivers other than biological parents, would need to be recognised and addressed in order to effectively share the HTFWP-drawing series when the child/adolescent is in therapy. The guidance and support from the psychologist in this context would need to be tailored to the specific

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family with whom they are working (Moretti et al., 2015). Caregivers who are not biological parents may require more HTFWP-drawing elicitation conversations than those indicated in my study.

8.3.2.3 Lack of longer term follow-up

The temporal boundary I decided on for my study allowed for four months of contact time with informants (see Chapter 4, Section 4.3.1.2). Although this time with the primary and secondary informants provided me with rich data for my research, I wondered about the limitation of this period as at the end of the process, some children did require additional time in therapy. I managed the concern that some children may have needed more time by alerting their parents to this during our final session and offered two additional sessions at no cost to help transition to another therapy setting like non-payment therapy services available in our area. However, these parents had a 'let's-wait-and-see' approach for various reasons. A possible reason could have been that the last session with primary informants happened at the end of the school year and start of the school holidays. The other possible reason could have been the positive outcomes experienced by these parents regarding their child's therapy process. However, I kept the door open by mentioning that they had my contact details and were welcome to make contact should the need arise. Since my final contact (November, 2022), three of the primary informants have reached out – one to address the concerns of a younger sibling, another primary informant contacted me two years later for continued therapy for their child who had been part of my research study, and a third for a referral letter for the family for counselling at a centre providing no-payment family therapy.

Relatedly, one of my findings was the potential of sustaining therapy gains (see Section 5.2.3.1). However, I included no delayed follow-up as part of my study

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and so I cannot be sure that the therapy gains were sustained over time. My reason for this related to time constraints and my need for completing my degree. However, it would be beneficial to follow up with the parents and the child to see if the benefits of sharing the HTFWP- drawing series were sustained 6 months and a year later.

8.3.2.4 The setting of my study

My study was based in a private practice setting. Reflecting on this setting I realise that it is a limitation as results may be different for psychologists working in a public health care setting. When considering the current state of the mental healthcare system in South Africa, there are several disparities between the private and public healthcare system including limited resources with financial resources allocation skewed toward inpatient care in the public setting (Sorsdahl et al., 2023). There is also a stigma surrounding mental healthcare in Africa resulting in barriers accessing these services (Okunade et al., 2023). Public mental healthcare services in Africa also present privacy issues as there are designated areas allocated within a bigger public space, for meetings with parents and children (Mokitimi, 2024). All these challenges would need to be taken into account in order to effectively share the HTFWP-drawing series with parents in a public healthcare system.

8.3.2.5 Limiting the therapeutic modality

The final limitation I considered as I reflected on my study was that I limited the child's therapy to sandplay therapy. Although this is my preferred modality when working with children and my work in sandplay therapy also sparked my motivation for my study, I realised that it is not the preferred modality of all psychologists working with children with GAD. For example, there has been research on the effective use of CBT when children are anxious (Beesdo, 2009; Creswell et al., 2020; Doyle, 2022; Lunn et al., 2023; Ollendick & Davis, 2013; Schiele & Domschke, 2018; Strawn et al., 2020). However, I specifically chose the HTFWP drawing with

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sandplay therapy as they share fundamental similarities. Sandplay therapy and the HTFWP are based on Jungian psychology and therefore, symbolism. It would be interesting to see if this drawing can be used as effectively with a different therapeutic modality, especially one that is not Jungian based and does not rely on the understanding of symbols.

8.3.3 Reflecting on the Assumptions I Brought to My Study

My review of the literature and extensive experience working with children as an Educational Psychologist and sandplay therapist, informed my assumptions. Many of my assumptions were accurate. For example, considering the increase in COVID-19-related anxiety reported in children worldwide and in SA (di Fazio et al., 2022; Harrison et al., 2022), I assumed that parents would want help trying to co-manage their child's anxiety. This was evidenced by the quick positive response from parents regarding participation when hearing about my study. This quick response impresses upon me the need for psychological services, especially for those with financial constraints for accessing these services (Sorsdahl et al., 2023). Mental health services could also do more to support parents to be co-therapists making them feel more empowered to co-manage their child's anxiety.

Part of my study was asking children to complete a series of HTFWP drawings with a specific instruction. They were also asked to explain their drawing in their own words. This technique allowed children to express their feelings with me and their parents in a less intrusive way (Angell et al., 2015). My assumption, supported by research where children were asked to draw (Hall & Theron, 2016; Malindi & Machenjedze, 2012, Malindi & Hay, 2023), was that the children in my study would readily engage in drawing activities.This assumption proved to be

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accurate which has encouraged me to continue to use drawings/this drawing series and to advocate for others to do the same.

In addition, I rightly assumed that children would willingly allow me to share their drawings with their parents. This assumption was based on my personal professional experience of children eager to share their creations (clay sculptures, sandplay scenes, and drawings) with their parents after their therapy sessions. Studies have also suggested that children, given the ability to express their emotions through their drawings, would most likely be willing to share these drawings with their parents (Çetin & Güneş, 2021; Pivnick, 2023; Willer et al., 2018). However, the willingness of children to share their drawings with their parents would most probably depend on their level of comfort and the therapeutic relationship. The accuracy of this assumption would probably be based on the degree of trust between the psychologist and child and the sensitivity used when interacting with the child, so that the child recognises that the psychologist represents their best interest and their well-being when sharing their drawings. I also wondered about the relationship between child and parent and the child's belief that there will be no negative repercussion when their drawing is shared with their parents. In other words, I feel fellow psychologist should consider this assumption that the child would readily share their drawings with parents, with caution.

Another of my assumptions which was spot-on, was that sharing the child-client's HTFWP drawing series with their parents during the feedback sessions would enhance the parent-psychologist alliance. This assumption, however, was not grounded in existing literature specific to HTFWP drawings for this purpose. Instead, it was based on general findings that emphasised the significance of a strong parent-psychologist alliance (De Greef et al., 2017; Diamond, 2000; Feinstein et al., 2009;

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Kazdin & Whitley, 2006; Nevas & Farber, 2001; Zemmelman, 2018). It therefore encouraged me to continue using this drawing series in this way for the purpose of creating alliances with the parents of my child-clients.

Based on the general literature on the value of sharing drawings with parents (see Section 3.3.1; Broecher, 2012; Diamond, 2000; Maloney, 1981; Molinari, 2013), I made the assumption that sharing the HTFWP drawing series would benefit parents to better understand their children, ultimately improving parenting practices and bolstering the child's resilience (Masten et al., 2021). This assumption was corroborated in my findings of the benefits of sharing the child-clients HTFWP-drawing series with their parents (see Section 5.1.1.1). As my assumption proved to be accurate, using this drawing as a tool for bolstering parental insight and parental practices has now been documented. I can now employ this technique with confidence for future clients and these benefits can be achieved by fellow mental health professionals using the same documented process.

8.4 Recommendations for Future Research and Practice

Reflecting on my study's contributions and limitations prompted thought about future studies. Firstly, to address the limitation of longer term follow-up to confirm the finding of potentially sustained therapy gains, I would recommend a longitudinal study. A longitudinal study will enable the researcher to track development or changes with regard to the benefits found in the original study with the same informants at multiple points in time (Creswell & Creswell, 2023; Merriam & Tisdell, 2016). In this way, the potential benefit of sustaining therapy gains can then be tracked over time.

Secondly, to address my limitation of children as secondary informants I recommend including adolescents as secondary informants in future studies. This

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idea was inspired by my primary informants who wondered about their other older children benefitting from this type of process. For the effective sharing of the HTFWP drawing series the relationship between psychologist and adolescent would need to be one of trust. The adolescent's relationship with their caregivers would also need to be explored to discern challenges specific to that relationship which may result in a barrier to therapeutic progress (Barone et al., 2021; Moretti & Obsuth, 2009; Moretti et al., 2015) or being able to enjoy the benefits of sharing the adolescent's HTFWP-drawing series with their parents.

Thirdly, to address my limitation of primarily using biological parents, I recommend a study focussing on caregivers who could include biological parents but also allows for foster parents, grandparents acting as parents and adoptive parents. This is important in the South African context considering the high rate of orphanhood in our country due to the AIDS and COVID-19 pandemics (Casale et al., 2015; Freeze et al., 2014; National Institute for Communicable Diseases [NICD], 2021, August 26; Richards et al., 2012; Sharer et al., 2015). Many South African adolescents live in communities experiencing high levels of poverty, violence, stress, physical abuse and socio-economic challenges. The positive influence of a caregiver's parenting practices is vital for mitigating the negative impact of these circumstances (Casale et al., 2015; Richards et al., 2012; Roman et al., 2016). In addition, parental behaviours of low warmth and minimal involvement and monitoring of their adolescents have been shown to contribute to the development of problematic behaviours in adolescents (Freeze et al., 2014; Theron et al., 2022). Therefore an intervention like the effective sharing of the adolescents HTFWP drawing series with their caregivers that fosters authoritative parenting, would be potentially beneficial for resilience building and the well-being of adolescents.

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Providing support for caregivers is particularly important for South African adolescents to bolster their resilience (Bhana et al., 2016).

To address my limitation of a study undertaken in private practice, I recommend exploring the benefits of the HTFWP-drawing- series to the therapeutic process in a public health setting. This is important as many families in South Africa do not have the benefit of private mental health support partly due to the limited service and partly due to financial constraints (Sorsdahl et al., 2023). It would therefore be beneficial for families, specifically South African families, to receive the type of support where parents become co-therapist as in my study, to ultimately foster their child's resilience to anxiety or potentially other mental health challenges, thereby reducing their need of mental health services. In addition, exploring the benefits of the HTFWP-drawing- series in a public health setting may also lift the stigma related to mental health challenges (Okunade et al., 2023), as caregivers get to better understand the adolescents in their care. An important consideration in that setting revolves around privacy issues (Mokitimi, 2024); this would need to be effectively addressed to help create a safe, supportive therapeutic space.

To address my singular focus on GAD that was motivated by the increased COVID-19 pandemic related anxiety experienced by children (di Fazio et al., 2022; Harrison et al., 2022; Luthar et al., 2020; Masten & Motti-Stefanidi, 2020; Yoshikawa et al., 2020), I recommend a study that considers a different mental health challenge, like depression. In a study exploring the association of ACE's with anxiety and depression with children aged 8 to 17 years (n=39 929), the prevalence rates for depression was 4% of South African youth from the sample (Elmore & Crouch, 2020; see Section 2.3.4.1). The prevalence rate of paediatric depression in the Western Cape in a study with 621 young adolescents (aged 10-14 years), was found to be

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33.5% (Mkhize et al., 2024; see Section 2.2.1). Another recommended could be one with adolescents instead of children. One could explore a mental health challenge which is prevalent in adolescents. This could include mood disorders or Substance Use Disorders (Shorey et al., 2022; Simon et al., 2022; Unwin et al., 2022). This shift in focus to a different mental health challenge as well as a different age range, will help determine if the benefits I found in my study are repeatable when the focus is not GAD and the age range is adolescence.

Finally, although I found the shared Jungian base of the HTFWP drawing and sandplay therapy to support the motivation for my study, it would be interesting to explore the benefits to the therapeutic process when the client's HTFWP drawing series is shared with their parents when the therapeutic modality is different to sandplay therapy. For example, a therapeutic modality like CBT, which has been shown to be an effective intervention when working with children who are anxious, could be considered (Beesdo, 2009; Creswell et al., 2020; Doyle, 2022; Lunn et al., 2023; Ollendick & Davis, 2013; Schiele & Domschke, 2018; Strawn et al., 2020). Similarly, play therapy or some other modality other than sandplay therapy would allow one to explore the efficacy of sharing the HTFWP drawing series in a therapeutic modality that does not share the Jungian base that sandplay therapy and the HTFWP drawing share.

8.5 Conclusion

In this study, my purpose was to explore the benefits, if any, to the therapeutic process of sharing the child-client's series of HTFWP-drawings with their parent(s) during parent-feedback sessions when this child was in sandplay therapy for GAD. In the event that I determined that sharing the child-client created HTFWP drawing series was beneficial, I also aimed to identify and delineate recommendations for

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psychologists regarding the effective integration of the child-client's HTFWP drawing series into parent feedback sessions to enhance the therapeutic process for children in sandplay therapy for GAD. With the grounding of my paradigmatic lenses, my review of the literature related to my topic, my research design and analysis of my data using reflexive thematic analysis, I believe that my instrumental multiple case study has fulfilled its purpose (Braun & Clarke, 2021a, 2021b, 2019, 2022). Through fulfilling my purpose, I believe that I have filled the gap in the understanding of how to create a parent-psychologist alliance (de Greef et al., 2017; Diamond et al., 2000; Feinstein et al., 2009; Fox, 2012; Gvion & Bar, 2014; Kazdin & Whitley, 2006; Nevas & Farber, 2001; Ruberman, 2009; Zemmelman, 2018). I have contributed to the theoretical understanding of the benefits of the HTFWP drawing and contributed towards praxis in relation to the therapeutic use of the HTFWP drawing and including parents when a child is in sandplay therapy.

Ultimately, I hope that more children and their parents will benefit from psychologists applying the theoretical insights and practical recommendations of this PhD study. I believe that when they do, psychologists will experience the resilience-supporting benefits of using the HTFWP therapeutically. I trust that this will include their own resilience too, as the profession of psychology is an increasingly challenging one (Bell et al., 2024). Seeing the benefits of the HTFWP drawings for the child and parent informants in my study certainly bolstered my resilience, as did their affirmation of this drawing-faciliated way of working best expressed in Michael's words (one of my secondary informants; see

Figure 31): "It's like you just get me. Not all people are good are getting me". May psychologists who are inspired by my study's results to use the HTFWP

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drawing series be similarly affirmed when their clients experience the benefits of this drawing series first hand.

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Appendix A

Ethics Clearance from Department of Education

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Education

Ethics Committee

7 April 2022

Dear Mrs JM Bredekamp

The application for ethical clearance for the research project described below served before this committee on 16 March 2022:

Ethics Protocol No:	**EDU168/21**
Principal investigator:	**Mrs JM Bredekamp**
Student/Staff No:	**21684279**
Degree:	**Doctoral**
Supervisor/Promoter:	**Prof LC Theron**
Department:	**Educational Psychology**

The decision by the committee is reflected below:

Decision:	**Approved**
Comments:	
Period of approval:	**Three years**

The approval by the Ethics Committee is subject to the following conditions being met:

1. The research will be conducted as stipulated on the application form submitted to the Ethics Committee with the supporting documents.
2. Proof of how you adhered to the Department of Basic Education (DBE) policy for research must be submitted where relevant.
3. In the event that the research protocol changed for whatever reason the Ethics Committee must be notified thereof by submitting an amendment to the application, together with all the supporting documentation that will be used for data collection namely; questionnaires, interview schedules and observation schedules, for further approval before data can be collected. The changes may include the following but are not limited to:
    - Change of investigator,
    - Research methods any other aspect therefore and,
    - Participants.

The Ethics Committee of the Faculty of Education does not accept any liability for research misconduct, of whatsoever nature, committed by the researcher(s) in the implementation of the approved protocol.

Best wishes

Prof Funke Omidire
Chair: Ethics Committee
Faculty of Education

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Appendix B

Ethics Clearance from Department of Health Sciences

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences

Institution: The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.

- FWA 00002567, Approved dd 18 March 2022 and Expires 18 March 2027.
- IORG #: IORG0001762 OMB No. 0990-0278 Approved for use through August 31, 2023.

Faculty of Health Sciences **Research Ethics Committee**

15 June 2022

Endorsement Notice

Dear Mrs JM Bredekamp

Ethics Reference No: EDU168/21
Title: Using drawings made by anxious children in therapy to advance rapport between parents and psychologist

The **New Application** as supported by documents received between 2022-04-14 and 2022-06-15 for your research, was approved by the Faculty of Health Sciences Research Ethics Committee on 2022-06-15 as resolved by its quorate meeting.

Please note the following about your ethics approval:

- Ethics Approval is valid for 1 year and needs to be renewed annually by 2023-06-15.
- Please remember to use your protocol number (EDU168/21) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, monitor the conduct of your research, or suspend or withdraw ethics approval.

Ethics approval is subject to the following:

- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

We wish you the best with your research.

Yours sincerely

On behalf of the FHS REC, Dr R Sommers
MBChB, MMed (Int), MPharmMed, PhD
Deputy Chairperson *of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria*

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes, Second Edition 2015 (Department of Health).

Research Ethics Committee
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Gezina 0031, South Africa
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Fakulteit Gesondheidswetenskappe
Lefapha la Disaense tša Maphelo

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Appendix C

Recruitment Flyer

Looking for volunteers

Do you want to participate in a research study which looks at **collaborating with your child's psychologist to help your anxious child?**

Is your child:

- 10 – 12 years old
- Anxious
- Being referred to my study by a mental health professional?

As the parent/caregiver

- Do you live in or near Table View in Cape Town,
- Are you able to bring your child for the 10 therapy sessions,
- Can you meet with me for three conversational sessions about your child and three feedback meetings, and
- Are you comfortable speaking, writing, and reading English?

If you answered yes to **all** of the above and you are interested in participation, please speak to the mental health practitioner from whom you got the flyer for an explanation of the next steps

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Appendix D

Script for Recruitment

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UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Education

Script for recruitment

Hi there – thank you for the interest in the flyer which relates to a study being done by my colleague, Judith Bredekamp. Judith is an Educational Psychologist registered with the Health Professions Council of South Africa and has been practising for 14 years. She is also a doctoral candidate registered at the University of Pretoria (South Africa) and so has to complete a research study. Thank you so much for showing an interest in her study.

Judith's study is called: using drawings made by anxious children in therapy to advance rapport between parents and psychologist**.** Broadly, she is looking for participants who are parents of anxious children aged 10 to 12. Through doing therapy with your child and having conversations with you, she wants to learn how psychologists and other mental health professionals can use a series of drawings (called the House-Tree-Fire-Water-Person drawing) to create a good relationship with parents and effectively communicate with parents during the therapy process of their anxious children. She wants to see if using your child's House-Tree-Fire-Water-Person drawing when she gives you feedback of your child's progress in therapy, will make it possible to come to a shared understanding of your child, their anxiety and what parents can do to help manage their child's anxiety and contribute to the strengthening of their resilience.

If you think you would like to participate, the next step would be to take these consent forms with you. One form is for you and the other for your child to complete (provided your child wants to participate; your child can say no if that is their preference). The forms tell you more about the study and also ask for your permission and your child's permission for participation. Even though you take these forms with you, you are under no obligation to take part in the study. However, if you would like to take the forms, with your permission, I will send Judith your contact details via whatsapp or email and she will contact you in about a week's time to check if you are still interested. She will also let you know how she will collect the completed forms if you are still interested for yourself and your child to participate in the study.

Note to recruiting professional: If parents decide to take the consent/assent forms, with their permission, please send me their contact details via whatsapp (072 583 4228) or email (judith@discoverymail.co.za)

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www.up.ac.za

Faculty of Education
Fakulteit Opvoedkunde
Lefapha la Thuto

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Appendix E

Comprehensive Explanation of My Study and Parents' Consent Forms

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PARTICIPANT INVITATION AND CONSENT FORM

Dear Parents and Caregivers

Parent/caregiver consent for their children and themselves, Cape Town

I invite you and your child to participate in my PhD study titled: *Using drawings made by anxious children in therapy to advance rapport between parents and psychologist*.

Who am I?

I am an Educational Psychologist registered with the Health Professions Council of South Africa and I have been practising for 14 years. I am also a doctoral candidate registered at the University of Pretoria (South Africa). My contact details are at the end of this letter if you need them. Linda Theron (professor, Department of Educational Psychology, University of Pretoria) will mentor my PhD study. Her contact details are at the end of this letter too. My qualification and experience as an Educational psychologist will be important in this study but my primary role will be researcher and therefore I will refer to myself as the researcher in the rest of this letter.

What am I doing in this PhD study?

Broadly, I want to learn how psychologists and other mental health professionals can use a series of drawings (called the House-Tree-Fire-Water-Person drawing) to create rapport with parents in order to effectively communicate with parents during the therapy process of their anxious children. I want to see if using your child's House-Tree-Fire-Water-Person drawing when I give you feedback of your child's progress in therapy, will make it possible to come to a shared understanding of your child, their anxiety and what parents can do to help manage their child's anxiety and contribute to the strengthening of their resilience. Understanding the drawings of children formed part of my

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professional training as an Educational Psychologist at the University of Stellenbosch. Furthermore, the House-Tree-Fire-Water-Person drawing, was introduced to me during my training for certification as a sandplay therapist and my use of it was supervised.

Why am I asking you and your child to be part of this PhD study?

Because your child

- Is 10-12 years old, *and*
- Has anxiety, *and*
- Was referred to my study by a colleague who works as a mental health professional

Because you

- Live in or near Table View in Cape Town, *and*
- Are able to bring your child for the 10 therapy sessions, *and*
- Can meet with me for three conversational sessions about your child and three feedback meetings
- Are comfortable reading, writing and speaking English

What will your child be asked to do: if you and your child decide to participate

- Your child will be asked to participate in weekly sandplay therapy sessions (described in Table 1) to assist them with their anxiety. There will be a total of 10 sessions which will each be 40 minutes long. Therapy sessions will happen after school on a day and time you and I agree to. The venue for therapy will be my psychology practice (4 Ceresa Close, Table View). As the therapy process is once a week, it will take 10 weeks to complete.
- During three of these 10 therapy sessions, your child will be asked to do a drawing which includes a house, a tree, fire, water and a person. Each time I will ask them to help me understand what their drawing means. The reason for the House-Tree-Fire-Water-Person drawing is to help us (you and I) understand your child's anxiety better, how they are trying to cope with it and what can be done in order to strengthen them. With their permission I will share these drawings and their explanation of each drawing, with you during the feedback meetings.

What will you be asked to do: if you and your child decide to participate

Firstly, I will ask you to ensure that your child is brought each time for their therapy session with me. I will also meet with you on six separate occasions at my practice. These six sessions will be split up in the following ways:

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- The first session with you is to get some background history on your child, for you to complete a child behaviour checklist in order to help explain their anxious behaviour and to decide on a weekly appointment time for your child to attend therapy sessions with me.
- Three of the sessions will consist of feedback meetings where each time, you and I will discuss your child's latest House-Tree-Fire-Water-Person drawing.
- Finally, we will meet for two conversations (one at the beginning of the research and one at the end) to discuss your understanding of your child's anxiety and how you respond to their anxiety.

The following sessions will be video and audio recorded and a written record of these recordings will be made: all conversation/feedback sessions between parent/caregiver and researcher. I have summarised the information of what you and your child will be asked to do in a table below to make clear when and where each step of my PhD study will take place:

Table 1: Overview of research activities with parent/s and child

When each activity takes place		Venue	Activity
Session number	**Date and time**		
1	To be decided	Judith Bredekamp Psychology Practice 4 Ceresa Close Table View	**The first session with parents** I will ask you for some biographical information on your child and you will be asked to complete a behaviour checklist which will be used to help me understand their anxious behaviour. This meeting should take 40 minutes. This session will be video and audio recorded and a written record of these recordings will be created.
2 and 16	To be decided	Judith Bredekamp Psychology Practice 4 Ceresa Close Table View	**Conversational sessions with parent** I will ask you some questions about your child and their anxiety. For example, I will ask what your child's anxiety looks like. Each meeting should take 40 minutes. These sessions will be video and audio recorded and a written record of these recordings will be created.
4, 9 and 15	To be decided	Judith Bredekamp Psychology Practice 4 Ceresa Close Table View	**Feedback meetings with parents** Each time we will look at one of the House-Tree-Fire-Water-Person drawings done by your child and talk about what we see and how the drawing makes us feel in order to come to a shared understanding of your child's anxiety. Each meeting should take 40 minutes. These sessions will be video and audio recorded and a written record of these recordings will be created.
3, 8 and 14	To be decided	Judith Bredekamp Psychology Practice 4 Ceresa Close Table View	**Drawings with child** On three occasions I will ask your child to do a drawing that includes five things: a house, a tree, fire, water and a person. When their House-Tree-Fire-Water-Person drawing is done I will ask them to help me understand what their drawing means

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5 – 8 and 10 - 13	To be decided	Judith Bredekamp Psychology Practice 4 Ceresa Close Table View	**Sandplay therapy with child** Sandplay therapy is a therapy method used to help children who are experiencing difficulties like anxiety. Sandplay therapy makes use of sandboxes, toy figurines, and sometimes water, to create scenes of miniature worlds that reflect a person's inner thoughts, struggles, and concerns. The child is given a selection of toy figurines to choose from and one dry and one wet sandbox. They choose the sandbox they want to use and then create a picture/world in the sandbox, using the toy figurines. Once they have built this world, they will be asked if they would like to say anything about the world they've built. During the sandplay therapy process, the child is invited to build a world in the sandbox in each therapy session. Their creation in the sand is photographed each time to keep a record of their therapy process.

What will happen to the data collected during my study?

The data will consist of:

1. Audio and video recordings of all discussions with you
2. Your child's drawings as well as photographs of these drawings
3. Photographs of the sand trays your child creates.

I will upload the photographs onto a password-protected computer. I will employ a third party transcription service to type up all audio recordings (this is called a transcript). This individual will sign an agreement of confidentiality to ensure that your information remains private. Furthermore, to also ensure privacy, only your first name will be used on the audiofiles and your surname will not be divulged. Once the transcripts have been typed, I will check them against the video recordings to add non-verbal detail. I will then replace your name and your child's name with pseudonyms. These transcripts will be stored on a password protected computer and the original audiofiles and videos will be deleted. My supervisor and I will have access to the transcriptions and photographs during my study. At the end of my study, the transcriptions and photographs will be stored by the University of Pretoria for 10 years. During these 10 years, the university would like to share the anonymised data with students busy with research projects on resilience, sandplay therapy, drawings in therapy or children with anxiety. They would reanalyse the data for their research projects.

Who will see the forms you sign and what happens to them?

Me, my supervisor (Linda Theron) and the two ethics committees monitoring the ethical procedures of my study, will have access to the consent forms you have signed. These forms will be stored at the University of Pretoria in a different place from where your transcriptions and photographs of your child's drawings and sandplays will be

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stored. We also would like to request your permission to use your data, confidentially and anonymously, for further research purposes, as the data sets are the intellectual property of the University of Pretoria. Further research may include secondary data analysis and using the data for teaching purposes. The confidentiality and privacy applicable to this study will be binding on future research studies.

Will this cost you anything?

Because the therapy and feedback sessions are part of my doctoral study, there will be no fee levied for your child's 10 sessions and the 6 parent-researcher conversational/feedback sessions.

What do you and your child get out of the study?

Your child will get 10 therapy sessions to potentially help them manage their anxiety and to strengthen their resilience.

You get the chance to potentially understand your child's anxiety in a different way, which will support your parenting of your anxious child and help them strengthen their resilience.

Can you or your child get hurt from taking part?

There may be some potential risks/discomforts to participation, particularly during this time of Covid-19. I have placed the possible risks and discomforts in Table 2 below and explained how they will be managed.

Table 2: Risks/discomforts and strategies to lessen them

Possible risks/discomforts	**Strategies to lessen risk/discomfort**
You may find it difficult to afford travel to my practice for the 16 sessions	If this happens you will be offered two MyCiti bus cards each loaded with R150 to help with travel expenses.
You may feel slightly uncomfortable at times when trying to understand your child's drawing	If this happens please let the researcher know so that she can help manage the discomfort, but should you need further support please inform the researcher or any contacts provided in this letter, so that we can possibly refer you to the no-cost services of social workers and psychologists as provided at: Jelly Beanz Inc 253 Blaauwberg Road Table View 021 556 2456
Only a specified number of	If this happens we can refer you to the no-cost services of social workers and

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sessions are offered for the study which may be less than what you/your child requires	psychologists as provided at Jelly Beanz Inc. During the transitional period of at least 2 months to the no-cost therapeutic services, therapy will continue with me at no additional cost.
The risk of Covid-19 may be a concern	A protocol to manage this risk includes: Postponing your session if you, your child or I 1. are not feeling well 2. have been in contact with a confirmed or presumed Covid-19 case or, 3. have been in contact with someone self-isolating. Covid-19 protocols for the day of your appointment include the following: 1. Before entering the room everybody will need to sanitise their hands. Sanitizer will be provided. 2. As per government regulation, everybody has to wear a mask, so please arrive wearing one. You will need to keep your mask on during session and it has to cover your mouth and nose. 3. Breathing breaks (about two minutes of breathing outside in the fresh air) will happen (if needed) during therapy sessions. 4. We will maintain the prescribed safety distance in the practice, however, when working at the desk (e.g., when your child makes the drawings) there will be a perspex desk screen providing an additional barrier. 5. Surfaces will be sanitised after each appointment and the practice room ventilated between sessions. 6. Any equipment used during therapy sessions will be sanitised after the session. Before working in the sand, children will have to sanitise their hands before and after the process. The figurines for sandplay will be sprayed with sanitizer after each session and sand in the sandbox will be swapped out.

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Can you change your mind and withdraw from the study at any point?

Your participation and your child's participation in the study are completely voluntary. You and/or your child may choose to stop participating at any time without giving reasons. Even if you and your child initially agree to participate, both of you can change your mind at any time during the 16 sessions and stop taking part.

If you and your child want to participate, then you, as parents/caregivers, will be asked to agree to your own participation and give permission for your child's participation. However, I will still ask your child for their permission as well and they also have the right to say no. Both of you will need to agree to participation in order to be part of the study. If you both agree then you will be asked to complete and sign the form for parents and your child must complete and sign a form which will be given to them.

How will your information be used?

- Your responses during the parent-researcher conversational sessions will be added to the responses of other parents in the study to evaluate if sharing and discussing the House-Tree-Fire-Water-Person drawing of the anxious child in therapy with parents/caregiver at feedback sessions 1) is useful to communicate progress of therapy with the parent/caregiver; 2) will result in a shared understanding between parent/caregiver and researcher of the anxiety of 10 – 12 year old children, and; 3) can help parents/caregivers of anxious children to better co-manage their children's anxiety and ultimately help strengthen the resilience of their children.
- The written reports of the feedback sessions will help maintain a record of our discussions for the different drawings to evaluate if there has been a change in our perception of your child's anxiety.
- The photographs of the sandtrays created by your child across all sessions will be compared to understand their anxiety better and to document the therapeutic process.

How will your personal information be treated?

The Research Ethics Committees of the Faculty of Health Sciences and the Faculty of Education, University of Pretoria, have to ensure that I work carefully and ethically in this study. To make sure of this I have used the ethical guidelines of the Health Professions Council of South Africa and the aforementioned committees. These committees may want to look at the forms you and your child sign (if you both agree to being in this study) to check that I did everything in the right way.

Each child in the study will have an electronic folder that is password protected and saved on a laptop that is also password protected. This folder will contain:

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- A scanned copy of the information and consent/assent letters confirming that you and your child agree to be participants in the study
- The photographs of your child's sandplay process
- Scanned copies of the house-tree-fire-water-person drawings created by your child
- A scanned copy of the child behaviour checklist which you will complete
- The video and audio recordings of the conversation/feedback sessions you and I will have
- The written records of these video and audio recordings.

Your name, your child's name and any other identifiable information will not be used in the written records of the recording in order to protect your identity and that of your child's. All written records and recordings will be kept confidential and only approved individuals whose contact details are in this document (Judith, Linda and Ethics committees of the University of Pretoria) will have access to your information. The original paper copies of your child's drawings , the information and consent/assent letters and the child behaviour checklist will be stored at the University of Pretoria for 10 years.

There are three things that I cannot keep confidential: 1) if your child tells me that they are being abused or is at risk of being abused; 2) if I learn that your child plans to harm themselves; or 3) if I learn that your child has harmed, plans to harm, or fears that they will harm someone else. If your child tells me any of these things, I am required to tell people (including the police) who can help.

On behalf of the University of Pretoria, I would like to request your permission to use your data, confidentially and anonymously, for further research purposes, as the data sets are the intellectual property of the University of Pretoria. Further research may include secondary data analysis and using the data for teaching purposes. The confidentiality and privacy applicable to my PhD study will be binding on future research studies.

Do you have any questions?

Should you have any questions or should you like an explanation about any of the content in this information and consent letter, you are welcome to contact me (Judith) or Linda:

Contact Details

Judith Bredekamp
Cell: 072 583 4228
Email: judith@sandplaytherapy.co.za

Linda Theron
Cell: 082 783 1728
Email: linda.theron@up.ac.za

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Complaints or Concerns?

If you have any concerns about your rights as a research participant and/or your experiences while participating in this study, you may contact the Faculty of Health Sciences and/or the Faculty of Education Research Ethics Committees, University of Pretoria, telephone numbers 012 3563084 / 012 3563085.

You will receive a copy of this information and consent letter for your own records.

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Declaration by Parent/Legal Guardian

By signing below, I ..... agree to participate and I allow
Full name

my child/the child I legally care for .....to take
Child's full name

part in the PhD study titled: *Using drawings made by anxious children in therapy to advance rapport between parents and psychologist.*

I declare that:

- I have read and understood this information and consent form and it is written in a language with which I am fluent enough and comfortable.
- I have had a chance to ask questions of the researcher, and all my questions have been adequately answered.
- I understand that my participation in this study and that of my child's is **voluntary** (I can say no and my child can too) and my child or I have not been pressurised to take part.
- I understand that my child and I may choose to leave the study at any time during the 16 sessions and that will not be a problem. I also understand that once the researcher starts to analyse the data (e.g., add what I have answered to what everybody else answered to understand the effectiveness of the sharing and discussion of the house-tree-fire-water-person drawing of my child during feedback meetings) I cannot withdraw what I have contributed to the study.
- I understand that my identity and my child's identity will never be made known by the researcher outside of the designated members mentioned in this letter.
- My child and I may be asked to leave the study before it has finished, if the researcher feels it is in our best interests.
- I understand that the researcher will have to report abuse/harm (e.g., to child protection services) if they should become aware that my child is being abused/harmed or intends self-harm.
- I agree to video and audio recordings of my feedback and conversational sessions with the researcher and photographs of the sandplay scenes created by my child.
- I agree that the materials that are part of the study, including the child behaviour checklist, feedback and conversational session recordings and written records can be used for research purposes with the understanding that my identity and that of my child remains confidential
- I agree that scanned copies of drawings made by my child can be put up on research websites and be used in research-related publications/conference papers.
- I understand that what I contribute (conversations) could be reproduced publicly and/or quoted and that my full name or that of my child will not be included in this.

Signed at ..... on ..... 202_
Place Date

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....

Signature of parent/legal guardian **Signature of witness**

My contact details are:

Name and surname	
Cellphone number	
Email Address	
Residential Address	
Postal Address	

Declaration by researcher

I ..... declare that:
Name

- I explained the information in this document to .....
Name of parent/caregiver
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use an interpreter.

Signed at ..... on ..... 202_
Place **Date**

....

Signature of researcher **Signature of witness**

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Appendix F

Child's Assent Forms

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ASSENT FORM FOR CHILDREN



TITLE OF THE RESEARCH PROJECT: *Using drawings made by anxious children in therapy to advance rapport between parents and psychologist*

Hello!

My name is Judith Bredekamp and I am inviting you to be part of my research study.

Who is doing the research?
I am a psychologist who works with children and parents. The job of a psychologist is to help children feel better, like feel less scared, by doing different things with them like playing, drawing and telling stories. But I am also a student at the University of Pretoria and one of the things I am expected to do as a student is to work on a research project (called a research study). Research is something we do to find new knowledge about the way things (and people) work. We use research projects or studies to help us find out more about children and teenagers and the things that affect their lives, their schools, their families and their health. We do this to try and make the world a better place!

What is this research study all about?
This study is to help me and other psychologists understand how to build a good relationship with parents and show them what to do to help their children, ages 10-12, feel less scared.

Why have I been invited to take part in this research project?
You have been asked to take part in this study because

- You are between the ages of 10 to 12 years old.
- You are scared a lot of the time and sometimes you cannot figure out why

What will happen to me in this study?
For this research study I am going to ask you to come and play at my office with sand and toys once a week for 10 weeks. Playing with sand and toys often helps children who feel scared, feel less scared.
I'm also going to ask you to make drawings and then to tell me the story of your drawings. I will also need to know that it is OK with you for me to show your parents your drawings and tell them about the stories of your drawings so that they can try to help you to be less scared.

Can anything bad happen to me?
Nothing bad can really happen to you in this study but if you feel uncomfortable in any way please let me know so that I can try to make things easier for you. You can also tell your parents if you feel uncomfortable in any way. No-

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one will be angry at you for doing this and it will help me do things better.

I also have some rules that we will need to follow to keep us safe from Covid-19. I will explain these to your parents but a lot of them are what you are already doing at school like wearing a mask and sanitizing your hands.

Can anything good happen to me?
I am hoping that after spending time with me in my office you will start to feel less scared and your parents will also have a plan of how to help you if scared feelings happen again.

Will anyone know I am in the study?
Some people will know you are part of this study. Besides me and your parents, my supervisor (like a teacher) at the university will know, and also two university committees whose job it is to make sure I do things the right way. One of the things I need to share with those people is this signed form. If you say it's OK, I will show your parents your drawings and tell them about your stories. I will also write about them in the book I must write for my study and when I talk about my study, but I will not use your real name when I do that.The one time I can't keep things to myself is if you tell me someone is hurting you in any way, if you are hurting yourself and if you plan to hurt someone else. Then I will have to tell other people (like the police) who can help.

What if I do not want to do this?
To be part of this study I will need you and parents to agree. But even if your parents have said yes, you can say that you do not want to take part in this study. You can also say yes now but then change your mind later and stop being in the study. You can change your mind at any time without getting in trouble.

Who can I talk to about the study?
Just in case you have any questions you would like to ask someone about this study, I have put my contact details below. I have also added the contact details of my supervisor (teacher):

Judith Bredekamp (Me) Cell: 072 583 4228 Email: judith@sandplaytherapy.co.za	Linda Theron (My supervisor) Cell: 082 783 1728 Email: linda.theron@up.ac.za

Thank you for taking the time to read my invitation!
Judith

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Assent page

Do you understand this research study and are you willing to take part in it?

YES NO

Has the researcher answered all your questions?

YES NO

Do you understand that you can STOP being in the study at any time?

YES NO

Do you agree that I can show your drawings to your parents, tell them what you said about your drawings and what endings you gave to the stories I told you?

YES NO

Child's full name: _____

_____ _____
Signature of Child Date

My parent says I can be part of the study

YES NO

Parent's full name: _____

_____ _____
Signature of parent Date

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Appendix G

Demographic Questionnaire

Referral Information

Child's name:

Birthdate: Age: Sex: ☐ Male ☐ Female

How did you hear about this study?

Presenting Problem

Briefly describe the child's current difficulties:

How long has this problem been of concern to you?

When was the problem first noticed?

What seems to help the problem?

What seems to make the problem worse?

Have you noticed changes in the child's behaviour?

☐ Yes ☐ No

If yes, please describe:

Has the child received evaluation or treatment for the current problem or similar problems: ☐ Yes ☐ No

If yes, when and with whom?

Educational Background

Which primary school/s has your child attended?

School	Date of Admission	Date of Departure

What is your child's current grade?

Has your child repeated a grade? ☐ Yes ☐ No

If yes, what grade and why?

Has the child received special tutoring or therapy? ☐ Yes ☐ No

If yes, please describe:

Has the child missed a lot of school? ☐ Yes ☐ No

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If yes, please indicate reasons:

Educational Checklist

Please tick any educational problem that the child currently exhibits

☐Has difficulty with reading
☐Has difficulty with arithmetic
☐Has difficulty completing tasks
☐Has difficulty sitting still in class
☐Refuses to do homework
☐Has difficulty paying attention in class
☐Has difficulty with spelling
☐Has difficulty remembering things
☐Resists going to school
☐Has difficulty taking notes in class
☐Forgets homework
☐Has difficulty getting along with other children
☐Has difficulty with handwriting
☐Has difficulty with comprehension
☐Dislikes school
☐Has difficulty respecting others' rights
☐is disorganised at school
☐Has difficulty getting along with teacher

Family Data

Marital status of parents:

If divorced, how old was child at the time of divorce:

List all people living in the household:

Name	***Sex***	***Relationship to child***	***Age***

List the name, sex, relationship to child, and age of any brothers, sisters or other significant people living outside of the home:

Dominant language spoken in the home:

Other languages spoken in the home:

What language does the child speak to you?

What language does the child use to speak to friends?

Was the child adopted? ☐Yes ☐No If yes, at what age? Does the child know? ☐Yes ☐No

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What are the child's assets or strengths?

Is there any other information that you think may help me in working with your child?

Family stress survey

Every family sometimes experiences some form of stress. Please tick each event that your family has experienced in the last 12 months.

☐ Child's mother died	☐ Family's financial condition changed
☐ Child's father died	☐ Member of family was accused of child abuse or neglect (list person)
☐ Child's brother died	☐ Someone in the family was in trouble with the police (list person)
☐ Child's sister died	☐ Child started having trouble with parents (caregiver)
☐Parents divorced	☐ Neighbourhood was changing for the worse
☐ Parents separated	☐ Child was a victim of violence (Bullying)
☐ Grandparent died	☐ Family experienced a natural disaster (list)
☐ Someone in the family was seriously injured or became ill (list person)	☐ Child started having trouble with parents (caregiver)
☐ Parent remarried	☐ Child started having trouble with sister/brother
☐ Father lost job	☐ Child started having trouble in school
☐ Mother lost job	☐ Child changed schools
☐ Family moved to another city	☐ Child's close friend moved away
☐ Family moved to another part of town	☐ Child's pet died
	☐ Other types of stressors (list)

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Information on Parents		
Parents' Personal Details	*Father's Details*	*Mother's Details*
Occupation		
Name/type of business		
Working hours		
Qualifications		

Information on Parenting and Family Life

Which three words would best describe your parenting?

What time does the child usually go to bed on weekdays? On weekends?

Which disciplinary techniques are commonly used and are usually effective?

With what types of problems?

Which disciplinary techniques are usually ineffective?

With what types of problems?

Which parent (caregiver) usually administers discipline?

Child's responsibilities

Does the child take responsibility for his/her personal hygiene? ☐Yes ☐No
If no, why not?

Is the child's behaviour generally age appropriate? ☐Yes ☐No
If no, please describe in what ways it is not age appropriate?

Other areas

What do you enjoy doing with the child?

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Appendix H

Child Behaviour Checklist (CBCL/6-18)

ASEBA

Please print **CHILD BEHAVIOR CHECKLIST FOR AGES 6-18**

For office use only
ID #

CHILD'S FULL NAME First Middle Last

CHILD'S GENDER ☐ Boy ☐ Girl

CHILD'S AGE

TODAY'S DATE Mo._____ Date _____ Yr. _____

CHILD'S BIRTHDATE Mo._____ Date _____ Yr. _____

GRADE IN SCHOOL _____

NOT ATTENDING SCHOOL ☐

Please fill out this form to reflect *your* view of the child's behavior even if other people might not agree. Feel free to print additional comments beside each item and in the space provided on page 2. ***Be sure to answer all items.***

PARENTS' USUAL TYPE OF WORK, even if not working now. *(Please be specific — for example, auto mechanic, high school teacher, homemaker, laborer, lathe operator, shoe salesman, army sergeant.)*

FATHER'S TYPE OF WORK _____

MOTHER'S TYPE OF WORK _____

THIS FORM FILLED OUT BY: (print your full name)

Your gender: ☐ Male ☐ Female

Your relation to the child:

☐ Biological Parent ☐ Step Parent ☐ Grandparent
☐ Adoptive Parent ☐ Foster Parent ☐ Other (specify)_____

I. Please list the sports your child most likes to take part in. For example: swimming, baseball, skating, skate boarding, bike riding, fishing, etc.

☐ None

	Compared to others of the same age, about how much time does he/she spend in each?				Compared to others of the same age, how well does he/she do each one?			
	Less Than Average	Average	More Than Average	Don't Know	Below Average	Average	Above Average	Don't Know
a. _____	☐	☐	☐	☐	☐	☐	☐	☐
b. _____	☐	☐	☐	☐	☐	☐	☐	☐
c. _____	☐	☐	☐	☐	☐	☐	☐	☐

II. Please list your child's favorite hobbies, activities, and games, other than sports. For example: stamps, dolls, books, piano, crafts, cars, computers, singing, etc. (Do ***not*** include listening to radio or TV.)

☐ None

	Compared to others of the same age, about how much time does he/she spend in each?				Compared to others of the same age, how well does he/she do each one?			
	Less Than Average	Average	More Than Average	Don't Know	Below Average	Average	Above Average	Don't Know
a. _____	☐	☐	☐	☐	☐	☐	☐	☐
b. _____	☐	☐	☐	☐	☐	☐	☐	☐
c. _____	☐	☐	☐	☐	☐	☐	☐	☐

III. Please list any organizations, clubs, teams, or groups your child belongs to.

☐ None

	Compared to others of the same age, how active is he/she in each?			
	Less Active	Average	More Active	Don't Know
a. _____	☐	☐	☐	☐
b. _____	☐	☐	☐	☐
c. _____	☐	☐	☐	☐

IV. Please list any jobs or chores your child has. For example: paper route, babysitting, making bed, working in store, etc. (Include both paid and unpaid jobs and chores.)

☐ None

	Compared to others of the same age, how well does he/she carry them out?			
	Below Average	Average	Above Average	Don't Know
a. _____	☐	☐	☐	☐
b. _____	☐	☐	☐	☐
c. _____	☐	☐	☐	☐

Be sure you answered all items. Then see other side.

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Please print. Be sure to answer all items.

V. 1. About how many close friends does your child have? (Do *not* include brothers & sisters)
☐ None ☐ 1 ☐ 2 or 3 ☐ 4 or more

2. About how many times a week does your child do things with any friends outside of regular school hours? (Do *not* include brothers & sisters) ☐ Less than 1 ☐ 1 or 2 ☐ 3 or more

VI. Compared to others of his/her age, how well does your child:

	Worse	Average	Better	
a. Get along with his/her brothers & sisters?	☐	☐	☐	☐ Has no brothers or sisters
b. Get along with other kids?	☐	☐	☐	
c. Behave with his/her parents?	☐	☐	☐	
d. Play and work alone?	☐	☐	☐	

VII. 1. Performance in academic subjects. ☐ Does not attend school because _____

Check a box for each subject that child takes	Failing	Below Average	Average	Above Average
a. Reading, English, or Language Arts	☐	☐	☐	☐
b. History or Social Studies	☐	☐	☐	☐
c. Arithmetic or Math	☐	☐	☐	☐
d. Science	☐	☐	☐	☐
e. _____	☐	☐	☐	☐
f. _____	☐	☐	☐	☐
g. _____	☐	☐	☐	☐

Other academic subjects–for example: computer courses, foreign language, business. Do *not* include gym, shop, driver's ed., or other nonacademic subjects.

2. Does your child receive special education or remedial services or attend a special class or special school?
☐ No ☐ Yes—kind of services, class, or school:

3. Has your child repeated any grades? ☐ No ☐ Yes—grades and reasons:

4. Has your child had any academic or other problems in school? ☐ No ☐ Yes—please describe:

When did these problems start?_____
Have these problems ended? ☐ No ☐ Yes–when?

Does your child have any illness or disability (either physical or mental)? ☐ No ☐ Yes—please describe:

What concerns you most about your child?

Please describe the best things about your child.

Be sure you answered all items.

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Please print. Be sure to answer all items.

Below is a list of items that describe children and youths. For each item that describes your child ***now or within the past 6 months***, please circle the ***2*** if the item is ***very true or often true*** of your child. Circle the ***1*** if the item is ***somewhat or sometimes true*** of your child. If the item is ***not true*** of your child, circle the ***0***. Please answer all items as well as you can, even if some do not seem to apply to your child.

0 = Not True (as far as you know) **1 = Somewhat or Sometimes True** **2 = Very True or Often True**

0 1 2 1. Acts too young for his/her age
0 1 2 2. Drinks alcohol without parents' approval (describe):_____
_____
0 1 2 3. Argues a lot
0 1 2 4. Fails to finish things he/she starts
0 1 2 5. There is very little he/she enjoys
0 1 2 6. Bowel movements outside toilet
0 1 2 7. Bragging, boasting
0 1 2 8. Can't concentrate, can't pay attention for long
0 1 2 9. Can't get his/her mind off certain thoughts; obsessions (describe): _____
_____
0 1 2 10. Can't sit still, restless, or hyperactive
0 1 2 11. Clings to adults or too dependent
0 1 2 12. Complains of loneliness
0 1 2 13. Confused or seems to be in a fog
0 1 2 14. Cries a lot
0 1 2 15. Cruel to animals
0 1 2 16. Cruelty, bullying, or meanness to others
0 1 2 17. Daydreams or gets lost in his/her thoughts
0 1 2 18. Deliberately harms self or attempts suicide
0 1 2 19. Demands a lot of attention
0 1 2 20. Destroys his/her own things
0 1 2 21. Destroys things belonging to his/her family or others
0 1 2 22. Disobedient at home
0 1 2 23. Disobedient at school
0 1 2 24. Doesn't eat well
0 1 2 25. Doesn't get along with other kids
0 1 2 26. Doesn't seem to feel guilty after misbehaving
0 1 2 27. Easily jealous
0 1 2 28. Breaks rules at home, school, or elsewhere
0 1 2 29. Fears certain animals, situations, or places, other than school (describe): _____
_____
0 1 2 30. Fears going to school
0 1 2 31. Fears he/she might think or do something bad
0 1 2 32. Feels he/she has to be perfect
0 1 2 33. Feels or complains that no one loves him/her
0 1 2 34. Feels others are out to get him/her
0 1 2 35. Feels worthless or inferior
0 1 2 36. Gets hurt a lot, accident-prone
0 1 2 37. Gets in many fights
0 1 2 38. Gets teased a lot
0 1 2 39. Hangs around with others who get in trouble
0 1 2 40. Hears sounds or voices that aren't there (describe): _____
_____
0 1 2 41. Impulsive or acts without thinking
0 1 2 42. Would rather be alone than with others
0 1 2 43. Lying or cheating
0 1 2 44. Bites fingernails
0 1 2 45. Nervous, highstrung, or tense
0 1 2 46. Nervous movements or twitching (describe): ____
_____
_____
0 1 2 47. Nightmares
0 1 2 48. Not liked by other kids
0 1 2 49. Constipated, doesn't move bowels
0 1 2 50. Too fearful or anxious
0 1 2 51. Feels dizzy or lightheaded
0 1 2 52. Feels too guilty
0 1 2 53. Overeating
0 1 2 54. Overtired without good reason
0 1 2 55. Overweight
56. Physical problems ***without known medical cause:***
0 1 2 a. Aches or pains (***not*** stomach or headaches)
0 1 2 b. Headaches
0 1 2 c. Nausea, feels sick
0 1 2 d. Problems with eyes (***not*** if corrected by glasses) (describe): _____
0 1 2 e. Rashes or other skin problems
0 1 2 f. Stomachaches
0 1 2 g. Vomiting, throwing up
0 1 2 h. Other (describe): _____
_____

 Be sure you answered all items. Then see other side.

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Please print. Be sure to answer all items.

0 = Not True (as far as you know) **1 = Somewhat or Sometimes True** **2 = Very True or Often True**

0 1 2 57. Physically attacks people
0 1 2 58. Picks nose, skin, or other parts of body (describe): _____
_____
0 1 2 59. Plays with own sex parts in public
0 1 2 60. Plays with own sex parts too much
0 1 2 61. Poor school work
0 1 2 62. Poorly coordinated or clumsy
0 1 2 63. Prefers being with older kids
0 1 2 64. Prefers being with younger kids
0 1 2 65. Refuses to talk
0 1 2 66. Repeats certain acts over and over; compulsions (describe): _____
_____
0 1 2 67. Runs away from home
0 1 2 68. Screams a lot
0 1 2 69. Secretive, keeps things to self
0 1 2 70. Sees things that aren't there (describe): _____
_____
_____
0 1 2 71. Self-conscious or easily embarrassed
0 1 2 72. Sets fires
0 1 2 73. Sexual problems (describe): _____
_____
_____
0 1 2 74. Showing off or clowning
0 1 2 75. Too shy or timid
0 1 2 76. Sleeps less than most kids
0 1 2 77. Sleeps more than most kids during day and/or night (describe): _____
_____
0 1 2 78. Inattentive or easily distracted
0 1 2 79. Speech problem (describe): _____
_____
0 1 2 80. Stares blankly
0 1 2 81. Steals at home
0 1 2 82. Steals outside the home
0 1 2 83. Stores up too many things he/she doesn't need (describe): _____
_____
_____
0 1 2 84. Strange behavior (describe): _____
_____
0 1 2 85. Strange ideas (describe): _____
_____
0 1 2 86. Stubborn, sullen, or irritable
0 1 2 87. Sudden changes in mood or feelings
0 1 2 88. Sulks a lot
0 1 2 89. Suspicious
0 1 2 90. Swearing or obscene language
0 1 2 91. Talks about killing self
0 1 2 92. Talks or walks in sleep (describe): _____
_____
0 1 2 93. Talks too much
0 1 2 94. Teases a lot
0 1 2 95. Temper tantrums or hot temper
0 1 2 96. Thinks about sex too much
0 1 2 97. Threatens people
0 1 2 98. Thumb-sucking
0 1 2 99. Smokes, chews, or sniffs tobacco
0 1 2 100. Trouble sleeping (describe): _____
_____
0 1 2 101. Truancy, skips school
0 1 2 102. Underactive, slow moving, or lacks energy
0 1 2 103. Unhappy, sad, or depressed
0 1 2 104. Unusually loud
0 1 2 105. Uses drugs for nonmedical purposes (***don't*** include alcohol or tobacco) (describe): _____
_____
_____
0 1 2 106. Vandalism
0 1 2 107. Wets self during the day
0 1 2 108. Wets the bed
0 1 2 109. Whining
0 1 2 110. Wishes to be of opposite sex
0 1 2 111. Withdrawn, doesn't get involved with others
0 1 2 112. Worries
113. *Please write in any problems your child has that were not listed above:*
0 1 2 _____
0 1 2 _____
0 1 2 _____

Please be sure you answered all items.

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Appendix I

Audit Trail

This audit trail consists of three parts to illustrate my analysis of my study's data from the different data sources. In part one, I have included extracts to show how I open coded data from different data sources. In part two, I use a table to show how I inked data to a thematic code (Table A). In Part 3, again through the use of a table (Table B), I show how I refined my themes through the use of the inclusion and exclusion criteria to ensure that they are relevant and aligned with the data.

Yellow - A win for the parents

Green - A win for the psychologist

Blue - A win for the child

Semi-structured interviews

Extract 1

Like I say, we both, Eliana and I, both went through changes and that wouldn't have been possible if I didn't get regular feedback sessions. We dealt with active anxious, look she was actively anxious at the time and it was becoming a big problem, and now we nipped it in the bud. But it wasn't just you, it wasn't just me, it wasn't just her, it was all three of us. Everybody worked together and say my problem was worse, I'm sure you would've given me even more tools to use to be able to help her and I mean, if there wasn't feedback sessions then she would've been fine, now but I wouldn't of known what, what's going on and if she's really fine, I would've just had to wait and see. Now I don't have to wait and see, I know she's fine, because I know where we've started, I know what we've been through, and I know… So, it becomes team work because ultimately she's not alone in this. She feels alone if I'm not involved...(Winnie)

Extract 2

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Yeah, I definitely, obviously I know Eric's a structured and routine-based child, however I didn't realize that, biggest thing that stood out was where's the floating tree, obviously that sense of belonging or that sense of stability or routine or structure or whatever that represents, is missing. So that helps me a lot to see what's happening in his mind and figure that he clearly is feeling a little lost and drifty I suppose, you know. So that helps me to try and think about things a bit more before I act or make things happen in the household or whatever. And also relay that information to my husband, who's obviously his other parent and my mom who's the other adult in the house, and then between siblings too. My eldest I can speak to him and say "listen, you need to try and x, y, z" or the youngest, try and tech them to be patient with each other and each other's differences. (Cathy)

Extract 3

I definitely take a step back. Whereas before I try and like, "you'll be fine just relax", now I sort of say, "okay you're feeling anxious, how are you going to cope with it? What are you going to do now?". Or I'll say "I hear you, you've got this let me know if you need me to do anything" and then I'll kind of step back a little more. And if I forget, and I say to her "well.." then she'll say "mom, mom let me deal with it, let me deal with it in my own time", cause my immediate wanting to step in and help and help. You know I say to her that I don't want to see you feeling anxious, I want to fix it but I know I can't. It's for her to figure it out in her own time. She's got the tools now, so she's just got to practice using them. ... Definitely, cause I'm like a bit of a controlling, I wanted to like fix it all for her and then get frustrated when it wasn't like fixing, you know... I like the fact that we've met regularly throughout the process. So, there was an initial meeting and then it wasn't just like ten weeks of therapy and then we met at the end again, I like the fact that it was a continuous process and that I was sort of, we met more than once throughout the process. So, it wasn't just you and her, it was actually you, me and her, which I liked ... it's not just her, it's not just you, it's not just you and her, all of us have to be working together to figure this out because she'll only, you know, one would only see the therapist for a period of time, and then it still needs to be managed at home. So, the parent absolutely needs to be an integral sort of part of it, you know. So, I did

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like that, uhm, I liked the fact that you, uhm, without sort of guiding, there were like a little bit of guided questions but it was sort of like, what do you think? How do you interpret? You know, it wasn't like this is how, you know, I see it, this is how, you know, it was more like how do, how are you, sort of seeing it, if you know what I mean. (Kimberley)

HTFWP-drawing elicitation conversation

Extract 4

Clint's First HTFWP Drawing



I use to dream about being small and everything around me is big I had nightmares about that when I was younger, much younger and just when you spoke about it now and you mentioned it I use to have nightmares that everything was so big and overwhelming and I was this small little person (Ashley)

I see that happening with Clint as well now.... But he's becoming this jokey character to sort of mask, his a big joker, like his dad doesn't let things or the way I see it from my perspective he doesn't let things get to him he will rather make a joke about it even up until today like nothing will be too serious for us, where I will go into like frustration and it will bother me and it will eat on me he will turn it into something funny so I actually see that starting to happen now with Clint where he will turn something rather into a joke than to deal with it. Maybe it was a coping mechanism for you maybe it was for you and maybe he's picking up on it as well. (Hadley)

Insight parents had prior to the study. Apply exclusion criteria

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The thing that stands out to me that I think would speak to his anxiety is how perfectly straight the house lines are... Yes, very very perfectly straight where I would have thought a child his age would have drawn it freehand perhaps but it's very straight and and I know Clint is a bit of a perfectionist and if he gets things wrong he's very very hard on himself extremely hard on himself so that stands out… Ashley

The rigidity of the house, I don't know if its…I don't think we are that rigid in our parenting. (Ashley)

Maybe me. (Hadley)

or maybe he wants a little more structure? I dunno... cause sometimes it gets a lot of unstructured it gets like very unstructured sometimes it goes chaotic in the house. (Ashley)

Extract 5

Ella's First HTFWP Drawing



For me I think it's just surprising she normally is a bit more detailed with the people and I'm trying to, I can see that the persons got light I can't really see without my glasses, if she is looking at the fire then it's shade at the back so my first thought was my first thought was it's shade on one side and light on the other but now it looks like a frightened somebody looking at the fire...I like her I like her house with a staircase from the back, I think it's very cool. ..(Grant)

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She's also terrified of climbing stairs, funny enough so I don't know if that is something to do with the fact that she drew stairs there. (Hailey)

Almost like not enough water to put out the size of the fire... it's almost like she is thinking there isn't really a solution…(Hailey)

...the house looks like it's having a big fright. (Grant)

I suppose she hasn't drawn anyone else in the picture but that could be because she feels alone. (Hailey)

Drawings and how elements changed (circled)

Michael's first and last HTFWP drawing



Tessa's first and second drawing



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Table A

Coding Process Illustrated

Extract answering research question	Open code	Candidate themes
...we both, Eliana and I, both went through changes and that wouldn't have been possible if I didn't get regular feedback sessions...and say my problem was worse, I'm sure you would've given me even more tools to use to be able to help her and I mean, if there wasn't feedback sessions then she would've been fine, now but I wouldn't of known what, what's going on and if she's really fine, I would've just had to wait and see. Now I don't have to wait and see, I know she's fine, because I know where we've started, I know what we've been through, and I know (Winnie)	Parent finds the feedback sessions useful	Parent feels supported
 Yeah, I definitely, obviously I know Eric's a structured and routine-based child, however I didn't realize that, biggest thing that stood out was where's the floating tree, obviously that sense of belonging or that sense of stability or routine or structure or whatever that	Sharing the drawing at the feedback sessions help primary informants understand their child and their child's anxiety better	Fostering insight into the child's anxiety

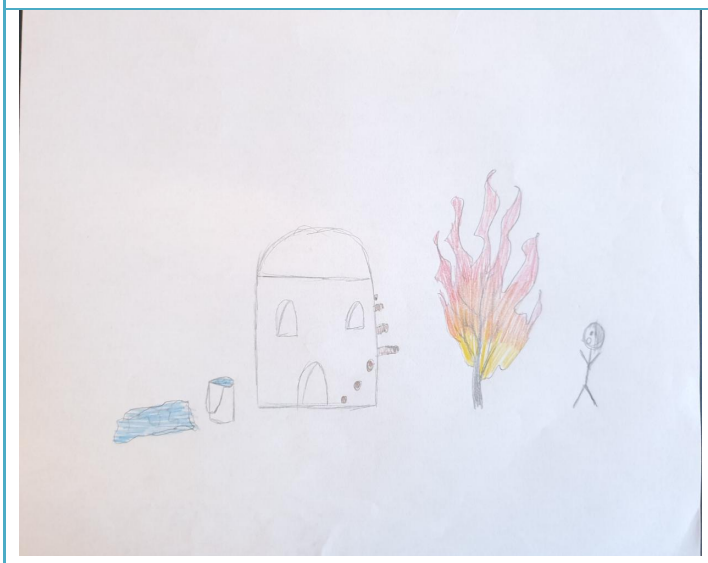
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represents, is missing. So that helps me a lot to see what's happening in his mind and figure that he clearly is feeling a little lost and drifty I suppose, you know. (Cathy)		
So that helps me to try and think about things a bit more before I act or make things happen in the household or whatever. (Cathy)	Parent's insight into their influence	Parental insight
Definitely, cause I'm like a bit of a controlling, I wanted to like fix it all for her and then get frustrated when it wasn't like fixing, you know. (Kimberley)	Parent speaks of parenting style	Insight into the influence of parenting style
I like the fact that we've met regularly throughout the process. So, there was an initial meeting and then it wasn't just like ten weeks of therapy and then we met at the end again, I like the fact that it was a continuous process and that I was sort of, we met more than once throughout the process (Kimberley)	Parent is appreciative of regular feedback sessions	Parent feels supported
So, I did like that, uhm, I liked the fact that you, uhm, without sort of guiding, there were like a little bit of guided questions but it was sort of like, what do you think? How do you interpret? You know, it wasn't like this is how, you know, I see it, this is how, you know, it was more like how do, how are you, sort of seeing it, if you know what I mean.	Parent feels her opinions were respected and feels supported	Parent feels supported

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 The thing that stands out to me that I think would speak to his anxiety is how perfectly straight the house lines are... Yes, very very perfectly straight where I would have thought a child his age would have drawn it freehand perhaps but it's very straight and and I know Clint is a bit of a perfectionist and if he gets things wrong he's very very hard on himself extremely hard on himself so that stands out…(Ashley)	Parent's understanding of child's anxiety deepens	Parental insight
I use to dream about being small and everything around me is big I had nightmares about that when I was younger, much younger and just when you spoke about it now and you mentioned it I use to have nightmares that everything was so big and overwhelming and I was this small little person (Ashley) I see that happening with Clint as well now.... But he's becoming this jokey character to sort of mask, his a big joker, like his dad doesn't let things or the way I see it from my perspective he doesn't let things get to him he will rather make a joke about it even up until today like	Insight parents had prior to the study	Pre-study insight

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nothing will be too serious for us, where I will go into like frustration and it will bother me and it will eat on me he will turn it into something funny so I actually see that starting to happen now with Clint where he will turn something rather into a joke than to deal with it. Maybe it was a coping mechanism for you maybe it was for you and maybe he's picking up on it as well. (Hadley)		
The rigidity of the house, I don't know if its…I don't think we are that rigid in our parenting. (Ashley) Maybe me. (Hadley) or maybe he wants a little more structure? I dunno... cause sometimes it gets a lot of unstructured it gets like very unstructured sometimes it goes chaotic in the house. (Ashley)	How the environment affects their child's anxiety	Parental insight into the influences on a child's anxiety
 it's almost like she is thinking there isn't really a solution... I suppose she hasn't drawn anyone else in the picture but that could be because she feels alone. (Hailey)	Parents start relating the drawing to their child's anxiety	Emerging parental insight

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But it wasn't just you, it wasn't just me, it wasn't just her, it was all three of us. Everybody worked... So, it becomes team work (Winnie)	Parent feels like a co-therapist	Relationship between parent and psychologist is fostered
So, it wasn't just you and her, it was actually you, me and her, which I liked ... it's not just her, it's not just you, it's not just you and her, all of us have to be working together to figure this out because she'll only, you know, one would only see the therapist for a period of time, and then it still needs to be managed at home. So, the parent absolutely needs to be an integral sort of part of it, you know. (Kimberley)	Parent feels like a co-therapist	Relationship between parent and psychologist is fostered
 	An element in the drawing is better developed	Tracking therapy progress
 	The fire in the drawing is better contained	Tracking therapy progress

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…because ultimately she's not alone in this. (Winnie)	Parent's empathy for child is enhanced	Child is better supported and connected to parent
And also relay that information to my husband, who's obviously his other parent and my mom who's the other adult in the house, and then between siblings too. My eldest I can speak to him and say "listen, you need to try and x, y, z" or the youngest, try and tech them to be patient with each other and each other's differences. (Cathy)	Child's environment changes to support them	Child is better supported and connected to parent
I definitely take a step back. Whereas before I try and like, "you'll be fine just relax", now I sort of say, "okay you're feeling anxious, how are you going to cope with it? What are you going to do now?". Or I'll say "I hear you, you've got this let me know if you need me to do anything" and then I'll kind of step back a little more. And if I forget, and I say to her "well.." then she'll say "mom, mom let me deal with it, let me deal with it in my own time", cause my immediate wanting to step in and help and help. You know I say to her that I don't want to see you feeling anxious, I want to fix it but I know I can't. It's for her to figure it out in her own time. She's got the tools now, so she's just got to practice using them. (Kimberley)	Parent adjusts parenting style to support child	Child is better supported and connected to parent

Table B

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Inclusion and Exclusion Criteria

Inclusion and exclusion criteria				
Main theme	Inclusion criteria Data related to how sharing the drawing benefits the role players in a child's therapy process Exclusion criteria Data related to benefits of the different role players in the child's therapy process that is fostered through another mechanism other than the sharing of the child-client's HTFWP drawing series.			
Everyone wins when there is a parent-psychologist alliance created by sharing drawings done by children	Subthemes	Sub-subtheme	Inclusion criteria	Exclusion criteria
	A win for the parent	Fostering insight	Data related to the parent's insight into their child's anxiety being fostered by the sharing of the HTFWP drawing	Data that shows insight that is not directly related to the sharing of the HTFWP drawing. Data where parents show a lack of insight into their child's anxiety. Data on insight prior to the study
		Feeling supported and effective	Data related to parents feeling supported and	Data that explains that parents feel

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		as parents	effective related to the sharing of the HTFWP drawing	supported and effective that is not related to the sharing of the drawing
	A win for the child	Fostering understanding and connection	Data that relates to the child feeling understood and supported fostered through sharing the HTFWP drawing with their parents	Data that relates to the child feeling understood and supported fostered but is not directly related to the sharing the HTFWP drawing with their parents.
		Sustaining therapy gains	Data related to sustaining therapy gains fostered through sharing the HTFWP drawing with the parents.	Data related to sustaining therapy gains that is not related to the sharing of the HTFWP drawing.
	A win for the psychologist	Building rapport with	Data relating to the rapport between	Data related to rapport building

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		the parent	the psychologist and the parents as fostered through sharing the HTFWP drawing series with the parents.	not related to the sharing of the HTFWP drawing series with parents.
		Feedback on therapy progress	Data related to tracking therapy progress via the changes seen in the HTFWP drawing series.	Data related to tracking therapy progress that does not come via the changes seen in the HTFWP drawing series.

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Appendix J

Three Samples from My Reflexive Journal

27 January 2023

I have collated biographical information and tabulated it – relating to the literature.

I looked at all the data I have and it's scaring. I need a way to manage this data. I found Nvivo online and its a good tool to manage all my data. Like keeping it in one cupboard but now the cupboard has drawers I can look into, so I can group similar sections (like all the intake interviews) and easily access. It also has coding possibilities.

Step one – just code

Step two – make code groups that are thematically similarly

Step three – now can play with the groups and look at it from different perspectives – gender, age etc

In Nvivo you can make a list of attributes.

I've also printed out my research questions in a massive font and placed where I can see so that I code per question

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14 February 2023

Parent realises son has emotions he might not want to share with her and is comfortable sharing these feelings with his psychologist which she is okay with...

Go through all interviews based on the insight question to see what other parents had to say about their insight before paraphrasing each one. Then look through the paraphrasing for each to find the commonalities. This parent may be the only one to say this which makes her an outlier. Once I know that I can decide what to do with that.

Currently, I've coded insight before for each case separately and then looked for similarities and differences. I've done the same for, insight during feedback sessions and insight after the process.

I noticed many parents spoke about the impact of anxiety on the family also impact of pressures at school on child's anxiety...these sound like insights related to causal

A lot of detail was given for question one and two from the semi-structured interview. I need to distil in all that detail about what parents understand/know about e.g. impact on the family, what contributes to anxiety etc.

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10 March 2023

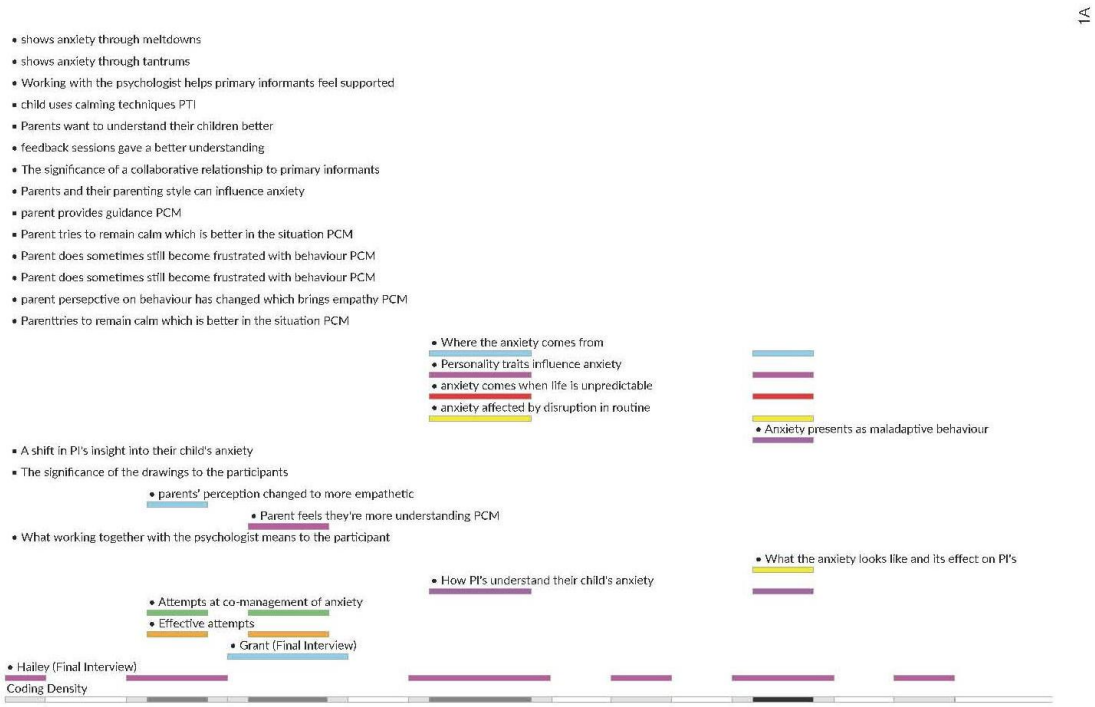
I'm checking for saturation for themes at the moment. I placed the themes in a diagram just to help me reflect on my themes. Just looking at what I have I can see my diagram will change over time. This gives me an idea of whether all, most, some informants have contributed to the themes.

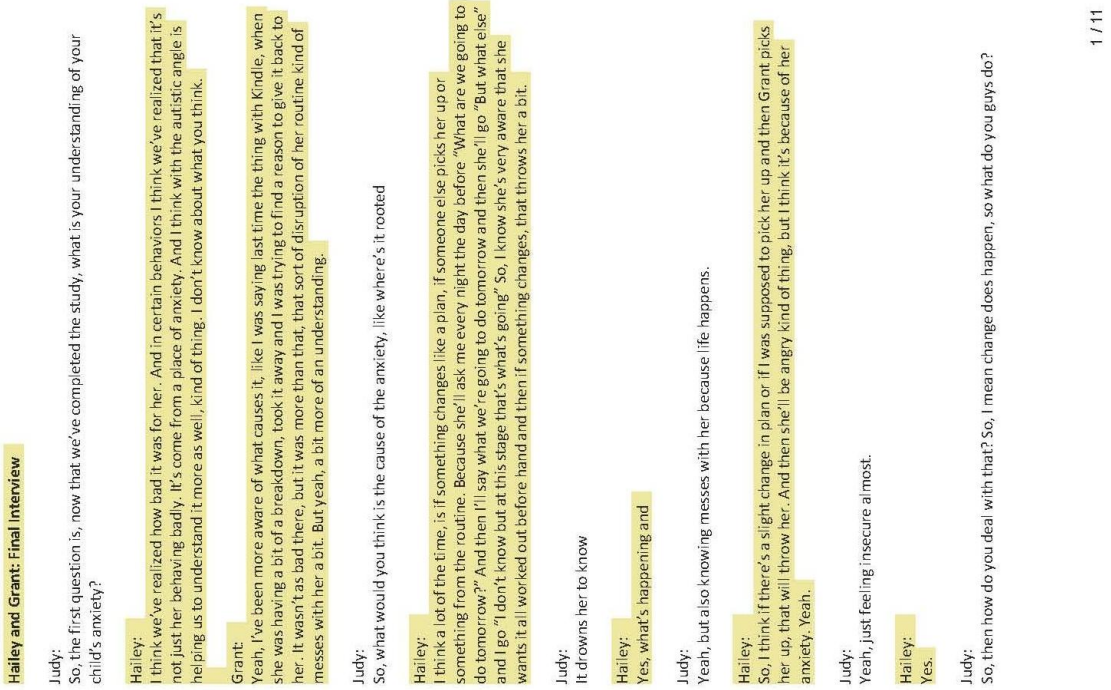
Of the seven families, in two both mother and father were present for sessions. Do I then speak about 9 caregivers when reporting my findings or 7 families/cases. During sessions when both parents are present, I do notice that when chatting about a topic, one would speak and then the other would add to this thought. So they discuss topics as a unit. My rapport with them was then more like a unit so for this reason, even though I have 9 parents, I'll speak about seven families/cases.

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Appendix K

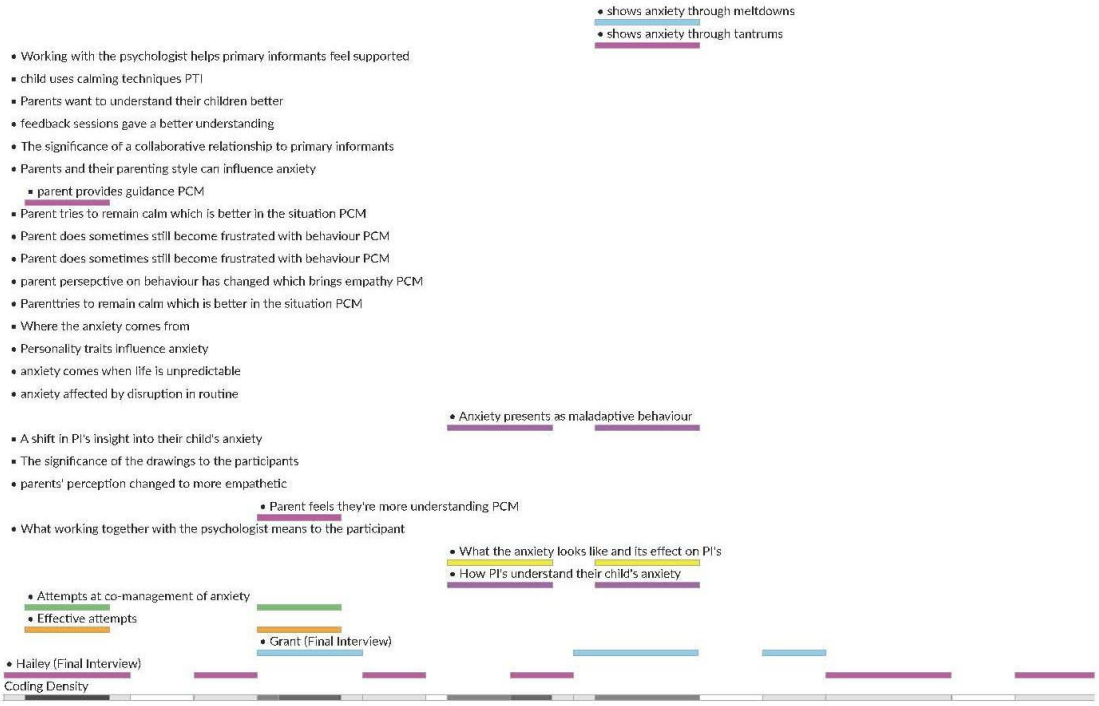
Sample of a Coded Transcript





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2A



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Hailey:
We try to prep her as much as we can if we know somethings going to change, like picking up or whatever but sometimes it's hard because sometimes things happen that you can't predict. So, we, I think we just sort of talk her through it or something, I'm trying to think now, if anything's happened in the last, specifically

Judy:
So, helping her manage it is to just prep her. That there's going to be something different or

Hailey:
Yeah.

Grant:
I think also to just be a bit patient with her, to get from A to B but sometimes you have to get going or whatever and then, like if you're on your way somewhere and you need to leave and she first want to finish her chat or something.

Hailey:
Yeah, because you have to give her warnings.

Judy:
Okay, that helps. So, you were also saying that she, when you were angry picking her then she was, I mean when you were late picking her up she was angry. And so how else does she show her anxiety?

Hailey:
Shouting.

Grant:
Yeah, she just has a meltdown and has a tantrum. Then you, then sometimes you don't know why, like if it's for other reasons other than things aren't going the way that they were. So, I think the anxiety comes from something else but she deals with it by reading or whatever she does. And if you disrupt her then, she doesn't know what she's angry about or anxious about but she just has a higher, a lower thresh hold of

Judy:
Tolerance.

Grant:
Tolerance, but she's been quite good at managing herself sometimes when she knows it's

Hailey:
I noticed on the camping trip she bought an orange heart that my mom had knitted her, and she was squeezing that and she was walking around with it. So, I thought she's obviously feeling anxious, she was very excited about it but I think she was feeling a little bit anxious but then I saw her walking around with it in her hand and squeezing it and stuff.

Judy
Okay, so she's pre-empting things as well.

Hailey:
Yeah, and she also brought a little box of like fidget toys and stuff that she plays with in the camping

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stuff as well that she packed in, I didn't realize, I saw it when she was unpacking. So, it's almost like she brought that with to help her.

Judy:
Yeah, I don't know if you remember the last talk we had, I asked her "So, how do you, how can you prevent these things from" and then she said "But when you're playing you don't really notice these things happening". So, it's nice to hear that she's actually trying to pre-empt things. Okay, so that's one way of her trying to manage things herself. Do you notice other ways that she tries to do this?

Grant:
Mostly we notice when she loses her

Hailey:
Yeah. But she has done stuff, when she first started seeing you she did something where she said "I'm going to go and" she was stressed about something and she said," I'm going to go and do what Judith taught me now" and then she went into her room and like calmed down and then came out again. So, she has picked up stuff that you've, tools that you've given her. She has used them, she doesn't always show us those are, but at least she does them and it calms her kind of thing.

Judy:
I think one way for her to show you is to say "Can you give me a tool, because I'm feeling a bit you know, because work is overwhelming like give me something that you experience"

Hailey:
Oh that's a good idea

Judy:
Because then she doesn't feel like you're checking up on her and she's actually helping you. And I was just thinking of, like sometimes you said you don't know why this is happening and she goes into her books. So, her books, they very, it's a quiet space where she has control and could it be, and it's often with children on the spectrum that they just get overwhelmed by so many things around them and then she needs to just withdraw and go into her world

Hailey:
I think so, definitely. Because if we're in a more, or if we've been to birthday parties at like the Spur and stuff she actually wants to go home, she says "I need to go home now" and

Judy:
It's too unpredictable

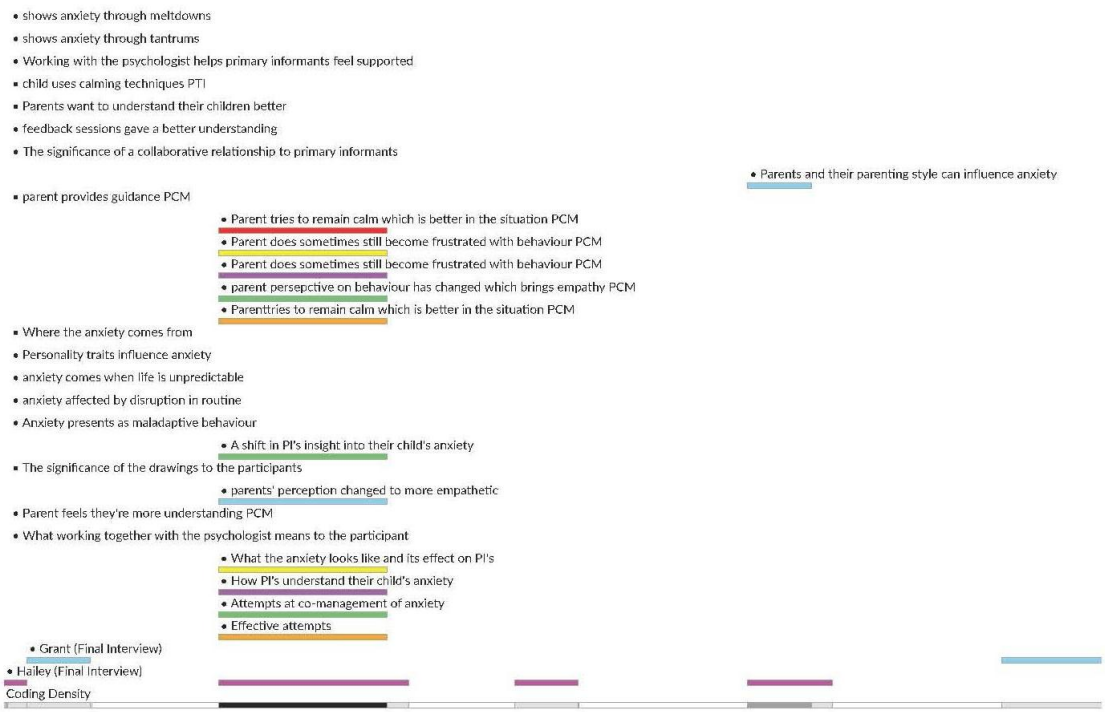
Hailey:
And it's too I think overwhelming with all the noise and all that stuff. So, she definitely doesn't like noisy places and things like that, she does get overwhelmed.

Judy:
So, that is her way of just cutting out all the outside stimuli. Okay so, what is it, do you see a difference to before she came to now where she's at the moment?

Hailey:
Yes, it's definitely less, before the tantrums, well outbursts were every single day, multiple times a day, now it's not. Now it's like maybe once or twice a week

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4A



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Grant:
Yeah, it's not too bad.

Judy:
Okay, and have you noticed a change in, I know you said that at the beginning, she did, she used the technique and then at camp she pre-empted possible, and you guys have changed in your way of looking at things?

Hailey:
I think we've had more patience, well from my side anyway, I think I've realized it's more anxiety than behavior in some instances and I think I've sort of not reacted as much to try and sort of, I think I've tried to stay calm, calmer than I was before. Where before I'd be like "just stop screaming" where now I'm just sort of letting her and then she stops sooner because I'm not getting worked up as well, kind of thing. So, I think it's just helped me to sort of put things in perspective and just like, not always. I mean after an hour sometimes I do lose it when she's screaming at me for an hour, I will say "just stop now" but it definitely hasn't been as much as before.

Judy:
Could it be that the next step is, I see when you do that, obviously when she's calmed down already, when you do that, I know, I'm assuming that you're frustrated, you angry, you anxious is there a better way to express that?

Hailey:
Okay

Judy:
Because she is a bright girl and so to speak to her like that, like say everybody feels anxious and frustrated at times but not everybody can go around screaming. Imagine what the world would look like, so can you think of a better way to express it? And a way that will help people actually listen rather than have other people shut down. Like what happens to you? So, you can say how it makes you feel, "It makes me feel like, I just want it to stop, and I would rather want to assist" So, yeah. Get it from her, maybe that would be the next step

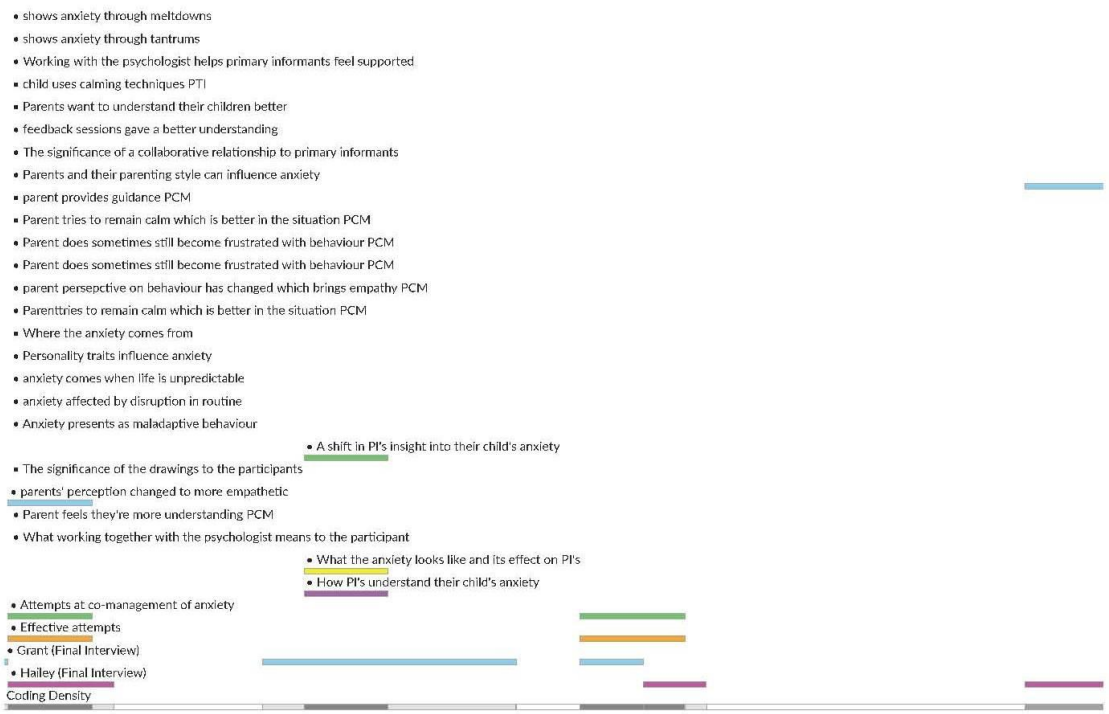
Hailey:
And I think we do it when she's in the, I think I try and say stuff like that when she's in the meltdown instead of afterwards when she's calm.

Judy:
So, when she's in the meltdown, she's in a different part of her brain, she's not in the reasoning part, she's at the back here. So, yeah she has to first calm down so the reasoning part is engaged again and then you can speak. So, it doesn't have to be after meltdown, it can be anytime, like if you guys are walking and then you just start talking about those things. Or if you in the car, so it's moment when you have her undivided attention, like she can't leave the room, so you driving somewhere and maybe, either one of you, or you walking, or yeah something like that.

Grant:
She's quite funny when you say it now, "Yesterday you were very angry" she says "It's in the past, let's not talk about the past"

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Hailey:
But I think she feels embarrassed after the fact, I think she gets very embarrassed. And she's very embarrassed to say sorry, like she doesn't actually say sorry but she will come and like give you a hug or something and I think it's just her embarrassment that she behaved in that way.

Judy:
So, I think saying, okay just say "You know when you were screaming, this is what happens to me and this is what I would prefer. I want to be there for you, but can't we do that differently?" So, you not saying, pointing fingers and saying you were angry or, you trying to find a solution together with her. Okay, so, the next question is how do you respond to that behavior. So, how do you respond? I mean I heard how you. So, Grant how do you respond to that behavior?

Grant:
I've tended to be more, I'm just more laid back than Hailey generally. If things don't go the way I expected them to, I'm you know, I'm not that bothered. But I think I've been more aware of, I don't know, I just sort of realized that she's just a bit odd. But she just has a different way of seeing things and responding to things and sometimes there's just no way of getting through to her with one thing or the other. So, I tend to stay calm for maybe five seconds longer than Hailey. But generally, she, Ella she likes to punch me and head butt me and that doesn't really, then she gives me a hug. She just gets frustrated. But generally, I try to stay calm as long as possible and I think with the whole trying to take her Kindle away from her, I learnt a lesson there not to try that again. But yeah, she's just always trying to negotiate things and then I've been a bit better at saying to her "Get your own noodles" when she wants noodles. So, she's actually been doing that.

Judy:
So, you, so in that way you've changed? You not

Grant:
Yeah. Better at saying "get it yourself" yeah. So, if I'm in the kitchen and she wants something I'll

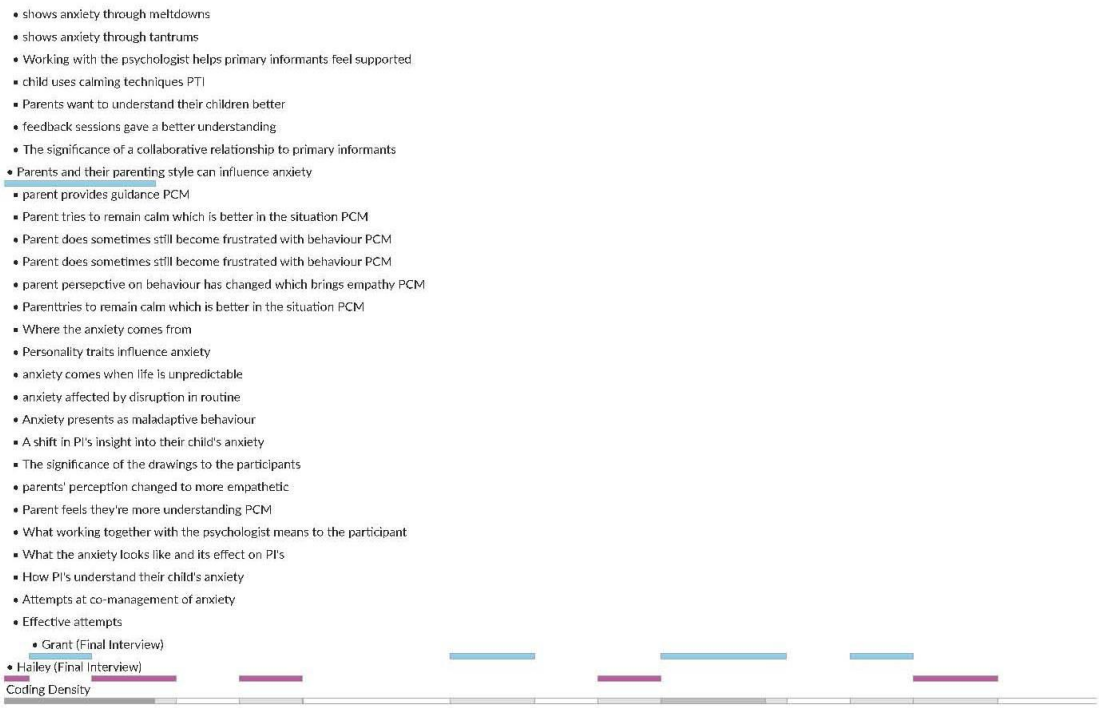
Hailey
But you have been better at letting her do it herself.

Judy:
So, I'm thinking, that when she's at school or with me, she's you know that controlled person, and then when she gets frustrated at home. So, what we try, what we need to do is to try and get her to the middle. So, that when she's at school she doesn't have to be so controlled. She can just be and then when she's at home, she doesn't have to get so frustrated. So, that could be part of the talk that you have with her, "How can we do this better so that, also when you're at school and you get frustrated, you can also express it instead of just bottling it quiet and trying to be invisible." So, this is, so when I did things with Ella it was like just plant a seed and then just leave it alone because she then immediately wants to block, and then you just say something and then you just do something else. But that seed is kind of, so for example, me saying "You know, what can you do to prevent this?" "No but you just can't notice these things when you're playing." So, she's so very logical but she's blocking but I just leave it but the seed was planted. So, to just you know plant a little seed. So, even if you think "Oh my gosh. She's not listening to these ideas". She kind of is, and she's bright so she will

Hailey:
And she's quite thoughtful, she like writes notes on her phone, sometimes I'm not like "Did you write that or did you copy it from somewhere" and she'll be like "No I wrote that".

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Grant:
Yeah, like inspiring quotes and things.

Hailey:
Quite like, inspiring, thoughtful stuff so she's very, she does think about things. But I don't think she verbalizes them as much to us but then she writes it

Judy:
Which is fantastic

Hailey:
Which is good, so yeah

Judy:
So, that's great that she does that, it's great that she draws, it's great that she reads. She's got all the you know, things that you want school kids to do. Now we just need to get that other part sorted just to, because that will socialize her better with other kids and will make life at school easier. So, just think about how to approach it so that she doesn't feel threatened and feel like she's on the spot and that you guys are trying to figure things out together.

Grant:
We were at the Checkers yesterday and she wanted some chips, I said "I'm not buying you chips now" and she said "Well then I'm going to tell you random facts about dinosaurs"

Judy:
And she knows many

Hailey:
She did yeah

Grant:
She carried on and on and on and on, I can tune her out after a while and I feel a bit bad because then after half an hour she's actually saying something to me and I don't hear. Yoh, she can go. But she didn't, it was actually maybe positive. She didn't have a tantrum, she just weaponized her knowledge to dinosaurs.

Judy:
So, you didn't get the mushroom talk, you had the dinosaur talk.

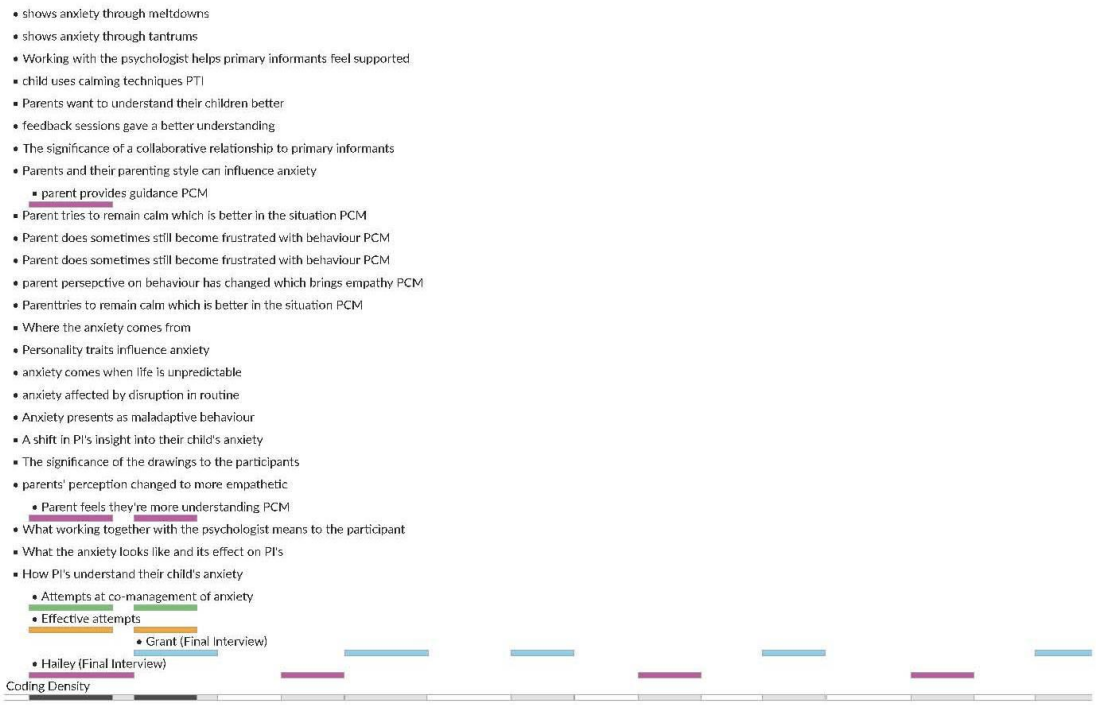
Grant:
Yeah. We had the mushroom talk yesterday.

Hailey:
I heard her telling the children on camp all about mushrooms. Should be a mycologist or something else, an engineer.

Judy:
She's already thinking in that direction. Mmm. She's going to be awesome, whatever she chooses. So, if you think about three words that describes the word you help her manage her anxiety, what would you say they are?

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7A



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Hailey:
I think for me I would say more understanding. From my side. And then, I think talking and just loving her through it kind of thing. Like afterwards when she wants a cuddle, I just give it to her, because I think she's feeling vulnerable.

Grant:
Humor, hugs and patience, for me. Humor, because she likes, if she's angry and you do something really funny, then she does find it funny.

Judy:
Oh, you can speak to her

Hailey:
Sometimes, not when we took the Kindle, that wasn't funny.

Grant:
Yeah, but there's somethings that she'll find funny. Sort of, angry laugh but she thinks my jokes are lame but

Judy:
But it gets her going. Because that is, that shows some kind of flexibility there, that she's able to switch out of that anger mode and hear what you're saying, that she can react to it.

Grant:
Not often.

Judy:
But

Hailey:
But it's a start.

Judy:
Yeah, that is a sign of hope, that there is a little bit of flexibility, you not working with a brick wall. You can shift. So, you said, you used humor, what was the other two?

Grant:
Patience and hugs.

Judy:
Okay so, there's loving on both sides. With you, it's more understanding. So, do you find that your perception of what is happening is a little bit different.

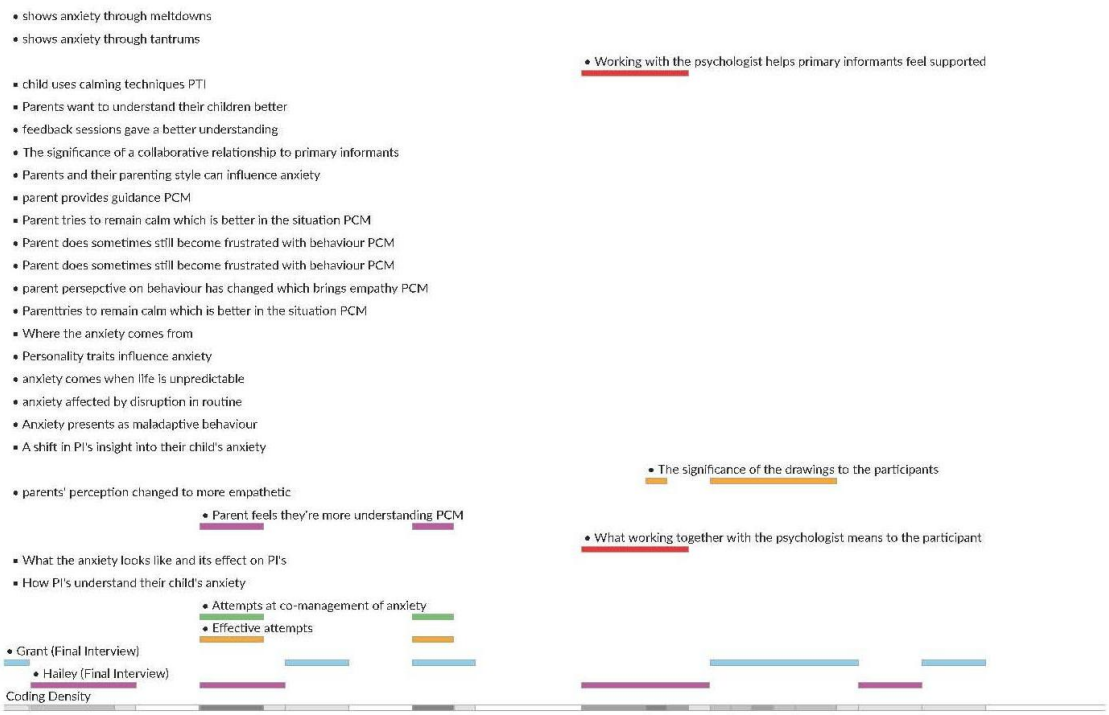
Hailey:
I think so for me.

Judy:
What would you say Grant?

Grant:
Uhm yeah, I think it is a bit different. I'm more

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8A



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Hailey:
I think we've both been calmer. I mean you are normally calmer than me, but I think we've both, even when it's been going for an hour we manage to stay calm because normally that's our breaking point, after an hour of screaming. But we've kind of both managed to stay calmer.

Judy:
So, what has made that happen?

Hailey:
I think for me it's the more understanding. Like for me it's like, she can't actually help this, she's not doing it to get to you, she can't help herself kind of thing.

Grant:
She's stuck.

Judy
Would you say the same for you or what's the difference for you?

Grant:
Yeah, I think more, I appreciate it more the fact that she just gets stuck in some ways than usual.

Judy:
So, moving away from Ella and moving a bit more towards what we've been doing with these feedback sessions that we've had. Okay, so the question is, if your child went to therapy again, what would your expectations of a parent psychologist feedback session be?

Hailey:
I quite like this sort of in between the sessions. So, it hasn't been like you saw her for ten sessions and then us at the end of that long, I think the constant communication in between was helpful. So, we could sort of see the progression and sort of help her earlier on in the counseling journey, for me anyway.

Grant:
I think it was very helpful to see the picture and how it changed. And to think about what it meant, in terms of where she was, in terms of her anxiety and stress. And if I think about that then I, also helps me to see that she's come quite a long way over these last few months. And realizing the need for her to build up confidence in things, and I think like getting her to make her own food or whatever, telling her she can actually do it. Not that she doesn't think she can

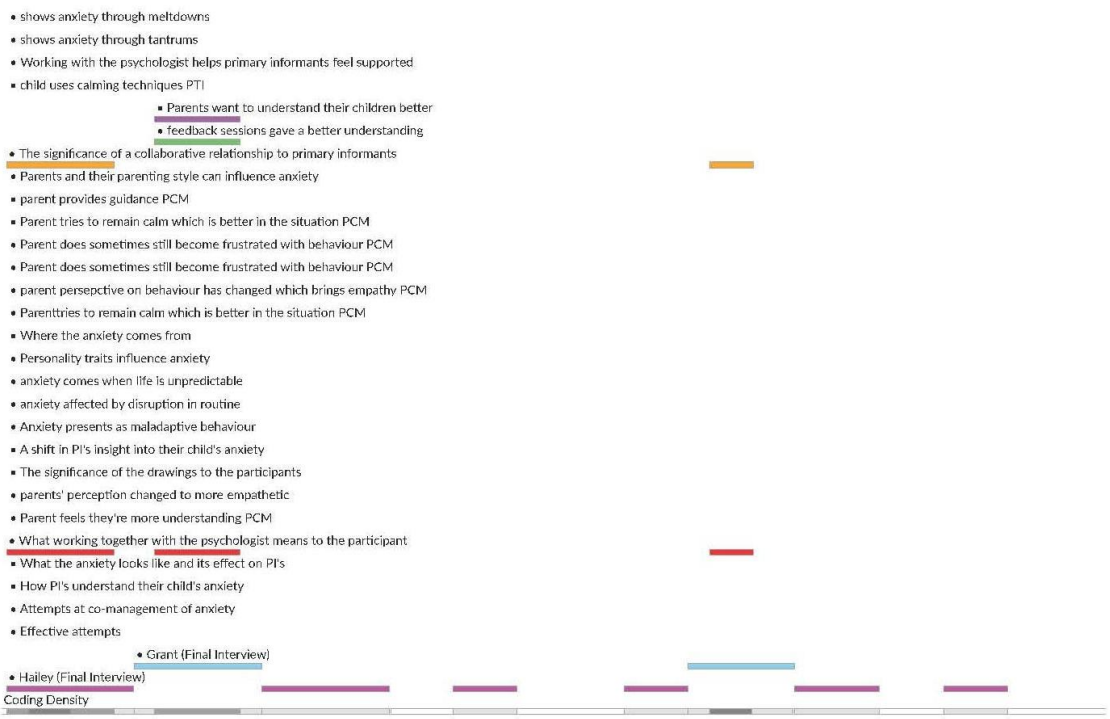
Hailey:
Just a bit lazy.

Grant:
But yeah, I think she feels a bit more empowered in those things.

Judy:
Mmm, giving her the responsibility as well. Okay, so how do you think a working collaborative relationship between parent and psychologist fits into a child's therapeutic process? So, you did say that the fact that you didn't get it right at the end only. Works better for you

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Hailey:
I think also from a teaching background, the sooner the parents are involved and you're working together the easier and the quicker the sort of outcomes are. So, for me it helps to work together, like if you give us feedback and we try that it helps obviously quicker than hearing at the end kind of thing.

Grant:
I think it's also nice to sort of come and, so we gone ten, eleven years without consultation you know, and to have somebody else sort of have a look and then to come back with some sort of hypothesis and then you go back and see how that works out at home. And then you get some insight and apply it. So, I think that coming back, applying it, and going, and coming again and saying

Hailey:
If I compare it to Zack who's seeing a psychologist now for the last year, in the beginning we were seeing him as a family but then he's just seeing Zack. Not that I want to know what 's going on with him and Zack talking but it would be helpful to know what we can do to make it easy, so you kind of don't know what's going on.

Judy:
So, this model is different because we work team kind of.

Hailey:
Team yeah.

Judy:
And then as Ella progresses the team also is updated because as you saw with the pictures, as you were saying Grant, it changed. So, if you had seen the first one and then the last one you would've missed

Hailey:
Exactly, the middle part. Because we've never actually had counseling in between

Grant:
I also think maybe there's an age where you can and can't, like Zack is more of a teenager you can't like, but at this age you can do this and she's not phases by the fact that we coming to talk about her. But I think Zack would find that a bit

Hailey
No, like I said it's not that I want to know what Zack's talking about, it's not that I just want to know if there's stuff that we're doing, that's not helping him improve

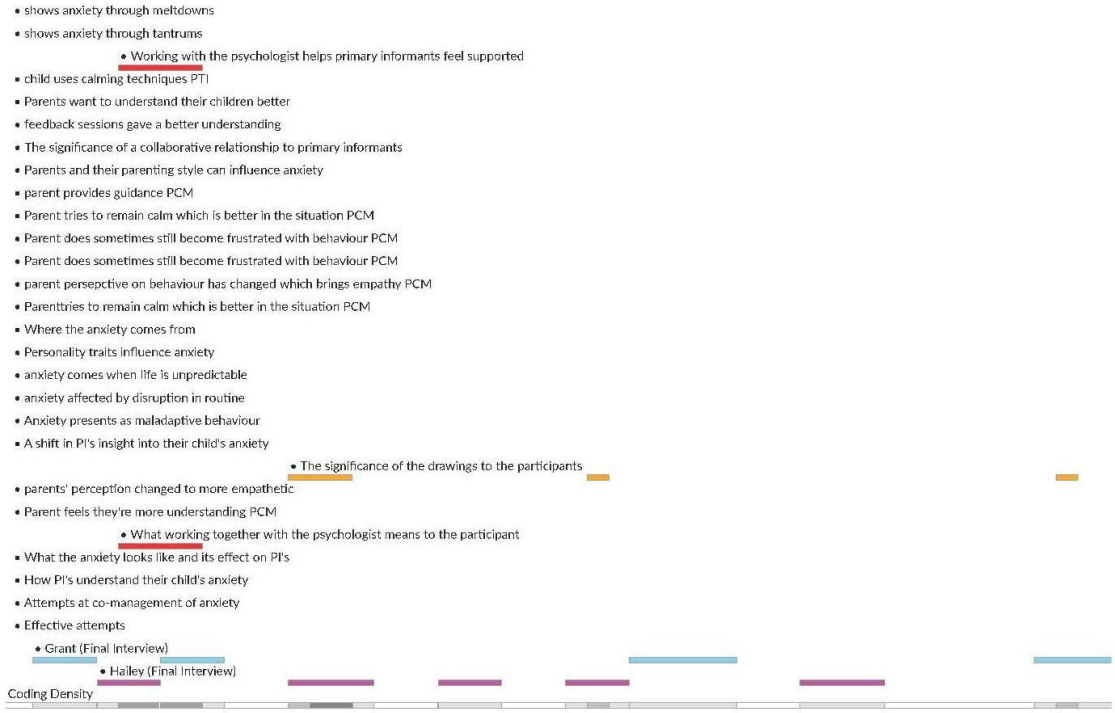
Judy:
How you can adapt your parenting.

Hailey:
Yeah, I think that's more what I mean.

Judy:
Yeah, and as we, even though, yes we chatting, but it was with Ella's consent. So, every time she did a picture, I would I ask "Is it okay if I share this and we chat about it just the way you and I have?" and she said "Yeah it's fine"

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10A



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Grant:
Yeah, she's a more open.

Hailey:
And she was quite fine with us coming.

Grant:
I think she also knows that we need help. She knows that she's complicated.

Judy:
Okay, so, what aspects of feedback sessions could be considered particularly useful? Would you say?

Hailey:
I like the, explaining the drawing, well discussing the drawing thing and seeing that progression. It sort of gave more understanding of where she was at I think. So, I found that very helpful.

Judy:
Yeah, something concrete to look at.

Hailey:
Yes, yeah. And then you can sort of remember it in your mind, as well kind of thing.

Judy:
Oh yeah, I didn't think of that.

Hailey:
Because for me I'm more of a visual person so it, I remember it more than if it was just verbal.

Grant:
And I think yeah, hearing your experience or observations of her and having some idea you know, like you say she's so reserved in this place and then you see her change when she comes out, those things.

Judy:
And I think the drawing really, kind of stimulated conversation.

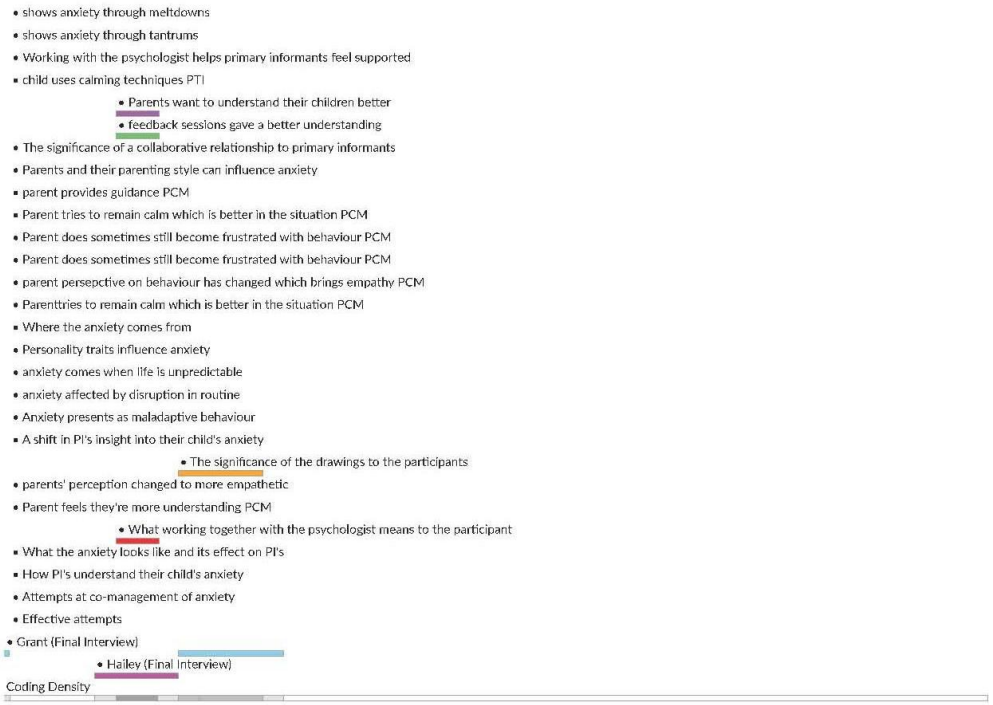
Hailey:
Especially for someone like Ella who doesn't easily talk to people. If she's doing something she likes then

Judy:
And yeah, she loves drawing and expressing herself. So, I could ask her about the house and, it's not directly you are like A, B and C. We working through, which is the same as the sand play. So, I think that was great for her, but also I think it helps with parenting feedbacks because we go in avenues we may not have gone to. And also I'm not speaking at you, you know, I cannot do it without your input.

Grant:
It's quite nice it sort of brings her voice into the conversation.

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Judy:
Yes, it does. Okay, the last question, what do you think he possible value of feedback sessions could be? For families, for you as parents?

Hailey
I think for me more understanding of situations or our situation or like our parenting and stuff like that and understanding how she's feeling. So, for me it was just understanding more.

Grant
It was quite, like that first picture and, I think of Ella as quite steadfast and you know, head strong and all those things but in that first picture how insecure it sort of came across. It was helpful to get that feedback to understand more of where she is and then being able to help her a bit.

Judy
It's funny how the pictures actually have a feeling about them, like you can sense stuff that you wouldn't normally. Okay, so, that's the end of our interview.

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Appendix L

Confidentiality Agreement for Transcriber

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Faculty of Education

Confidentiality Agreement for Transcription Services

Title of the research implicated in this declaration:
Using drawings made by anxious children in therapy to advance rapport between parents and psychologist

Ethics Reference No: EDU168/21
Doctoral Student: Judith Bredekamp

As a transcriber of this study, I understand that I will be listening to audio recordings of private and confidential interviews. The information relayed in these audio recordings has been willingly revealed by participants, who expect strict confidentiality. I understand that I have an important responsibility of honouring this agreement of confidentiality.
I agree not to discuss or share any information found in the audio recordings with any third parties except the doctoral student, providing the audio recordings. I am confirming that I will strictly adhere to the agreement in full.

I, _____ transcriptionist, agree to maintain full confidentiality of all research data received from Judith Bredekamp related to this research study.

1. I will treat the identity of any individual that may be revealed during the transcription of interviews as highly confidential.
2. I will hold in strictest confidence the contents of the recordings.
3. I will not make copies of any audio-recordings or other research data.
4. The research data will not be discussed with or provided to any third parties without Judith Bredekamp's consent.
5. I will transcribe the audio recordings in private, and I will store all study-related data (while working on them) in a password protected file on a password protected device.
6. All work completed by me will be sent to Judith Bredekamp via a password protected file.
7. When I have received confirmation that the transcription work I performed has been satisfactorily completed, any of the research data that remains with me will be returned to Judith Bredekamp or destroyed, pursuant to the instructions of Judith Bredekamp.

Transcriber's name (printed) _____

Transcriber's signature _____ Date _____

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Lefapha la Thuto

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Appendix M

Recommendations for Using the HTFWP Drawing and Sharing Them with Parents

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RECOMMENDATIONS FOR USING HTFWP DRAWINGS

SETTING THE SCENE

Obtain informed consent and assent at the beginning and assent after each drawing. Essentially the assent has to be in child friendly language. For example:
Right at the beginning I asked you to sign a piece of paper giving me permission to share your drawings with your parents. You said yes then, but you are allowed to change your mind at any time and that is why I am asking you again. I will not be upset with you if you say no. Or you may have questions before you decide if it's okay for me to share your drawing with them. Next week (or whenever the meeting with parents will take place), I meet with your parents again and I would like to share your drawing with them so that your parents and I can have a conversation about your drawing, just like the chat you and I just had. Will you be okay with me showing them your drawing so that I can have that conversation with your parents?
.

Provide several sheets of blank white A4 paper and a variety of coloured pencils, an HB pencil, sharpener and eraser.

PRE-EMPT PITFALLS

Iconic spePre-empt pitfalls that can lead to a child feeling anxious when considering the setting for the drawing. For example:

- Use a table that is big enough for the stationery while still allowing for enough space for the drawing activity
- Use a plastic table cloth to allow for easy cleaning
- Put the child's mind at peace if there is a spill by saying something like, "Oh that happens sometimes, but luckily the floor is tiled so it is easy to clean."
- Enough sheets of paper in case the child makes what they consider a mistake.

c

DRAWING INSTRUCTIONS

I would like you to draw a picture of a house, tree, fire, water and person. You can do it in any order. It is not about how well you draw, but more about the story your drawing is telling me.



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HTFWP DRAWINGS

Provide several sheets of blank white A4 paper and a variety of coloured pencils, an HB pencil, sharpener and eraser.

WHAT DO YOU DO

Have other artworks in your room to help you illustrate the drawing instructions. E.g. drawings by an established artist like Portchie that tells a story, and drawings by a child.

.

Observe the child when drawing, writing down your observations. Explain to the child why you are writing by saying something like:
What you are doing is important and sometimes I need to write things down to help me remember how you did the drawing.

After the child completes their drawing, say something affirming like; "Wow! You really worked hard at that" or "you were concentrating so well when you did that drawing," making sure not to comment on the quality of the drawing.

Ask the child for their story/explanation of their drawing after they have completed their drawing.
Remind the child that their story is important.

Try to understand the child's perspective in their drawing, sandplay scenes and drawing narratives before meeting with their parents; then bracket your understanding (i.e., put aside your preconceptions).

FOLLOW-UP OPEN-ENDED QUESTIONS

How has the way you have drawn the house/tree/fire/water/person helped you tell that story?
Can you tell me more about the characters/objects in your drawing?
What emotions/feelings do you think the drawing represents?
Are there any specific details in the drawing that stand out to you? What about that detail makes it stand out?
How does the drawing relate to your experiences/thoughts about anxiety?
In which way have the colours you used helped convey that story?

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Make parents feel welcome in your therapy space – being careful with regard to seating and creating rapport.



HTFWP-DRAWING ELICITATION CONVERSATIONS

If the child's drawing is particularly upsetting say something like:
"it is amazing how well children can show us how they feel through their drawings, but it can sometimes be hard to bear. But we can now do something to change things".

INSTRUCTIONS BEFORE SHOWING PARENTS THE DRAWING

I am about to show you a drawing done by your child that they have given permission for me to share with you. I am showing you this drawing so that we can better understand your child's challenges and gain a glimpse of the way they view life. It may be your natural response to focus on what you see rather than how it makes you feel, but the first thing I would be interested in are the feelings the drawing evokes and then what the various aspects of the drawing make you think of with regard to your child, your family, or yourself. You could start with your immediate emotional reaction to the drawing.

FOLLOW-UP OPEN-ENDED QUESTIONS

What emotions or feelings arise for you as you look at this drawing?

What thoughts or associations come to mind when you look at the different elements of the drawing?

How do you understand the use of colours and symbols in the drawing?

What aspect of the drawing resonates with your child's experiences, your family dynamics or your own reflections?

Are there any particular details or patterns in the drawing that stand out to you? If so, what do you think they might represent?

Which part of this drawing tells you about your child's anxiety?

Which part of the drawing speaks about your child's autonomy/self-sufficiency or dependency?

Just looking at the elements of the drawing, which parts do you wish were different?

Which aspects speak about resources and resilience in your child?

What gives you a sense of hope?

Respond to parents' comments about positive changes at home with emotionally charged language. E.g., "Wow! That must make you feel so good. How did you manage to do that?" Or "What did you do differently so that you were able to get that change?"

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Appendix N

Confirmation of Article Submission

Judith Bredekamp

From: Psychology and Psychotherapy: Theory, Research and Practice [no-reply@ablypanrex.com]
Sent: Monday, 30 September 2024 1:12 PM
To: Judith Bredekamp
Subject: Manuscript submitted to Psychology and Psychotherapy: Theory, Research and Practice

Dear Judith Bredekamp,

Your manuscript "THE BENEFITS OF SHARING HOUSE-TREE-FIRE-WATER-PERSON DRAWINGS WITH PARENTS WHEN THEIR ANXIOUS CHILD IS IN SANDPLAY THERAPY" has been successfully submitted and is being delivered to the Editorial Office of *Psychology and Psychotherapy: Theory, Research and Practice* for consideration.

You will receive a follow-up email with further instructions from the journal editorial office, typically within one business day. That message will confirm that the editorial office has received your submission and will provide your manuscript ID.

Thank you for submitting your manuscript to *Psychology and Psychotherapy: Theory, Research and Practice*.

Sincerely,
The Editorial Staff at Psychology and Psychotherapy: Theory, Research and Practice

By submitting a manuscript to or reviewing for this publication, your name, email address, and affiliation, and other contact details the publication might require, will be used for the regular operations of the publication, including, when necessary, sharing with the publisher (Wiley) and partners for production and publication. The publication and the publisher recognize the importance of protecting the personal information collected from users in the operation of these services and have practices in place to ensure that steps are taken to maintain the security, integrity, and privacy of the personal data collected and processed. You can learn more by reading our data protection policy. In case you don't want to be contacted by this publication again, please send an email to pspt@wiley.com.

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Appendix O

Article Submitted to Journal

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THE BENEFITS OF SHARING HOUSE-TREE-FIRE-WATER-PERSON DRAWINGS WITH PARENTS WHEN THEIR ANXIOUS CHILD IS IN SANDPLAY THERAPY

Abstract:

Introduction

The purpose of this study is to critically reflect on the value of the House-Tree-Fire-Water-Person (HTFWP) drawing as a tool to engage their parents for when children aged 10 to 12 are in sandplay therapy for Generalized Anxiety Disorder (GAD). To do so, we draw on empirical work that addressed gaps in the existing parent-psychologist alliance literature by exploring the usefulness of sharing the HTFWP drawing series with parents at feedback sessions.

Methods

We employed an instrumental, multiple case study design. The sample consisted of 7 purposefully selected cases, involving parents (n=9) and child-clients referred for GAD (n =7). Parent-generated data included the verbatim transcripts of intake interviews, three HTFWP-facilitated feedback sessions, and a post-intervention interview. Child-generated data included three HTFWP drawings and child-driven explanations of these drawings. Using reflexive thematic analysis, we identified patterns in the transcribed data and drawings.

Results

An alliance created between parent and psychologist through sharing the HTFWP drawing series with parents was a win for everyone (parents, child and psychologist). This 'win-win' situation included enhanced care for the child, bolstered parental support, and heightened efficacy for the psychologist.

Conclusion

The HTFWP drawing is has high potential to support the therapeutic process, with emphasis on its facilitation of a parent-psychologist alliance and spill-over benefits for parents, the treating psychologist and the child client.

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Keywords:

anxiety in children, GAD, House-Tree-Fire-Water-Person drawings, parent-psychologist alliance, resilience to anxiety, therapy

Data availability statement:

The data that support the findings of this study are available from the corresponding author upon reasonable request.

Acknowledgements:

We would like to thank the parents and children who made this research possible.

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Introduction

Generalized Anxiety Disorder (GAD) is one of the most common anxieties in children (Brown, 2019; Sonmez et al., 2020). It is characterised by uncontrollable, persistent worry for more than six months and cannot be alleviated by reassurances (Yang, 2023; Zygouris et al., 2022). In short, GAD undermines children's health development and challenges family functioning (Gouze et al., 2021; Meers et al., 2020). It is therefore not surprising that many parents seek therapy for children presenting with GAD (Brown, 2019; Zygouris et al., 2022).

Psychologist-parent rapport and parent involvement in their child's therapy are key to positive therapy outcomes (Núñez et al., 2022; Zorzella et al., 2017). However, how best to involve parents in their child's therapeutic process and build rapport with them, is unclear. This is particularly unclear when children are in therapy for GAD (Kissos et al., 2020; Lev-Wiesel et al., 2021), not least because childhood anxiety is often associated with parental anxiety (Bilsky & Friedman, 2022; Marzilli et al., 2021). While there is some understanding that drawings or shared sandplay sessions could be useful in this regard (Green & Connelly, 2009; Homeyer, 2015; Liu et al., 2023), no previous study has explored the usefulness of the House-Tree-Fire-Water-Person (HTFWP) drawing to establish parent-psychologist rapport and involve parents in their anxious child's therapy. In response, this article reports on the use of a series of HTFWP drawings to advance psychologist-parent rapport and parent involvement in their child's sandplay therapy in the case of 7 children engaged in sandplay therapy for GAD in Cape Town, South Africa.

The House-Tree-Fire-Water-Person Drawing

The HTFWP drawing was developed by Ursula Eschenbach at the C.G. Jung Institute Stuttgart in the 1970s for diagnostic purposes for children and adolescents (Usländer & Reitz, 2015). This drawing evolved from previous projective drawings, such as human figure drawings, the House-Tree-Person drawing, and kinetic drawings (Kreuter-Hafer et al., 2016). The HTFWP drawing is grounded in Jungian psychology and relies on symbolic and metaphoric understanding of the elements of the drawing (Groschwitz, 2016; Wienand, 2016; 2020). Other than for diagnostic purposes, the general

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usefulness of the HTFWP drawing has not been investigated. Advancing understanding of the benefits of a series of HTFWP drawings to a child's therapeutic process redresses the limited theoretical understanding of how the HTFWP drawings can be used therapeutically. Simultaneously, it also offers psychologists and other mental health professions who work with children in therapy, a hands-on tool to maximise the involvement of these children's parents in the therapeutic process in ways that build rapport. Given that parental involvement is vital to children's progress in therapy (Feinstein et al., 2009; Fox, 2012; Kazdin & Whitley, 2006), such tools are a must for treating professionals.

Sandplay therapy and the HTFWP drawing share several similarities. They are both anchored in Jungian psychology using symbolic representation to convey thought and feelings (Liu et al., 2021; Park, 2020; Wienand, 2016). Via either expressive activity, children can establish a sense of trust, develop a connection with the therapist, and feel understood and validated (Clayborne et al., 2021; Vigdal & Brønnick, 2022).

A Brief Overview of GAD and Its Challenges to Child Development

GAD can manifest as physical symptoms that cannot be explained by physical causes. These symptoms include restlessness, fatigue, muscle tension, stomach aches or headaches, difficulty concentrating, sleep disturbances, and irritability (Gouze et al., 2021; Hanna, 2020). Children who struggle with GAD have difficulty with uncertainty, making decisions, and with perfectionism, tending to be excessively self-critical (Meers et al., 2020; Mohammadi et al., 2020). Their anxiety challenges often lead to social isolation (Brown, 2019; Hanna, 2020).

Anxiety disorders, including GAD have been associated with poor academic performance possibly due to its negative influence on memory, problem-solving and concentration (Harrison et al., 2021; Kurdi et al., 2018; Strawn et al., 2021). It places a strain on family functioning and the parent-child relationship possibly due to tantrums, irritability and emotional outbursts (Doyle, 2022).

Parents Are Important Co-Actors in a Child's Resilience To GAD

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Children's capacity for resilience requires more than personal strength (Masten, 2014). While personal strengths matter for resilience, relational and environmental resources matter too (Masten et al., 2024; Ungar & Theron, 2020). One of the important protective resources for children's mental health is warm parenting with moderate control, as found in an authoritative parenting style (Masten & Tellegen, 2012; Theron et al., 2022). Authoritative parenting promotes a child's autonomy, independence, emotional regulation and better interpersonal skills (Abed et al., 2023; Adlem, 2017).

Involving Parents in Their Child's Sandplay Therapy

Sandplay therapy is a type of therapeutic intervention that aims to help children express their feelings and deal with psychological challenges using miniature figurines and sand (Wiersma et al., 2022). It is particularly useful for GAD (Foo & Pratiwi, 2021). Parents have typically been included in the sandplay therapy of their child by having combined sessions with their child, either building in the same tray as their child or building a sandplay scene alongside their child (Green & Connelly, 2009; Homeyer, 2015; Liu et al., 2023). However, including parents in this manner has its limitations, particularly concerning the potential for parents to become overly involved in their child's therapy which can impede the relationship between the child and psychologist (Chandler, 2018). Possible controlling behaviours from parents can also hinder the child's development of healthy coping strategies (Butterfield et al., 2021; Pinquart & Gerke, 2019). In addition, research has shown that parents of anxious children are often experiencing their own mental health challenges (Bilsky & Friedman, 2022; Marzilli et al., 2021). When parents have their own mental health challenges, this could potentially have a negative emotional influence on the child during the therapy session.

An alternative to having parents actively participate during their child's sandplay therapy session through the use drawings. Research on the benefits of sharing children's drawings with their parents have shown that drawings stimulate discussion and enhance parental insight into the child's emotional world by facilitating communication of the child's experiences and concerns with parents (Rand, 2020). Broecher (2012), explored how expressive drawing helped a six-year-old cope with the

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fear and pain of surgery while Molinari (2013), described the sharing of the drawings of a five-year-old with her parents. Both researchers found that when engaging parents, parents are less likely to feel a sense of exclusion from their child's therapeutic process. The enhanced insight into their child's anxiety that parents gain when being included, empowers parents to bolster their child's resilience (Broecher, 2012; Molinari, 2013).

The Benefits of Involving Parents in Their Child's Therapy

When parents are included in a child's therapy process it fosters the formation of a parent-psychologist alliance that plays a critical role in promoting a child's resilience against anxiety and supporting the positive outcomes of therapy (de Greef et al., 2017; Zemmelman, 2018; Zorzella, et al., 2017). A strong parent-psychologist alliance enhances parenting skills like better communication, conflict resolution, and emotional responsiveness (Accurso & Garland, 2014; Schmidt et al., 2014). A parent-psychologist alliance nurtures support that psychologists provide to parents and bolsters parental empowerment (Bram, 2021; Gvion & Bar, 2014; Núñez et al., 2022). When parents feel aligned with and supported by their child's psychologist, they are more likely to adhere to treatment recommendations and remain engaged throughout their child's therapy (Marker et al., 2013; Shirk et al., 2011). This commitment is important for ensuring continuity and effectiveness of treatment. Despite the critical role the parent-psychologist alliance plays in promoting positive therapeutic outcomes for a child, there is very little information Bar the above on sandplay and drawings) on how to nurture this alliance particularly when a child is in sandplay therapy for GAD.

The Current Study

The study we report redresses the limited understanding of how to create a parent-psychologist alliance when a child is in sandplay therapy for GAD. To do so, it reports an exploration of the benefits of the HTFWP drawing series in a child's therapy process when these drawings are shared with their parents. Building a parent-psychologist alliance particularly important in contexts, like SA, where therapy is less accessible (and so must work well) and where parents are often

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sceptical of therapy/psychologists (Okunade et al., 2023). Child psychotherapy is yet another forum in which parents can feel disempowered, hence the criticality of the study.

Materials and Methods

Researcher Positionality

We, the authors, acknowledge that our positioning as psychologists – with varying levels of experience working with parents, personal experiences in parenting and teaching, as well as managing children's anxiety, particularly during and after the COVID-19 pandemic – played into our study. One of us is a seasoned scholar while the other is active in the sandplay therapy community. We were mindful that our identities and experience could shape the meaning we made of our informants experiences and proceeded cautiously and iteratively.

Research Design

As little is known about the potential benefits of sharing the child client's series of HTFWP drawings with their parent/s during parent-feedback sessions when this child is in therapy for Generalized Anxiety Disorder, our study had an exploratory purpose (Cohen et al., 2007; Guest, 2013; Thomas, 2010). To explore these benefits, we used an instrumental multiple case-study design as multiple case studies allow for theory building and also provides the potential to inform practice (Flick, 2018). The cases chosen were instrumental in providing answers to the following research question: How does sharing the series of the child-client's HTFWP drawings in parent feedback sessions benefit the therapeutic process, if at all, when a child is in psychotherapy for GAD?.

Case Selection

All cases were drawn from the population of primary school students attending two government schools in the Cape Town area, South Africa. These schools were purposefully chosen due to their proximity to the first author's practice (where the study took place). In addition, each school has a mental health professional on staff who served as gatekeepers for case selection. The gatekeepers used specific criteria to identify potential cases: a child between the ages of 10 and 12

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years, exhibiting symptoms of Generalized Anxiety Disorder and the child and their caregiver were willing to participate in the study.

While 9 cases were nominated to our study, two were excluded because those parents were unable to fulfil the commitments of all the contact sessions needed and were therefore not eligible for our study. Thus, a total of 9 parents (7 mothers and 2 fathers), and 7 children (4 boys and 3 girls) fulfilled were included. The parents constituted the primary informants and the children the secondary informants. Their details are summarised in Table 1 and 2.

Ethical Process

The study received ethics clearance from [blinded for review]. Given that both authors are registered with the Health Professions Council of South Africa (HPCSA) as psychologists, the HPCSA guidelines for ethical research were integral to the study's ethical processes. These guidelines included the complexity of fulfilling the dual role of treating psychologist and researcher which was the role of the first author. The dual role of researcher-practitioner (R-P) was managed through open communication with the informants in the study, fully explaining the research and therapy activities during the informed consent process. The first author R-P had the added responsibility ensuring that, if child-clients required further therapy after the research was completed, this would be recommended to their parents.

Primary informants consented in writing at the beginning of the study. The condition of assent was particularly important in the context of our study as children needed to willingly allow the psychologist to share drawings they had completed during therapy, with their parents during separate parent sessions. This, in addition to the written assent at the beginning of the research process, secondary informants were asked after each drawing if their drawing and narrative could be shared and discussed with their parents.

Data Collection Procedures

The data collection procedures involved 16 sessions over a 4 month period 2022. The setting of the study was at the private practice of the first author.

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Data Collection with Secondary Informants. Secondary (i.e., child) informants generated three HTFWP drawings. To this end, secondary informants received blank A4 sheets of paper and a variety of stationery. The following instruction was given: "I would like you to draw a picture of a house, tree, fire, water and person. You can do it in any order. It is not about how well you draw, but more about the story your drawing is telling me". Following the completion of the drawing they were asked what their drawing was about. To support this explanation, the R-P (first author) used probing questions. These were: How has the way you have drawn the house/tree/fire/water/person helped you tell that story? Can you tell me more about the characters/objects in your drawing? What emotions/feelings do you think the drawing represents? Are there any specific details in the drawing that stand out to you? What about that detail makes it stand out? How does the drawing relate to your experiences/thoughts about anxiety? In which way have the colours you used helped convey that story?

Data Collection with Primary Informants. Parents provided demographic information about their child, and participated in two interviews (baseline, endline) that explored the parents' understanding of their child's anxiety, their responses to it, and their expectations of therapy. To that end, the first author asked questions about their child, their relationship with their child, their parenting with regard to their child's anxiety, and their expectations of the therapy process. In the course of their child's therapy, they participated in 3 HTFWP-drawing-elicitation conversations. As in other visual participatory methodologies where an artefact is used to elicit a conversation (Billups, 2021; Johnson & Reavey, 2022; Roulston & Halpin, 2022), the first author used their child's HTFWP drawing to elicit a conversation about their child's anxiety . To that end she explored the different elements of colour, composition, the relationship between elements, their child's inner resources, and the emotions evoked by their child's drawing. The HTFWP drawings were introduced by saying the following to parents at the beginning of each HTFWP-drawing elicitation conversation:

> I am about to show you a drawing done by your child that they have given permission for me to share with you. I am showing you this drawing so that we can better understand your

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child's challenges and gain a glimpse of the way they view life. It may be your natural response to focus on what you see rather than how it makes you feel, but the first thing I would be interested in are the feelings the drawing evokes and then what the various aspects of the drawing make you think of with regards to your child, your family, or yourself. You could start with your immediate emotional reaction to the drawing.

To further elaborate on the parents' reflections on the drawings and to encourage deeper insights, parents were asked probing questions. These questions related to the feelings the drawing evoked, the associations that came to mind, their understanding of their child's use of colour as it related to their child's anxiety, how the drawing reflected their family dynamics, how it resonated with their child's anxiety and how it reflected their child's sense of autonomy and self-sufficiency. Following their reflections, the first author shared their child's narrative of their drawing that allowed for more conversation.

Data Analysis

The methods described above resulted in narrative (i.e., verbatim transcripts of 7 baseline and 7 endline semi structured interviews and 21 transcripts of HTFWP-drawing elicitation conversations) and visual data with their narratives (i.e., 21 drawings). To make meaning of this data, the first author used reflexive thematic analysis (Braun & Clarke, 2019; 2021a; 2021b; 2022). To that end, she familiarised herself with the data, generating initial codes. She then sorted the codes into potential themes, collating relevant coded data extracts within these themes (Braun & Clarke, 2006) and carefully and iteratively considering the meaningfulness of the themes she was identifying (Braun & Clark, 2022). Once the second author had reflected critically on the themes and interrogated how well they explained the benefits of the HTFWP drawing series when it is shared with parents during a child's psychotherapeutic process, both authors engaged in a consensus discussion and finalised the themes.

Rigor

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We used the constructs of credibility, transferability, dependability, confirmability and authenticity to ensure the trustworthiness of our study (Lincoln & Guba, 1985, 1994). These constructs helped ensure the quality of our research and made sure that our interpretations and understandings of the data were faithful to the perspectives and experiences of the informants and the context under study (Creswell, 2007, 2012; Creswell & Creswell, 2023; Levitt et al., 2018). To this end we employed triangulation of the various sources of data (verbatim transcriptions of interviews and HTFWP-drawing elicitation methods, drawings and observations of the first author during interviews and drawing sessions). Triangulation is useful in multiple case studies as varying viewpoints of informants are being considered while applying the same method (Cohen et al., 2007). We presented our study at conferences where colleagues in the field of child psychotherapy could critically review our work. In addition, we promoted transferability by providing detailed descriptions of the informants (Creswell, 2007, 2012; Arifin, 2018; Surmiak, 2018). We clarified our own views while engaged in a reflective process, to scrutinize and articulate our preconceived notions and biases (Braun & Clarke, 2021a; Lamba et al., 2022). We documented each phase of the research process to allow our research to be transferable to other settings that were similar to our research setting. Finally, we ensured fairness, authentically conveying the perspective of each informant.

Findings

One overarching theme summarises the study's findings: "Everyone wins when there is a parent-psychologist alliance created by sharing drawings done by children" (see Figure 1). This theme had subthemes which constituted the benefit for each role player in the child's therapy process (the parent, child and psychologist). The HTFWP drawings were key (i.e., integral) to each of these wins.

A Win for the Parent

Parents benefitted from perusing and discussing their child's drawing in two ways: their insight into and empathy for their child's anxiety challenges were fostered and they felt better supported and more effective as parents. As shown next, this helped redress their initial feelings of

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inadequacy when considering their ability to co-manage their child's anxiety when they brought their child to therapy.

Fostering Insight and Empathy. "But I mean, the drawings. There was so much information for us in those drawings which is amazing." This view expressed by Primary Informant 4b, reflects the sentiments of all the primary informants in the study. In the discursive space of the HTFWP-drawing elicitation conversations, primary informants gained insight into their parenting and into their child's anxiety. The opportunity to reflect on their child's drawing in a safe, discursive space allowed primary informants to voice hypotheses and fears. Doing so supported greater insight into their child's anxiety and into the influence of their parenting on this anxiety. For instance, when Primary Informant 4a and Primary Informant 4b reflected on their son's drawing (see Figure 2), their reflections showed a gentle understanding of how anxiety challenged him and some insight into how their parenting could be playing into that.

They said:

> ...The thing that stands out to me that I think would speak to his anxiety is how perfectly straight the house lines are... Yes, very, very perfectly straight, where I would have thought a child his age would have drawn it freehand perhaps. But it's very straight and I know Clint is a bit of a perfectionist and if he gets things wrong, he's very, very hard on himself. Extremely hard on himself... The rigidity of the house, I don't know if its...I don't think we are that rigid in our parenting?
>
> (Primary Informant 4b)
>
> Maybe me.
>
> (Primary Informant 4a)
>
> Or maybe he wants a little more structure? I dunno... cause sometimes it gets a lot unstructured [meaning disorganized]. It gets like very unstructured. Sometimes it goes chaotic in the house.
>
> (Primary Informant 4b)

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Primary Informant 6's reflection on her daughter's first drawing (See Figure 3) was similarly insightful and empathic. Primary Informant 6 thought that the fire in her daughter's drawing that engulfed the house and had jumped to the crown of the tree reflected her daughter's anxiety and showed how overwhelming it was. She imagined her daughter trapped inside the burning house, unable to extinguish the fire. Primary Informant 6 thought that the firefighter may represent herself unsuccessfully trying to extinguish the flames. She used the firefighter as a metaphor for her parenting style which she explained as too intrusive and over-protective and not successful in mitigating her daughter's anxiety.

Reflecting on their child's drawings supported a new and more empathic understanding of their child. This growth in empathy is reflected in the words of Primary Informant 1 and Primary Informant 4b who said:

> I think we're a lot more aware of where he's at. Instead of just accepting that he's just a child who's going through moods and us going on with our daily living, we're more aware that he is struggling; that he needs guidance; and we talk to him more often.
>
> (Primary Informant 1)

> To show him that he's not going through it alone. We are still there; he can lean on us... "You're not alone. Yes, you're feeling overwhelmed, but we're here to help you. We're here to support you. You can come to us... when you feel overwhelmed [and] we'll work it out together.
>
> (Primary Informant 4b)

Feeling Supported and Effective as Parents. At the start of the study, all primary informants expressed negative feelings about their efficacy as parents. Following participation in the study they commented that they felt less alone and appreciated the support and guidance of the first author as they faced the challenge of helping their child with their anxiety: "So, that's my one big thing, is the

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parents needs guidance as well, cause we don't know if we're doing it right.... It helped in the sense that I could change things as well, I could change, go home and look at the situation there and change things there." (Primary Informant 7)

In the process, primary informants' awareness of themselves grew along with the capacity to show compassion for themselves. To illustrate Primary Informant 3 said, "I'm not always calm and patient but I try to be." Similarly, when reflecting on her response to her son's behaviour when he was very anxious, Primary Informant 5 said, "I think I've sort of not reacted as much [she used to respond with extreme annoyance] ... I think I've tried to stay calm, calmer than I was before." This self-awareness and adaptation was also noted by Primary Informant 6 who admitted to initially being controlling and trying to fix things for her daughter. She stated:

> I don't try to solve it. Fights against my natural instinct but I've got to because she's got to figure it out on her own, you know? ...coz I'm like a bit of a controlling [parent]. I wanted to, like fix it all for her and then got frustrated when it wasn't like fixing, you know.
>
> (Primary Informant 6)

Parents expressed gratitude for the regular HTFWP-drawing elicitation conversations as it allowed them to adjust their parenting strategies and see progress made in their children which they felt they had contributed to. Primary Informant 5 stated that it was helpful to see the progress being made in therapy and that these sessions enabled her to support her child earlier in the therapy journey. Primary Informant 7's comment, "...we both, Eliana and I, both went through changes and that wouldn't have been possible if I didn't get regular feedback sessions," shows that she too appreciated the regular HTFWP-drawing elicitation conversations.

As parents engaged with the series of their child's HTFWP drawing they noted that the way in which the elements (house, tree, fire, water and/or person) were drawn, changed over time. These changes in the drawing supported their growing belief in their children's self-efficacy. They also felt more capable in co-managing their child's anxiety. These beliefs in their child's self-efficacy

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and their own parenting ability to co-manage their child's anxiety are noted in Primary Informant 2's comment: "He's starting to manage it without my help. Well, I'll give him the tools, but he can do it on his own."

Similarly, when reflecting on her daughter's last HTFWP drawing (see Figure 4), Primary Informant 6 also displayed this confidence in her daughter's self-efficacy when saying; "Her house is still standing strong...and she looks strong in the picture..she looks like she's got her feet firmly on the ground and she's ready to face climbing those hills".

A Win for the Psychologist

The R-P benefitted from utilizing the HTFWP drawing series in two ways: sharing the drawing with parents fostered rapport with the parent and the drawings provided a tangible means of tracking progress in therapy. As shown next, these benefits helped the R-P feel effective and the significance of this rapport and tangible tracking of therapy progress was noted by parents.

Building Rapport with the Parent. Establishing rapport with parents was a by-product of sharing their child's drawings with them but was also important for the efficacy of the HTFWP-drawing elicitation conversations. Parents appreciated this rapport because it made them part of the process, helping them feel part of the team helping their child build resilience against anxiety. As Primary Informant 5b stated: "That's helpful for us [discussing the drawing]. That shared knowledge of something. It's more than just information, it's kind of aspects of having seen something together. It's a connection."

Parents noted that the unique rapport they shared with the R-P, helped them adjust their parenting styles, aided in the child's therapy process and benefitted the family as a whole. The significance of rapport between parent and R-P was noted by Primary Informant 4a who said:

> And just being able to get that guidance to be able to help my child, help the family. Calm down a bit. Show a little bit more empathy... So, not only helped him but helped me in the process as well to change. So, I thank you big time for that. Like, I think there's nothing we can do to repay you.

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(Primary Informant 4a)

Parents appreciated a non-judgemental, personalised approach which made collaboration with the psychologist easier, supporting positive changes within the family. In addition, they spoke about the helpfulness of probing questions to get them to grapple, in a discursive, supportive space, with their own perceptions of their child's anxiety. In addition, parents expressed their appreciation for not being told an interpretation but allowed to develop their own understanding. Primary Informant 6 said:

> So, I did like that, uhm, I liked the fact that you, uhm, without sort of guiding, there were like a little bit of guided questions but it was sort of like, "what do you think? How do you interpret?" You know, it wasn't like "this is how, you know, I see it, this is how", you know, it was more like "how do, how are you, sort of seeing it", if you know what I mean.

(Primary Informant 6)

Tracking Progress In Therapy. The HTFWP drawing series and children's explanations of their drawings supported insight into their progress, or lack thereof. The changes noted in the visual presentation of the different elements (house, tree, fire, water, person, use of colour, lines of the HTFWP drawing) over the series of HTFWP drawings, helped track therapy progress. In some instances these changes reflected positive progress in therapy as in the drawings of Secondary Informant 6 (see Figure 5) and Secondary Informant 5 (see Figure 6). The tree in Secondary Informant 6's drawing changed from one reflecting fear and feeling overwhelmed (illustrated by a tree on fire), to one of strength (reflected by a sturdy trunk and a tree providing shelter). In addition, the destructive fire in the first drawing was contained and useful in the second drawing. These changes suggested that her anxiety was more contained and she was better able to manage it. She seemed less alone and there was a greater sense of playfulness.

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The person in Secondary Informant 5's drawing changed from a frightened stick figure in her first drawing to a three-dimensional person in her final drawing, someone capable of putting out a fire. Her first person had no hands or feet and no ground to stand on. The gender of the person could not be determined and there was a frightened expression on its face. In the second drawing, the person was now three dimensional and, according to Secondary Informant 5, was jumping up which is why the feet could not be seen. The girl in the picture had her hands raised and the facial expression was one of fear or shock. Secondary Informant 5 loved mushrooms and the mushroom on the t-shirt of the second person strongly suggests that Secondary Informant 5's drawing of this person was a reflection of herself. Again the ground was not visible. Secondary Informant 5's person became more differentiated and capable in the final drawing. Her person in her third drawing had a body, hands and feet and was pouring water over a fire. This final drawing suggested that Secondary Informant 5 felt more self-sufficient, grounded and supported.

The drawings not only showed positive developments but, in some instances also indicated that more therapy sessions were required. This is illustrated in the drawings of Secondary Informant 7 (see Figure 7). There was a sense of disturbance in all of her drawings. In the first drawing a house was on fire. The second drawing depicted a sad man barbequing in the rain while the final drawing showed a frightened stick figure running into a house which had a tree growing inside it. This tree was surrounded by water. The frightened figure was running from an attack on the village which took place at night.

Fostering a Parent-Psychologist Alliance. Acknowledging to primary informants, the progress the secondary informants made in therapy as evidenced in their drawings during HTFWP-drawing elicitation conversations, indicated my appreciation and validation for efforts the primary informants made at home and the positive impact this had on their child's anxiety. This validation and encouragement likely contributed to our collaborative relationship and replaced their initial feelings of hopelessness when their child started therapy, with hope and a sense of empowerment. In addition, as parents noted the tangible changes in their child's drawings, their trust in the

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expertise of the R-P also grew as well as their belief in the therapy process. This brought a sense of gratitude for the role played by the R-P and further enhanced the relationship between R-P and parent.

A Win for the Child

This drawing process with the secondary informant and sharing their drawings with the primary informant, resulted in two benefits for the child: developing a sense of connection and feeling understood and potentially sustaining therapy goals. Children struggling with anxiety need supporting relationships (Masten, 2014; Vigdal & Brønnick, 2022), in order to foster their resilience against anxiety. As shown below, sharing the child's drawing series was valuable in fostering supportive relationships potentially adding to the child's resilience to anxiety.

Shared Drawings Fostered Understanding and Connection. The improved parental insights positively influenced the parent's relationship with their child as children felt better understood and felt a stronger connection to their parents. Secondary informants' drawings inadvertently expressed their emotions and opened another avenue of communicating their feelings, adding to their sense of feeling better understood by the psychologist and their parents. This is illustrated by the thank-you card (see Figure 8), of Secondary Informant 1 who had a keen awareness of not feeling understood and the expressed relief that someone finally did. Secondary Informant 1 also implied that the drawings were important to the R-P's process but also valuable to him by adding one of his prized Pokémon cards (see Figure 9). This Pokémon, Smeargle, studies its opponents, drawing it with the ink that oozes from its tail. It can then mirror its opponent.

Similarly, the R-P was able to better understand Secondary Informant 1 through his drawings and could use his drawings to represent him in conversations with his mother. This added to Secondary Informant 1's feelings of being understood and connected to important supporting figures (his parents and treating psychologist) in this therapeutic context.

Sustaining Therapy Gains. Parental involvement through the HTFWP-drawing elicitation conversations led to deepened parental insight into their child's anxiety as well as a positive shift

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toward an authoritative parenting style which supports the improvement of anxiety symptoms (Abed et al., 2023; Theron et al., 2022). Parents felt that the changes they were able to make in their parenting and understanding could help their child through future anxious times. This understanding of potentially sustained therapy gains was illustrated by comments made by Primary Informant7 and 6 who said the following:

> It wasn't just you, it wasn't just me, it wasn't just her, it was all three of us... So, I knew she now learnt something, and now I know I can use it for her next time when she can't remember about it, I can then remind her. So, it becomes team work because ultimately she's not alone in this.
>
> (Primary Informant 7)

> it's not just you and her, all of us have to be working together to figure this out, because she'll only, you know, one would only see the therapist for a period of time, and then it still needs to be managed at home.
>
> (Primary Informant 6)

Primary informants appreciated that their involvement in their child's therapy, which fostered their insight and empathy, and gave them the support they needed during a difficult time, empowered them to possibly sustain therapy gains.

Discussion

The purpose of this multiple case study was to explore the potential benefits to the therapeutic process of sharing the series of the child-client's HTFWP drawings in parent feedback sessions when a child is in psychotherapy for GAD. As the reported findings show, sharing child-generated HTFWP drawings with their parents was invaluable to the therapy process. Essentially, the sharing of the drawings fostered a robust parent-psychologist alliance with spill-over benefits for the parent, child-client and the treating psychologist. These findings fit with earlier studies that reported the general usefulness of children's drawings to connect with and include parents in their child's therapy (Baghdadi et al., 2020; Kissos et al., 2020). Simultaneously, these findings extend previous

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understandings of the diagnostic value of the HTFWP drawing (Lutz, 2007; Wienand, 2016, 2020), to include its value as a tool to build rapport with the parents of child clients in therapy for GAD.

Sharing a Series of HTFWP Drawings Facilitated a Parent-Psychologist Alliance

The manner in which the child-client's HTFWP drawing was shared with their parents during drawing-facilitated feedback sessions involved establishing a meaningful connection (Markman, 2020; Monticelli & Liotti, 2021; Talia et al., 2020). A safe space was created for parents to express their concerns regarding their child's anxiety. Open dialogue and collaboration was encouraged by steering away from imposing the expertise of the psychologist in a top-down manner. Instead, primary informants were encouraged to express their thoughts, observations, and concerns regarding their child's HTFWP drawings. Parents' perspectives were valued, fostering a sense of partnership and equality in the feedback process. This open exchange of ideas encouraged communication and trust, strengthening the parent-psychologist alliance. This creation of a robust parent-psychologist alliance aligns with Bram (2021) who highlights that when parents felt valued, respected, and understood by the psychologist, their investment in their child's therapeutic process deepens.

Spillover Benefits of the Drawing-Facilitated Parent-Psychologist Alliance for the Stakeholders

Benefit for Parents. The creation of the drawing-facilitated parent-psychologist alliance had spill-over benefits for the primary informants.

Fostering Parenting Skills and Feelings of Support. Previous studies have indicated the significant challenges that parents face in co-managing their children's difficulties related to GAD symptoms (Beesdo et al., 2009; Bilsky & Friedman, 2022). This need was guidance was also expressed by our primary informants who felt alone and isolated in their difficulties. Our drawing-facilitated parent feedback sessions facilitated a parent-psychologist alliance and parental guidance. This finding concurs with several authors who emphasise the importance of establishing strong parent-psychologist to create opportunities for parental guidance (Accurso & Garland, 2015; Vigdal & Brønnick, 2022; Yamamoto et al., 2023). We found that the act of sharing the child-client's HTFWP

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drawing series opened up avenues for discussion and aided parents in addressing their child's struggles with anxiety. Empowering parents as active partners in the therapeutic process, contributes to the child's resilience and well-being (Bratton et al., 2005; Diamond et al., 2000). In addition, the regular contact we had via the HTFWP-drawing elicitation conversations helped parents feel less isolated. To date, studies highlighting the benefit of a robust parent-psychologist to support a parent's sense of isolation (Bram, 2021; Fox, 2012) have not proposed employing a series of drawings, particularly HTFWP drawings, to achieve this outcome.

Fostering Self-Compassion. The self compassion of primary informants was fostered during the HTFWP-drawing facilitated feedback sessions. As we reflected on that finding we considered that the empowerment and support provided through the drawing-facilitated parent-psychologist alliance encouraged parents to adopt a more forgiving and understanding attitude towards their own challenges. This empowerment could be associated with the strengthening of parents' confidence in their parenting abilities. The discursive context created when sharing the child's drawings with their parent likely played a significant role in facilitating this process, as it provided an opportunity for reflection and dialogue that could lead to increased self-compassion. To our knowledge, there are no studies highlighting the development of self-compassion as a result of a parent-psychologist alliance or via the sharing of drawings. Interestingly, there are studies about self-compassion and resilience, which posits that nurturing people's capacity for self-compassion can also nurture resilience (Belfi et al., 2024; Haldorai et al., 2023).

Heightened Affect Regulation. The primary informants described their initial frustration, impatience and anger with their children's anxious behaviour. During the HTFWP-drawing facilitated sessions, they started recounting instances where they struggled to maintain control but actively sought ways to regulate their own reactions. Parents' improved regulatory capacity and heightened frustration tolerance resonate with prior studies on the benefits of a parent-psychologist alliance (Bonanno et al., 2024; Fox, 2012). The distinction is that these studies did not use a drawing series, specifically the HTFWP drawing series, to achieve these findings.

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Benefits for the Child. The creation of the drawing-facilitated parent-psychologist alliance had spill-over benefits for the secondary informants.

Authoritative Parenting. A parent-psychologist alliance helps foster an authoritative parenting style (Bram, 2021; Diamond et al., 2000) which is considered a protective factor to a child's resilience to anxiety (Masten et al., 2021). Through the discursive style of the regular HTFWP-drawing facilitated conversations (which differentiates it from previous studies), primary informants who recognised tendencies towards being overly strict, adjusted their approach, becoming warmer and less overbearing. This adjustment in parenting, not only fostered a healthier parent-child bond but also ensured that children's individual needs were met through their parent's parenting style which allowed their children's autonomy and self-efficacy develop. These findings resonate with previous findings on the benefits of the parent-psychologist alliance in promoting authoritative parenting and improving the parent-child relationship (Bram, 2021; Diamond et al., 2000). The difference lies in the fact that these aforementioned studies did not include the use of drawings to achieve these outcomes.

Feeling Understood and Connected. When exploring the benefits of sharing the child's drawings during regular HTFWP-drawing elicitation conversations we found that it helped the secondary informant feel better understood by, and connected to, their parents. The enhanced empathy in primary informants due to involvement in their child's therapy process, enabled them to support their children emotionally. These findings of feeling supported and connected align with studies highlighting supportive relationships, particularly for children, as a critical protective resource in fostering resilience against anxiety (Masten, 2014; Vigdal & Brønnick, 2022; Yoon et al., 2021). However, these studies on the value of supportive relationships for children did not use drawings as a means of achieving this goal.

Benefits for the Psychologist. The creation of the drawing-facilitated parent-psychologist alliance had spill-over benefits for the first author (R-P).

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Bolstered Connection with the Child. By engaging primary informants in regular HTFWP-drawing elicitation conversations, the first author (R-P) gained a deeper understanding of the child's background and family situation, enhancing insight into the child's anxiety. Involving the secondary informant in explaining their drawings and seeking permission to share these drawings and narratives with their parents fostered a sense of teamwork between the secondary informant, primary informant and first author (R-P), empowering the secondary informant and fostering a sense of openness which positively contributed to the therapy process. The R-P's deepened relationship with the child reaffirmed the importance of fostering trust and collaboration in therapeutic practice and aligned with authors emphasizing the importance of a robust therapeutic working alliance to further the positive outcomes of therapy (Bordin, 1979; 1994; Halfon, 2021). However, the literature regarding the therapeutic alliance does not suggest sharing a child-client's drawings with parents, with the child's permission and knowledge, to achieve this connection.

Sharing the Drawing Series Fostered Insight

Fostering Insight into their Child's Anxiety

We found that during HTFWP-drawing elicitation conversations, primary informants developed a deeper and more nuanced understanding of their child's anxiety. Their ongoing engagement with the drawings, as they were presented with a series of their child's HTFWP drawings, enabled primary informants to recognise patterns, changes and emerging themes. At times, they were surprised by aspects of their child as they explored their HTFWP drawing (e.g., that the child still harboured a longing for parents to re-unite after their divorce, despite the fact that the father had remarried). Studies have shown that children's drawings effectively convey the child's experiences and concerns to their parents (Broecher, 2012; Molinari, 2013; Rand, 2020). However, these studies did not share a series of HTFWP drawings with parents, to achieve this outcome.

Tracking Therapy Progress

The series of HTFWP drawings created by the secondary informant, facilitated the R-P's understanding of the secondary informant's therapy progress (or lack thereof). Elements in the

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HTFWP drawing started transforming across the series (e.g., the fire was less destructive, the person was more detailed, the water started flowing). These changes reflected positive therapeutic outcomes. This benefit of the HTFWP drawing series providing a visual representation of therapeutic progress aligns with the literature on the use of drawings for mental health professionals (Girish et al., 2023; Pivnick, 2023). However, none of the aforementioned studies on the usefulness of drawings for psychologists used the HTFWP drawing.

Limitations and Recommendations for Future Research

The sample was limited to primary school children aged 10 to 12 years exhibiting symptoms of GAD. We wondered what the benefits would be when sharing the HTFWP drawing with parents when the study was not limited to GAD but rather considered another highly prevalent mental health challenge with children like depression (Elmore & Crouch, 2020). The prevalence rate of paediatric depression in the Western Cape in a study with 621 young adolescents (aged 10-14 years), was found to be 33.5% (Mkhize et al., 2024).

When reflecting on our sample delimitation, we wondered how different parenting and parental involvement is in therapy when the client is an adolescent with a different diagnosis (e.g., Major Depressive Disorder, Post Traumatic Stress Disorder or Substance Use Disorder) which would be a recommendation for a future study. One could explore a mental health challenge which is prevalent in adolescents. This could include mood disorders or Substance Use Disorders (Shorey et al., 2022; Simon et al., 2022; Unwin et al., 2022). This shift in focus to a different mental health challenge as well as a different age range, will help determine if the benefits we found when sharing the HTFWP-drawing of children with their parents are repeatable when the focus is not GAD and the age range is adolescence.

Another limitation was the coincidence that all the primary informants were the biological parents of the secondary informants. In the absence of biological bonds, caregiving has been known to face additional challenges (Barone et al., 2021; Moretti & Obsuth, 2009). Future studies should purposefully include e other caregivers (e.g. foster parents, adoptive parents, step-parents,

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grandparents, other relatives or legal guardians taking on the role of support, care and guidance for the children in their care) to explore the benefits to the therapeutic process of sharing the HTFWP drawings with them.

Another limitation is that the lack of follow-up to ascertain whether therapy gains were sustained. Without such follow-up, we cannot be sure that therapy gains were sustained over time. This limitation could be addressed by a longitudinal study (Creswell & Creswell, 2023; Merriam & Tisdell, 2016), which would allow researchers to track the sustained (if any) benefits of sharing the HTFWP drawing.

The fact that our study was based in private practice can be viewed as a limitation as results may be different for psychologists working in a public health care setting where there may not be private space and sufficient time to use a series of drawings discursively (Mkhize et al., 2024). A future study using the public health system as a setting would be particularly important in South Africa as many families do not have the benefit of private mental health support partly due to the limited service and partly due to financial constraints (Sorsdahl et al., 2023).

Conclusion

This article illustrated our exploration of the benefits of sharing the child-client's HTFWP-drawing with their parents when the child is in therapy for GAD. Through the series of case studies involving children with GAD in Cape Town, South Africa, the practice of sharing the child-client's HTFWP drawing series with parents during HTFWP-drawing elicitation conversations created a discursive space enhancing the parent's involvement in their child's therapy. Sharing the child-client's HTFWP drawing series with their parents contributed to the creation of a robust parent-psychologist alliance (with spill-over benefits for parents, the child in therapy and the treating psychologist). This child-client HTFWP drawing series served as catalysts for insight, offering parents a deepened understanding of their child's anxiety, helped toward more effective parenting and served as tangible cues of progress in therapy for the psychologist. It helped the child feel supported by their parents and the psychologist and strengthened the parent-child relationship. Ultimately,

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sharing the child-client's HTFWP drawing series with their parents contributed to more effective therapeutic outcomes for the children with GAD.

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Table 1

Demographic Details of Primary Informants

Which parent was the Primary Informant	Primary Informant	Age range	Marital status	Parent employment	Familial history of anxiety	Stressors in the family
Mother	Primary Informant 1	46 – 50	Married	Both parents	Yes	• A deteriorating neighbourhood in terms of safety • Loss of loved one • Parent has mental health challenges
Mother	Primary Informant 2	31 – 35	Divorced	Both parents	No	• Parents divorced • The child having challenges with his sibling relationships • The child having academic challenges • The family moving to another part of town
Mother	Primary Informant 3	26 – 30	Married	Father	Yes	Financial constraints in the family

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						• The child having challenges with his sibling relationships The child having academic challenges The child resisting attending school The child changing schools
Both parents	Primary Informant 4a and Primary Informant 4b	36 – 40	Married	Both parents	Yes	• Parent has mental health challenges • The child being the victim of bullying • The child having challenges with his sibling relationships • The child having academic challenges • The child having challenges with his sibling relationships
Both parents	Primary Informant 5a and Primary Informant 5b	41 – 45	Married	Both parents	Yes	A family member becoming seriously ill Sibling has mental health challenges The child resisting attending school
Mother	Primary Informant 6	41 – 45	Divorced	Mother	Yes	• Parents divorced

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						• The family moving to another part of town A family member becoming seriously ill
Mother	Primary Informant 7	36 – 40	Married	Father	Yes	• Mother lost her job • One/both parents have anxiety The child resisting attending school

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Table 2

Demographic Details of Secondary Informants

Secondary Informant	Gender	Grade	When was anxiety first noticed	Number of children in home	Birth order of Secondary Informant	Step-siblings
Secondary informant 1	Male	4	>1 year	2	Oldest	Yes
Secondary informant 2	Male	5	>1 year	1	Only child	Yes
Secondary informant 3	Male	5	>1 year	4	2nd oldest	No
Secondary informant 4	Male	4	>1 year	2	Oldest	No
Secondary informant 5	Female	5	>1 year	2	Youngest	No
Secondary informant 6	Female	6	>1 year	2	Oldest	No
Secondary informant 7	Female	6	>6 months	2	Youngest	No

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Figure 1

Main Theme and Subthemes

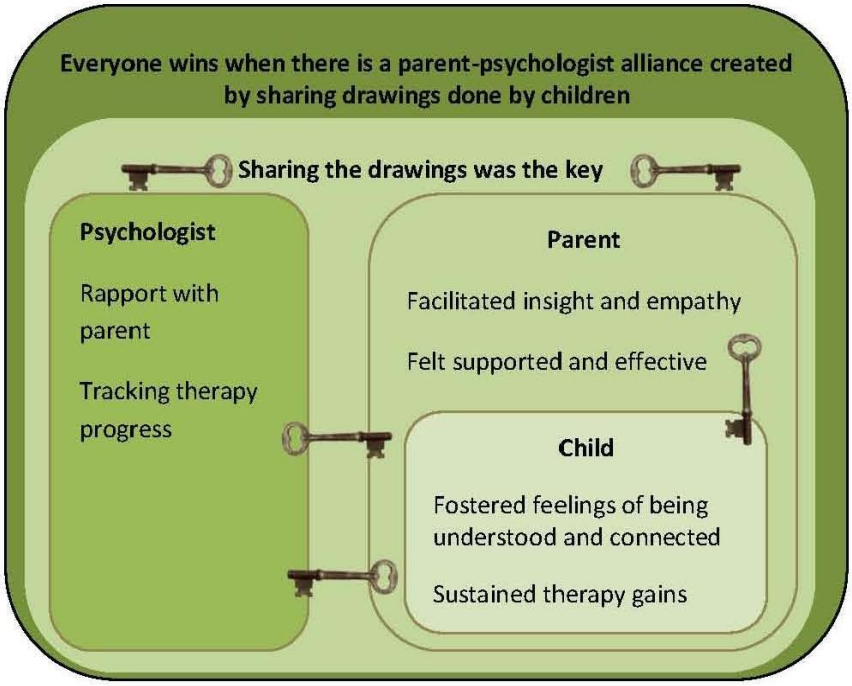


Figure 2

Secondary Informant 4's First HTFWP Drawing



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Figure 3

Secondary Informant 6's First HTFWP Drawing



Figure 4

Secondary Informant 6's Last HTFWP Drawing



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Figure 5

Secondary Informant 6's Tree in Her first and Second Drawing



Figure 6

-Secondary Informant 5's Person in Each of Her Drawings



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Figure 7

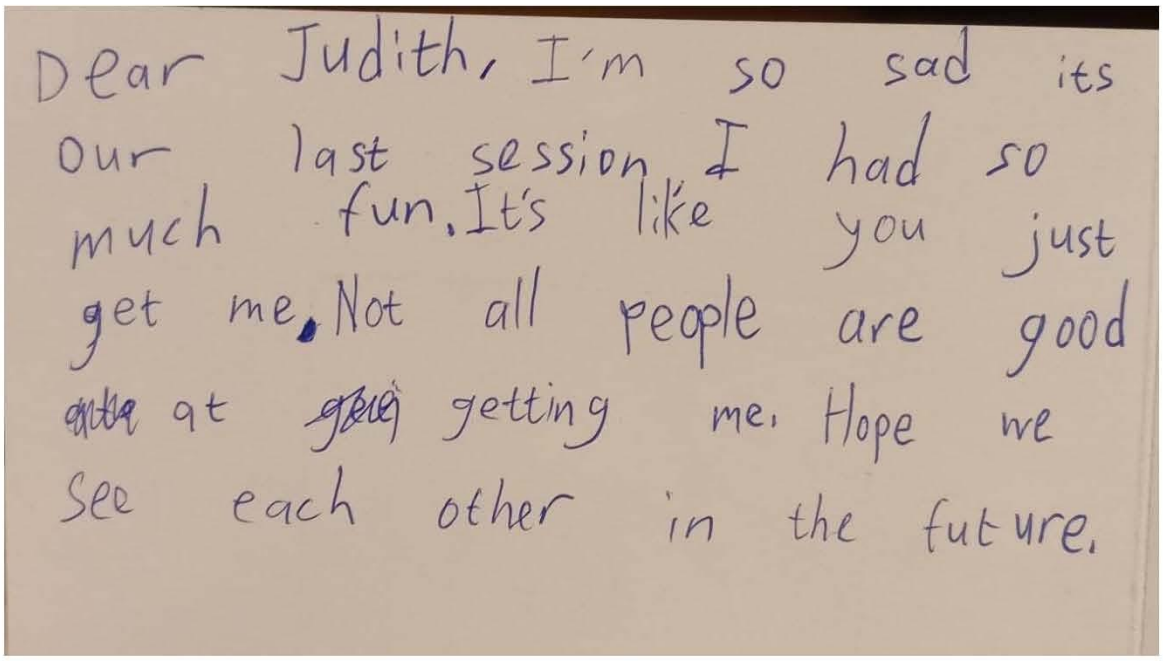
Secondary Informant 7's HTFWP Drawings



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Figure 8

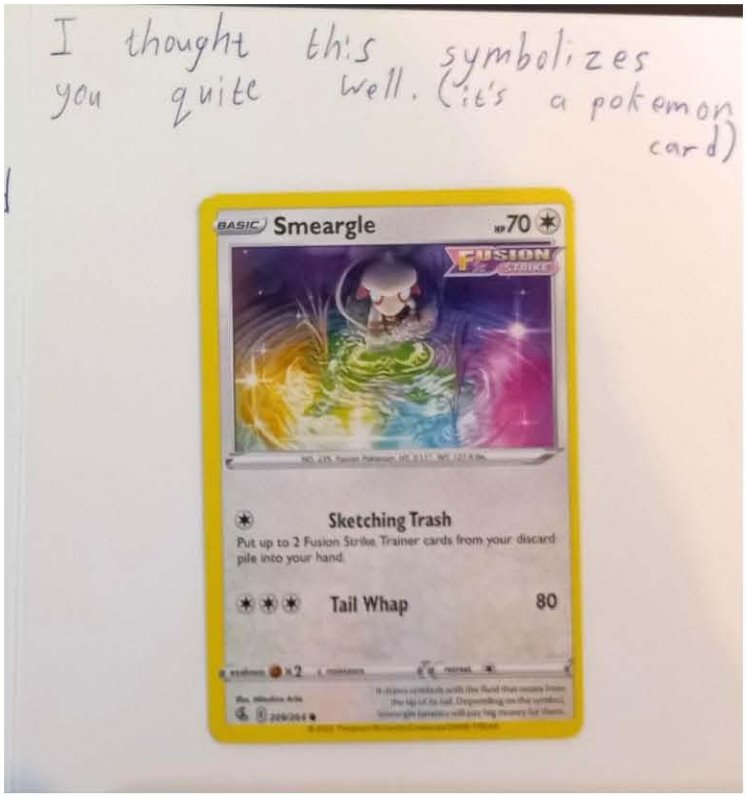
Secondary Informant 1's Thank-you Note



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Figure 9

Secondary Informant 1's Pokémon Card



"Smeargle draws symbols with the fluid that oozes from the tip of his tail" (Pokémon/Nintendo/Creatures/Game Freak, 2022)

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