Information sharing and confidentiality: Exploring the experiences of young people who are accessing a CAMHS service for virtual therapy within the context of COVID-19

Toni Garner

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Supervised by:

Dr Alys Griffiths

Dr Peter Lydon

Dr Luna Centifanti

Dr Lesley Doyle

Department of Clinical Psychology, University of Liverpool, UK

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Word count

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Thesis overview	383	257	623
Systematic review	9211	1375	10586
Empirical paper	9544	1212	10756
Appendices	4705	-	4705
Total	23843		26670

Thesis Overview

Adolescence is a critical developmental period, which is associated with increased autonomy, self-reliance, self-decision making, and identity formation (Blos, 1967; Erikson, 1994; Zimmer-Gembeck & Collins, 2003). During this time, changes occur in terms of the parent-child relationship (Larson, Richards, Moneta, Holmbeck, & Duckett, 1996) and adolescents often choose to exert increased privacy around what they disclose to their parents (Finkenauer, Engels, & Meeus, 2002; Keijsers & Poulin, 2013).

Within the context of Child and Adolescent Mental Health Services (CAMHS), parents are considered to be part of a young person's wider care and are important in enhancing a young person's engagement in therapy (Gross & Goldin, 2008; Iachini, Hock, Thomas, & Clone, 2015). However, young people also need to feel that therapists will prioritise confidentiality (Freake, Barley, & Kent, 2007). Thus, the need to balance issues of confidentiality and information sharing, between young people, their parents, and services, can pose challenges in clinical practice (Tebb, 2011).

The thesis consists of two chapters. The first chapter is a systematic review of the research literature, investigating the association between the parent-child relationship and adolescent disclosure. Sixteen papers were eligible for inclusion in the review, and each was appraised for methodological quality. Findings revealed that parent-child relationship quality was positively associated with higher levels of adolescent disclosure. However, the strength of these associations varied across studies. Methodological issues and suggestions for future research were discussed.

The second chapter employed a qualitative methodology, to further explore adolescents' experiences of confidentiality and information sharing, within the context of virtual therapy. Semi-structured interviews were conducted with adolescents between the ages

of 13 and 18 years and analysed using thematic analysis. The findings highlighted the importance of confidentiality and challenges relating to maintaining this in the home environment. Other themes in relation to the wider context of virtual therapy were also identified and discussed. Findings were discussed in relation to the literature, with clinical implications and recommendations for future research highlighted.

The two chapters have been prepared for submission to the *Journal of Child Psychology and Psychiatry*. It is acknowledged that these exceed the word limits for this journal however this was to allow for more in-depth discussion of the relevant research and findings. The word limits will be amended according to the journal requirements, prior to submission.

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Chapter One: Systematic Review

The association between parent-child relationship quality and adolescent disclosure: A systematic review

Correspondence to be addressed to:

Toni Garner

Department of Clinical Psychology

Whelan Building

Quadrangle

Brown Hill

Liverpool

L69 3GB

Telephone: 0151 794 5534

Email: Toni.Vedmore@liverpool.ac.uk

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Abstract

Background: Adolescent disclosure to their parents is associated with positive psychosocial outcomes. Research has investigated the parental factors which facilitate disclosure; however, the strength of these associations has not been investigated. The aim of this systematic review was to examine the association between the parent-child relationship and disclosure in adolescence.

Methods: Four electronic databases (PsychINFO, CINAHL, MEDLINE, and Web of Science) were searched to find relevant empirical studies, published between 2000 and 2021. Studies included adolescents (aged 11-20 years), reported on an association between adolescent disclosure and the parent-child relationship, and were written in English. Sixteen papers were included in the final analysis. The methodological quality of the papers was assessed using the Quality Assessment Tool for reviewing Studies with Diverse Designs (QATSDD) and data was synthesised.

Results: Quality assessment indicated varying levels of quality in the studies included in the review. There was also variability in the domains of the parent-child relationship measured across studies. Studies demonstrated consistent positive associations between measures of the parent-child relationship and adolescent disclosure, ranging from significant weak to strong correlations.

Conclusion: Parent-child relationship factors, including warmth, acceptance, and trust, are associated with greater disclosure of adolescents to their parents. However, further research which investigates associations been these two variables longitudinally is needed to further investigate the nature of this relationship.

Keywords: *Adolescents, Parent-child relationship, Disclosure, Review*

Introduction

Parents' knowledge about their child is important as they transition through adolescence and spend increasing amounts of time away from the family home (Larson et al., 1996). Historically, research surrounding parental knowledge has predominantly focussed on parental monitoring and parental solicitation of information, however, over the past 20 years, the significant role of child disclosure (i.e., the voluntary sharing of information by the child about their life) as a source of parental knowledge has been highlighted (Kerr & Stattin, 2000). Indeed, Kerr and Stattin (2000) demonstrated that a large proportion of parents' knowledge about their adolescent's life was predicted by how much information the adolescent voluntarily disclosed about this.

Further research has investigated the psychosocial consequences of adolescent disclosure and found that disclosure is associated with a number of positive outcomes. For example, research has highlighted that disclosure is associated with better health outcomes, lower levels of delinquency, and fewer depressive symptoms (e.g., Kerr & Stattin, 2000; Kerr, Stattin, & Burk, 2010). Given the contribution that disclosure makes to parental knowledge and the perceived psychosocial benefits associated with disclosure, studies have subsequently sought to investigate factors which facilitate greater disclosure, including the role of parenting practices and the parent-child relationship. However, we do not know how strong these associations are, to know whether they have a significant impact for adolescent disclosure. This review examines the strength of the association between the parent-child relationship and child disclosure, in adolescence.

Disclosure of information has been linked to a number of other constructs, which are thought to relate to parental knowledge, including parental solicitation of information and secrecy in adolescence. Research which has distinguished between parental solicitation of information and child disclosure has suggested that parental solicitation of information does

not always equate to child disclosure of information (Kerr & Stattin, 2000). Furthermore, research surrounding disclosure and secrecy has indicated that although these are two related constructs, they are empirically distinct (Finkenauer, Engels, & Meeus, 2002; Smetana et al., 2006). Thus, adolescent disclosure in the context of this review refers to the voluntary sharing of information by adolescents, with their parents, about their lives.

Developing autonomy and individuation from parents is considered critical as young people transition through adolescence (Blos, 1967; Erikson, 1994). Research has demonstrated that this transitional period is also related to changes in terms of parent-child communication, with adolescents being less inclined to share information with their parents during this time (Keijsers & Poulin, 2013). Moreover, adolescent disclosure has been shown to reduce throughout the adolescent period. For example, Keijsers, Frijns, Branje, and Meeus (2009) demonstrated that adolescent's self-reported disclosure declined gradually from ages 13 to 16 years, when assessed across four time points. Similarly, Finkenauer et al. (2002) reported that younger adolescents informed disclosing more information to their parents than older adolescents.

Although current research does not distinguish what would be considered to be an appropriate level of adolescent disclosure to parents for this age group, research suggests that friendships become more central during this time, and thus intimate disclosure to friends increases whilst disclosure to parents decreases (Demir & Urberg, 2004). Therefore, appropriate non-disclosure of information to parents may be an important part of development for adolescents, associated with increased autonomy, self-reliance, and identity formation (Blos, 1967; Erikson, 1994). However, it is difficult to define what would be considered an appropriate level of disclosure and non-disclosure for this age group as research has not investigated this.

Other research into adolescent disclosure has investigated the types of issues which adolescents are willing to disclose on (Smetana, Villalobos, Tasopoulos-Chan, Gettman, & Campione-Barr 2009; Kearney & Bussey, 2014). Such research has utilised Social Domain Theory (Turiel, 1983; 2006) as a way of conceptualising adolescent activities into different social domains; personal issues (relating to control over one's body, privacy, and preferences surrounding activities and friendships), prudential issues (surrounding health, safety, comfort, and personal harm), moral issues (concerning justice, welfare or rights of others), conventional issues (relating to behavioural norms), and multifaceted issues (issues which overlap between two or more domains) (Smetana, Metzger, Gettman, & Campione-Barr, 2006; Kearney & Bussey, 2014).

Smetana et al. (2006) suggested that adolescents may be most inclined to disclose information in relation to prudential activities and least obligated to disclose to parents about personal issues. Indeed, in their study, they demonstrated that adolescents disclosed more information about schoolwork than they did about peer or personal issues. Hare, Marston, and Allen (2010) distinguish between adolescent disclosure about behaviours versus emotional disclosure. They discuss that it is important to consider adolescents' willingness to disclose about emotional issues, as adolescence is often associated with an increase in these types of difficulties, which can be challenging to navigate.

Research into adolescent disclosure consistently indicates that disclosure leads to better psychosocial adjustment (Kerr & Stattin, 2000; Stattin & Kerr, 2000). Such research has focussed on areas of delinquency and conduct problems in adolescence and has demonstrated that adolescent disclosure is associated with fewer difficulties within these areas (Stattin & Kerr, 2000; Kerr et al., 2010). For example, Keijsers et al. (2009) showed a negative developmental link between adolescent disclosure and delinquent activities, whilst Stattin and Kerr (2000) reported that child disclosure was the most closely related source of parental

knowledge to measures of delinquency. Disclosure of information has also been associated with better health and wellbeing outcomes during adolescence, with higher levels of disclosure in relation to health conditions being associated with better health outcomes (Osborn et al., 2013). It has been suggested that adolescent disclosure may provide parents with greater opportunities to offer support and guidance, which in turn has a positive impact on adolescent adjustment and wellbeing (Keijsers et al., 2009).

Given the apparent advantages of adolescent disclosure and the role this plays in increasing parental knowledge during adolescence, research has focussed on parental factors which may facilitate disclosure. The role of parental solicitation of information (Kerr et al., 2010), authoritative parenting (Darling, Cumsille, Caldwell, & Dowdy 2006), and parental control (Soenens, Vansteenkiste, Luyckx, & Goossens 2006) in predicting adolescent disclosure has been examined. Much of the literature surrounding disclosure indicates that the quality of the parent-child relationships may be an important factor in the facilitation of child disclosure. Indeed, adolescents who disclose to their parents also tend to report positive relationships with their parents. Such research has indicated that disclosure is more likely to occur in the context of parent–child relationships which are considered by adolescents to be warm, trusting, and accepting, (Hare et al., 2010; Hunter, Barber, Olsen, McNeely, & Bose, 2011).

Given the literature surrounding adolescent disclosure and parent-child relationship factors, which indicates that better relationships are associated with more disclosure, positive correlations between these two variables would be expected.

Aims

The current review aims to focus specifically on evaluating evidence for the strength of the association between aspects of the parent-child relationship and adolescent disclosure. It is hoped that a more in depth understanding of the role of relational factors, which facilitate the

process of adolescent disclosure, will help to support parents in optimizing conditions for child disclosure.

Methods

Eligibility Criteria

Studies were eligible for the review based on the following inclusion criteria: a) papers written or translated into English; b) participants were adolescents aged between 11 and 20 years old; c) a measure of child disclosure was used; d) a measure of the parent-child relationship was used; d) the study examined a relationship between the parent-child relationship and child disclosure; e) peer reviewed research (see Table 1).

Studies were excluded if they used qualitative methodology only or used an intervention study design (i.e., parenting intervention studies). Unpublished theses and dissertations, book chapters, non-peer reviewed journal articles, reviews, and opinion pieces were excluded, as they have not been subjected to peer review. Studies prior to the year 2000 were also excluded from the study. This reflected the shift in the focus of research, which has occurred over the past 20 years, in terms of how parents gain knowledge about their child (Kerr and Stattin, 2000).

Search Strategy

Search terms were formulated following consultation with supervisors and relevant databases were searched using the following key words and Boolean operators: (adolescen* OR teen* OR "young people" OR youth* OR “young person”) AND (disclos* OR share OR sharing OR tell* OR “information sharing” OR secret* OR secrecy) AND ("parent child relationship" OR ((parent* N3 child*) AND relations*).

Literature searches took place in January 2021. The databases PsycINFO, CINAHL, MEDLINE and Web of Science were searched for relevant published literature. Attempts were made to identify additional eligible publications by hand searching reference lists. Endnote

reference management software was used to organise the articles and support the screening process.

Study Selection

The search yielded 3806 articles (PsychINFO, 1224; CINAHL, 1155; MEDLINE, 919; Web of Science, 508). Duplicate records were identified and removed leaving 2106 articles for screening. Titles and abstracts were screened for inclusion by the first author (TG). Following this, full texts were obtained and screened by TG. The inclusion/exclusion criteria were applied, and 16 studies were determined to be eligible for synthesis. A colleague of TG selected and screened 10% of the eligible papers at the full text stage (n=6). The final papers were screened by the second author (LC) and any discrepancies were resolved through discussion. The search flow diagram is presented in Figure 1.

Data Extraction

Information about the sample, the measure of disclosure, the measure of the parent-child relationship and the association between these variables was extracted by TG (Table 2 and 3). Only the data and findings relevant to this review were extracted.

Quality Assessment

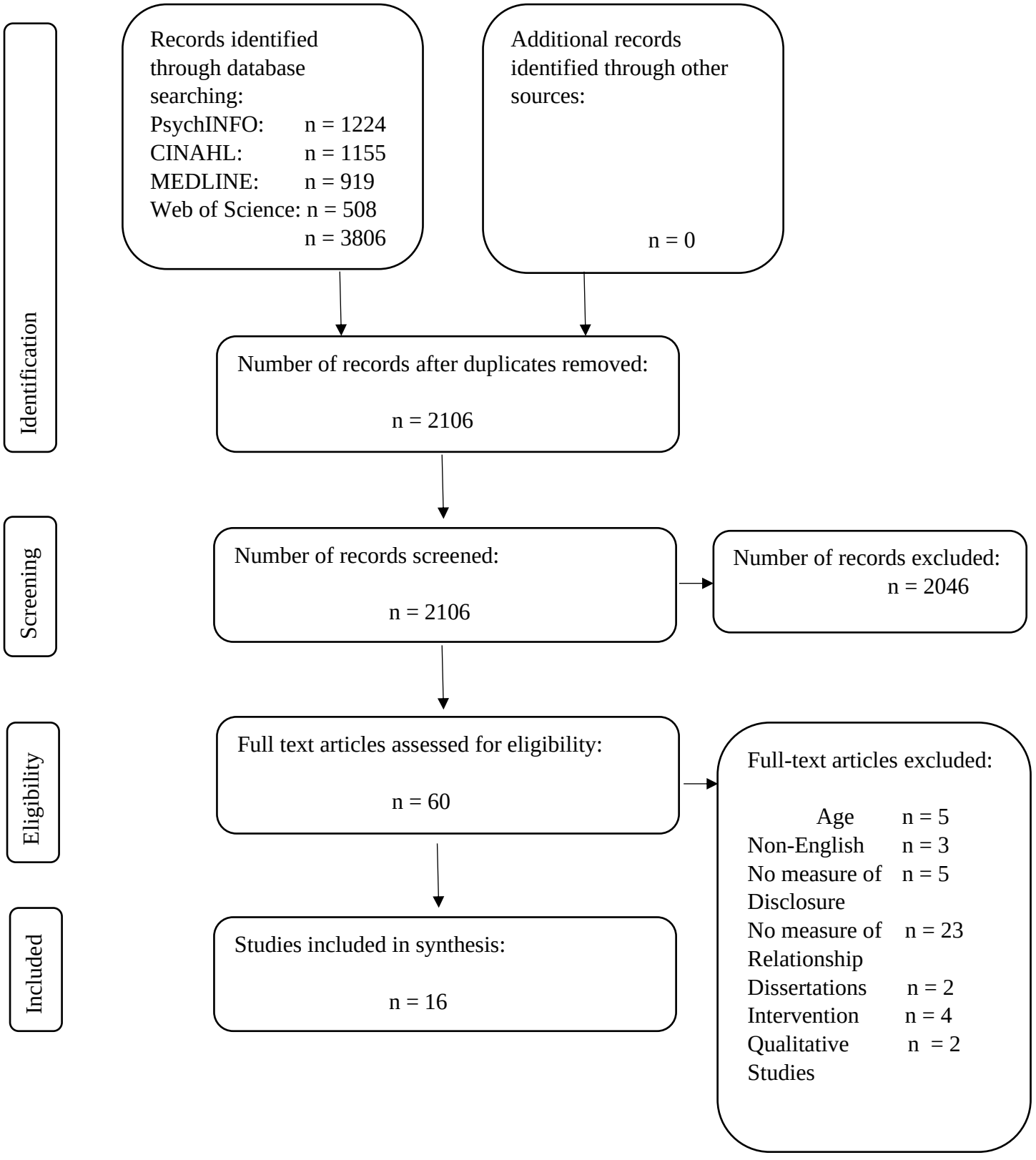
The Quality Assessment Tool for reviewing Studies with Diverse Design (QATSDD; Sirriyeh, Lawton, Gardner, & Armitage, 2012) was used to assess the quality of the papers involved in the synthesis. The original QATSDD assesses study quality across 16 areas of the research process (e.g., aims, design, sample, analysis). Two items were removed from the tool for the purpose of this study as they related to qualitative methodology only (items 10 and 13) which were excluded from this review. Thus, studies were rated across 14 areas in total. Each

area is rated against a set criterion on a 4-point scale (0= not at all, 3= complete). Overall quality scores are represented as percentages, with higher scores indicating greater quality (see Table 3).

Table 1. Inclusion and exclusion criteria

Study Parameters	Inclusion Criteria	Exclusion Criteria
Sample/population	Adolescents (aged 11-20)	Individuals above the age of 20 years and below the age of 11 years
Study focus	Includes a measure of parent child relationship quality Includes a measure of child disclosure Examined an association between parent-child relationship quality and child disclosure	No measure of parent child relationship quality No measure of child disclosure
Methodology	Quantitative	Qualitative studies Intervention studies
Language	English or translated into English only	Not written or translated into English
Study type	Peer reviewed primary research	Book reviews, book chapters, opinion pieces, commentaries, literature reviews, dissertations or unpublished theses, non-peer reviewed journal articles

Figure 1. Flow diagram showing identification of papers.



Results

The current review aimed to assess the associations between adolescent disclosure of information and the parent-child relationship. The results section will outline the measures used to assess these variables, provide an overview of the methodological quality of the studies included in this review, and provide a narrative synthesis of the data extracted.

Study Characteristics

The participant and study characteristics for the 16 included studies are displayed in Table 2. All studies were published from 2006 to 2020. Twelve of these studies used a cross-sectional design, with four studies using a longitudinal design. Most of these studies (10) were conducted in the United States of America (USA), one in Italy, one in Israel, one in the Netherlands, and one in Australia. Two studies recruited across multiple locations; one within Chile, Philippines, and USA; and the other across Costa Rica, Thailand, and South Africa.

The majority of the studies recruited from schools (n = 14). One study recruited from outpatient clinics (Berg et al., 2017) and the final study from a national database (Padilla-Walker & Son, 2019). As per the inclusion criteria, all of the studies recruited from an adolescent population, with the mean ages of participants falling between 11.8 and 17.7 years.

Quality Assessment

The results of the quality assessment are presented in Table 3. Total quality assessment scores ranged from 59.5% to 80.9 %. Eleven of the sixteen studies included used a cross sectional design, which limits the ability to establish and draw conclusions about causal relationships between variables. All studies included the aims and objectives within the main body of the report and referenced a theoretical framework.

Power calculations were consistently not reported across the included studies, with the exception of two studies (Berg et al., 2017; Dinizulu, Grant, Bryant, Boustani, Tyler, &

McIntosh, 2014). Only one further study made reference to sample size in relation to their analyses (Chan, Brown, & Bank, 2015). Although there was limited evidence of sample size consideration in relation to analyses across the majority of studies, some did identify limited sample sizes employed when discussing limitations of their respective studies. There was limited evidence of service user involvement across all studies.

All studies used self-report to measure the parent-child relationship and disclosure, with the exception of one study which used a maternal report of perceived adolescent disclosure only (Lippold, Duncan, Coatsworth, Nix, & Greenberg, 2015). Hare et al. (2011) used an observed measure of disclosure. Three studies, which used self-report measures, also included a parental report of perceived disclosure and the parent-child relationship (Padilla-Walker & Son, 2019; Reidla & Swenson, 2012; Smetana et al., 2006), whilst one other study included a parental measure of the relationship but not disclosure (Chan et al., 2015).

Table 2: Study characteristics.

Author, year	Location	Study design	N	Age	Gender (% female)	Ethnicity	Sampling method
Berg et al., 2017	USA	Longitudinal	247	*M*=17.77	60%	75.2% non-Hispanic White, 14.2% Hispanic, 4.8% African American	Purposive sampling
Chan et al. 2015	USA	Cross-sectional	249	*M* = 13.01	51.8 %	67.5 % European American, 7.6% African American, 5.6% Latino and 6.4% Asian American	Convenience sampling
Darling et al., 2009	Chile Philippines USA	Cross-sectional	707	*M*=16.2	56%	US: *N*= 200, 51% Hispanic, 34% Cuban American; Philippines: *N* = 151; Chile: *N* = 356	Convenience sample
Dinizulu et al., 2014	USA	Cross-sectional	152	*M* = 12.77	65.8%	100% African American	Convenience sample
Everri et al., 2016	Italy	Cross-sectional	322	*M* = 15.84	54.6%	*NS*	Convenience sampling
Fernandez et al., 2021	USA	Cross-sectional	209	*M*= 11.8	67.5%	61.2% White, Caucasian, or European, 38.8% Hispanic, Latino or Mexican American	Convenience sample
Hare et al., 2011	USA	Longitudinal	184	*M* = 13.36	53%	58% Caucasian, 29% African American, 13% other	Convenience sampling
Hunter et al., 2011	Costa Rica Thailand South Africa (SA)	Cross-sectional	2100	14-17	57-63%	Thailand: *N* = 590; Costa Rica: *N* = 600; SA -Black: *N* = 324; SA - Coloured: *N* = 290; SA-White: *N* = 300	Purposive sampling

Author, year	Location	Study design	N	Age	Gender (% female)	Ethnicity	Sampling method
Kearney & Bussey, 2014	Australia	Longitudinal	463	*M* = 13.97	42.1%	82% White, 10% Asian, 3% Middle-Eastern, 5% other	Convenience sampling
Lippold et al., 2015	USA	Cross-sectional	432	*M* = 12.14	54%	72 % Caucasian,16 % Black, 4 % Asian, 1 % Native American	Convenience sampling
Padilla-Walker & Son, 2019	USA	Longitudinal	463	*M* = 13.32 *M2*= 15.29 *M3*= 17.28	52%	73% European American, 13% African American, 8% multi-ethnic, 5% other	Random sampling
Reidla & Swenson, 2012	USA	Cross-sectional	232	11-16	55%	86 % European American, 5 % African American	Convenience sampling
Roth et al., 2009	Israel	Cross-sectional	126	*M*= 14.77	52.4%	*NS*	Convenience sampling
Smetana et al., 2006	USA	Cross-sectional	276	*M*=14.62	65.6%	70% European American, 9% African American, 9% Asian	Convenience sampling
Smetana et al., 2009	USA	Cross-sectional	118	*M*=12.77	49.1%	88% European American, 9% African American; 3% other	Convenience sampling
Villalobos Solís et al., 2015	USA	Longitudinal	102	*M* = 15.18	55.8%	37% Latino, 40% African American, and 23% ‘Other’	Convenience sampling

NS=Not stated

Table 3. Quality assessment

Criteria	Berg et al., 2017	Chan et al. 2015	Darling et al., 2009	Dinizulu et al., 2014	Everri et al., 2016	Fernandez et al., 2021	Hare et al., 2011	Hunter et al., 2011
Explicit theoretical framework	2	2	3	3	2	3	2	3
Statement of aims/ objectives in main body of report	3	3	3	3	3	3	3	2
Clear description of research setting	3	3	2	3	3	2	3	3
Evidence of sample size considered in terms of analysis	2	2	0	2	0	0	0	0
Representative sample of target group of a reasonable size	2	3	2	2	2	2	2	2
Description of procedure for data collection	2	2	3	2	2	2	2	3
Rationale for choice of data collection tool(s)	2	2	2	1	1	1	2	2
Detailed recruitment data	3	3	3	3	3	2	3	2
Statistical assessment of reliability and validity of measurement tool(s)	2	3	2	2	2	2	2	2

Criteria	Berg et al., 2017	Chan et al. 2015	Darling et al., 2009	Dinizulu et al., 2014	Everri et al., 2016	Fernandez et al., 2021	Hare et al., 2011	Hunter et al., 2011
Fit between stated research question and method of data collection	3	3	3	3	3	2	3	3
Fit between research question and method of analysis	2	3	3	3	3	3	3	3
Good justification for analytical method selected	1	1	2	2	2	1	3	1
Evidence of service user involvement	0	0	1	0	0	0	0	2
Strengths and limitations critically discussed	3	3	3	2	2	3	2	3
Quality score	71.4%	78.5%	76.2%	73.8%	66.6%	61.9%	71.4%	73.8%

0= not at all, 1=slightly, 2= moderately, 3= complete

Criteria	Kearney & Bussey, 2014	Lippold et al., 2015	Padilla-Walker & Son, 2019	Reidla & Swenson, 2012	Roth et al., 2009	Smetana et al., 2006	Smetana et al., 2009	Villalobos Solís et al., 2015
Explicit theoretical framework	3	3	3	3	2	3	3	3
Statement of aims/ objectives in main body of report	3	3	3	3	3	3	3	3
Clear description of research setting	3	2	3	3	2	2	3	3
Evidence of sample size considered in terms of analysis	0	0	0	0	0	0	0	0
Representative sample of target group of a reasonable size	2	2	3	2	2	3	2	2
Description of procedure for data collection	3	3	3	3	2	2	3	3
Rationale for choice of data collection tool(s)	2	1	2	1	1	2	2	3
Detailed recruitment data	3	2	3	3	2	2	3	3
Statistical assessment of reliability and validity of measurement tool(s)	2	2	2	2	2	2	2	2

Criteria	Kearney & Bussey, 2014	Lippold et al., 2015	Padilla-Walker & Son, 2019	Reidla & Swenson, 2012	Roth et al., 2009	Smetana et al., 2006	Smetana et al., 2009	Villalobos Solís et al., 2015
Fit between stated research question and method of data collection	3	3	3	3	3	3	3	3
Fit between research question and method of analysis	3	3	3	3	3	3	3	3
Good justification for analytical method selected	2	2	2	2	1	1	2	1
Evidence of service user involvement	2	0	0	0	0	0	0	0
Strengths and limitations critically discussed	3	3	3	3	2	3	3	3
Quality score	80.9%	69.0%	78.5%	73.8%	59.5%	71.4%	76.2%	76.2%

0= not at all, 1=slightly, 2= moderately, 3= complete

Summary of measures

Measures of child-disclosure

Details of the measures used in each study are presented in Table 4. Most studies used self-report measures of child-disclosure, which involved asking adolescents about voluntary disclosure to parents and non-disclosure. Two studies used both child and parental reports of child disclosure, whilst one study used a maternal report of child disclosure only, which involved looking at perceptions of adolescent routine disclosure about their whereabouts and activities. One study used an observational measure. The various methods used to measure child-disclosure are discussed in further detail below.

Questionnaires. Twelve of the studies used questionnaires in order to measure child disclosure. The most commonly used measure amongst studies was a measure of voluntary disclosure which was adapted from Stattin & Kerr (2000). This scale comprises of five items, which are rated on a 5-point scale, for example, "Do you spontaneously tell your parents about your friends (which friends you hang out with and how they think and feel about various things)?". Stattin and Kerr (2000) demonstrated good internal consistency (α= .81) for children's reports and child-reported disclosure was also reported to be highly reliable, according to a 2-month test–retest correlation (r = .87). Four studies used this scale with adolescents (Berg et al., 2017; Everri, Mancini, & Fruggeri, 2016; Fernandez, Loukas, & Pasch 2021; Roth, Ron, & Benita, 2009). Lippold et al. (2015) adapted this scale for use with mothers and demonstrated good internal consistency in their study (α=.84). Example items from this measure included ''How often does this child tell you what he/she is doing without your asking?''. Padilla-Walker and Son (2019) used a revised version of this measure with both parents and adolescents (α range = .71–.92 and .73 to .82, respectively).

Reidla and Swenson (2012) used a revised version of the Self-Disclosure Questionnaire (Rose 2002; adapted from Parker & Asher, 1993) to specifically assess child disclosure to

mothers, from both child and maternal perspectives. This involved rating five items relating to child disclosure on a 5-point Likert scale. Adequate reliability was demonstrated for this measure (child-report α= .91, M = 3.02, SD = 1.12; mother report α= .88, M = 3.46, SD = .85).

Dinizulu et al. (2014) used the Reasons for Keeping Things Private scale (RFKTP), which is an unpublished measure (McIntosh, 2003) that assesses the frequency and reasons why adolescents may choose not to disclosure information to their parents. The RFKTP scale is a 16-item scale in which participants are asked to respond on a 3-point Likert scale to include how often they choose not to disclose for a particular reason. Sample items include "How often would you keep something to yourself because your parent/other adult would overreact?". This measure demonstrated good internal consistency in this study (α= .87).

Other studies developed their own measures to assess disclosure based on their previous work (Chan et al., 2015; Hunter et al., 2011; Kearney & Bussey, 2014). Chan et al. (2015) used the Disclosure about Peers Inventory (DAPI), which was adapted from the Right to Know Inventory developed and used in the first part of their study. This assessed adolescents' willingness to disclose to their parents about 25 peer related issues, across four factors: activities with peers, relationship issues, peer prosocial characteristics, and peer antisocial characteristics. Six items were removed from this scale prior to analysis following a confirmatory factor analysis. Hunter et al. (2011) generated a survey based on their findings from the qualitative phase of their study, in which they identified eight potential reasons that adolescents may choose to voluntarily disclose. They found that the frequency that adolescents used the various reasons for disclosure did not vary meaningfully therefore they combined these items to create a general self-disclosure score. Kearney and Bussey (2014) created and used the Teen Overall Level of Disclosure Scale (TOLDS) to measure adolescents' spontaneous disclosure to mothers, across three domains (moral/conventional, personal, and

prudential issues). The measure consists of nine items which were rated on 6-point Likert scale. The scale demonstrated good reliability at both time points (Time 1 α= .85, Time 2 α= .87).

Smetana et al. (2006) developed a survey in which parents and adolescents rated how often they (or their adolescent child) are willing to disclose in relation to 12 personal, peer, and schoolwork issues. Examples include, getting a bad grade/not doing well on work or tests, spending time with someone their parents do not like, and how adolescents spend their free time. Alphas for adolescent ratings were between .67 and .81, and between .68 and .86 for parent ratings.

Finally, Darling et al. (2009) used the Strategic Disclosure Questionnaire to assess disclosure when adolescents disagree with their parents about an issue. On this measure, adolescents answered questions about 20 different issues, including whether they would "tell all", "avoid", "tell part", or "lie" about the issue when they disagreed with their parents about this. Disclosure was therefore measured by dichotomising the responses into disclosure versus the other three responses. This questionnaire was adapted by Smetana et al. (2009) to create a card sorting task. In this task, adolescents sorted 21 items into things they have done once, things they sometimes do, and things they have never done. They were asked to rate how likely they were to tell their parents about each of the behaviours they had indicated that they had done at least once on a 5-point scale (1=never, 5=always).

Diary measures. Two studies used daily diaries to measure disclosure to parents (Berg et al., 2017; Villalobos Solí, Smetana, & Comer, 2015). Berg et al. (2017) created a daily diary measure for the purpose of their study, which was used alongside the measure adapted from Stattin and Kerr (2000) to assess child disclosure to their parents, specifically in relation to their diabetes. Adolescents were asked to respond yes or no to the prompt, "Did you tell your mother/father about things that happened with your diabetes today, without her/him asking you?". Villalobos Solís et al. (2015) also used a diary measure in which adolescents rated how

much they told or disclosed to their mother without them asking, for 10 different behaviours, on five-point Likert-scale. These items encompassed personal, multifaceted, and negative behaviours; for example, "anything I've done that my parents might not approve of", "how I spend my free time". Diary measures of secrecy and solicitation were also obtained however these were not reported in the study included in this review.

Observational measures. Hare et al. (2011) used an observational measure to assess observed emotional disclosure of adolescents to their mothers at ages 13 and 16. This involved an 8 min Supportive Behaviour Task (SBT) during which adolescents asked their mother for support with a problem (for example, issues relating to dating, friendships, or joining sports teams). The interactions were observed and coded by two individuals, using the supportive behaviour coding system (Allen et al. 2001), to rate levels of disclosure. Interrater reliability calculations were completed at both time points (r = .87 and r = .62).

Measures of the parent-child relationship

The majority of studies used self-report measures only to assess the parent-child relationship (n=10), whilst the remaining studies utilised both parental and adolescent reports. This primarily involved asking adolescents (and parents) to rate items relating to specific domains of the parent-child relationship. All but one study used questionnaires to assess the quality of the parent-child relationship, with the remaining study using a daily diary measure. Domains of the parent-child relationship assessed included warmth (n=3), acceptance (n=4), trust (n=3), autonomy support/granting (n=2), affective quality (n=1), and general parental support (n=4). The various measures of the parent-child relationship are discussed in further detail below.

Questionnaires. Four studies used the Child's Report of Parent Behaviour Inventory (CRPBI; Schludermann & Schludermann, 1970) or a shortened version of this to measure the parent-child relationship (Hare et. al, 2011; Hunter et al., 2011; Kearney & Bussey, 2014;

Smetana et al., 2006). These studies used the acceptance subscale, which is considered to be a valid and reliable measure and has been used in previous research as a measure of parental support (Soenens et al., 2006, 2007). Kearney and Bussey (2014) used self-reports on the acceptance subscale from the shortened version of this inventory, the CRPBI-30 (Schludermann & Schludermann, 1970), to assess perceived warmth and parental responsiveness. They also used the open family communication subscale from the Parent-Adolescent Communication Scale (Barnes & Olson, 1982), to assess how able adolescents felt to discuss issues with mothers in an open and supportive way. Smetana et al. (2006) used the parental reports on the acceptance/rejection subscale from the CRPBI (Schludermann & Schludermann, 1970) to assess parental acceptance. This consists of ten items which are rated on a 3-point scale. The trust subscale from the Parent-Peer Attachment Inventory (PPAI; Armsden & Greenberg, 1987), was also used in Smetana (2006 & 2009) to assess adolescents' trust in parents. This was completed twice by adolescents, once for mothers and once for fathers.

Berg et al. (2017) also assessed the acceptance domain of the parent-child relationship using the five-item acceptance subscale from the Mother–Father–Peer scale (Epstein, 1983). This measure was completed by adolescents for both mothers and father separately and demonstrated good reliability in this study (α= .86 and α= .88 for mothers and fathers, respectively).

Chan et al., (2015) used the Network of Relationships Inventory (NRI; Furman and Buhrmester 1985) to assess closeness and conflict in parent-child relationships. Internal consistency for both scales was adequate.

Diary measures. Villalobos Solís et al. (2015) revised daily diary measures, which have been used in previous studies to examine relationships with romantic partners (Gable, Reis, Impett, & Asher, 2004), to assess the relationship quality with mothers. They asked

adolescents to rate their relationships with their mothers daily on a five-point scale (1= terrible, 5=terrific). They also rated their relationships that day with mothers on three items further items; “we had a lot of conflict”; “our relationship was pleasant”; and “we were in tune”.

Association between parent-child relationship factors and child disclosure

The study outcomes are reported in Table 4. In this section, correlation strength will be reported, and non-significance highlighted. For levels of significance for individual correlations, please see Table 4.

Bivariate correlations between the parent-child relationship and disclosure

Bivariate correlations, which reflect the relationship between two variables, were reported in fifteen of the sixteen studies, between the parent-child relationship and adolescent disclosure. Of these, all studies found positive associations between the parent-child relationship and disclosure, with the exception of one study which found a significant negative relationship between parent-child relationship quality and non-disclosure (Dinizulu et al., 2014). However, these associations varied in strength. Of the studies that reported on positive associations, only one study (Fernandez et al., 2021) demonstrated consistent moderate positive correlations between the two variables (*r's* = .53 to .66), which were reported by adolescents. Eleven of the studies found weak to moderate correlations between the two variables (*r's* = .04 to .51). The remaining three studies showed mixed strength associations, which ranged from weak to strong (*r's* = .22 to .71).

Darling et al. (2009) found differences in the strength of the positive association between parental warmth and child disclosure, across different cultures (USA, Chile, and the Philippines). Although they demonstrated a weak correlation across the sample as a whole (*r* = .22), a moderate to strong correlation between the two variables was found for participants from the United States of America (*r* = .71). Thus, some cultural differences in terms of the

strength of association between these two variables was highlighted, with the USA having the strongest associations. Hunter et al. (2011) also looked at bivariate associations between adolescent reported relationship quality and disclosure, across different cultures (Costa Rica, South Africa and Thailand) and found moderate to strong correlations (*r's* = .43 to .70). In this study, additional analysis also revealed that the associations between parenting and adolescent self-disclosure were not contingent on gender or culture in their sample. The strongest correlation was found by Reidla & Swenson, (2012), in relation to adolescent reported disclosure and parent-child relationship quality (*r* = .71). However, the correlations between child and maternal reported measures, and maternal reported measures only, were only weakly to moderately associated in their study (*r's* = .25 to .50).

The strength of associations differed across studies depending on who the informer was for disclosure and relationship quality (i.e., adolescent or parent). Adolescent reported measures of parent-child relationship quality were more highly correlated with adolescent reported disclosure than the correlation between parents' reports of relationship quality and adolescent reported disclosure. Smetana et al. (2006) reported that although there were significant bivariate associations between parents' trust in their adolescent and adolescent reported disclosure, adolescents' trust in parents was more strongly associated with disclosure (*r's* = .40 to .48) than parental rated trust in the adolescent (*r's* = .17 to .23). Similarly, Chan et al. (2015) found that adolescent rated closeness and conflict with their parents was significantly associated with disclosure, however, parent rated closeness and conflict with the child was not significantly associated with any domain of disclosure about peers. It is noted that studies which use the same method of measurement., i.e., adolescent self-reports on disclosure and relationship quality, may be subject to shared method variance, which has been suggested to inflate correlations between variables.

Most studies within this review used questionnaire measures of disclosure and relationship quality. The one study which used an observational measure of emotional disclosure (Hare et al. 2011) found the weakest associations between relationship quality (maternal acceptance) and disclosure (*r's* = .04 to .13). One study also used a daily diary measure, in addition to questionnaires. In their study, Berg et al. (2017) found a significant positive association between the measure of parental acceptance and a self-report questionnaire measure of disclosure; however, this positive association was not significant between the daily diary measure of disclosure and parental acceptance.

The parent-child relationship and domains of disclosure

Whilst twelve of the studies looked at associations involving general disclosure, four studies, which reported significant positive correlations, also looked at the association between the parent-child relationship and disclosure within specific domains or activities. Of these studies, three used Social Domain Theory (Turiel, 1983; 2006) as a way of conceptualising the different activities which adolescents disclosed about. The associations reported between relationship quality and disclosure varied in strength depending on the social domain which was being assessed.

Kearney and Bussey (2014) study found weak positive correlations between parental warmth and disclosure of prudential, personal, and moral/conventional issues (*r's* = .27 to .39). However, Smetana et al. (2009) found relationship quality to be significantly positively associated with the disclosure of personal and peer issues, only. Although they reported a positive association with disclosure of prudential and multi-faceted issues, these were non-significant (*r's* = .13 and .06, respectively). The final study, which used this framework, demonstrated moderate positive correlations between relationship quality and the disclosure of peer, school, and personal issues (Smetana et al., 2006).

Chan et al. (2015) focussed specifically on disclosure of information about peers within different domains (relationship issues, positive features, negative features, and activities). The strength of correlations did not significantly vary depending on the domain of disclosure about peers, for adolescent reports.

Longitudinal Studies

Three of the studies reported on the association between the parent-child relationship and child disclosure, across multiple time points. Padilla-Walker & Son (2010) found that adolescent disclosure was longitudinally related to parental warmth (across three time points). In their study, Kearney and Bussey (2014) found that higher ratings of openness in communication with mothers were associated with more disclosure to mothers over two time points. Although maternal warmth was related to disclosure concurrently, this association no longer contributed uniquely to adolescent reports of disclosure over time, after communication variables had been taken into account. These findings suggested that the communicative quality of relationships and affective quality may contribute differently to the facilitation of disclosure over time.

Hare et al. (2011) was the only study which reported on the association between the parent-child relationship and emotional disclosure, specifically. Although Hare et al. (2011) did not find a concurrent significant bivariate association between the two variables, higher levels of maternal acceptance at age 13 were predictive of greater observed adolescent emotional disclosure at age 16 ($\beta = .23$, $p < .01$).

Differences between maternal and paternal relationship quality and disclosure

All but six studies differentiated between mothers and fathers in terms of adolescent ratings of parent-child relationship quality. Five studies obtained adolescent reports of both maternal and paternal relationship quality, whilst the remaining five looked at associations with the maternal relationship only. Of the studies which obtained relationship measures for both

parents individually, one study combined adolescent ratings of trust for mother and father due to high intercorrelations (Smetana et al., 2006) and another used the higher of the two measures (Darling et al., 2009).

Studies which reported relationship quality for mothers and fathers individually demonstrated that adolescent disclosure was positively associated with adolescent reported relationship quality for each parent. However, variations were found in terms of the strength of association between mother and father relationship quality and adolescent disclosure. Chan et al (2014) found weak to moderate correlations between disclosure and adolescents' closeness with their mothers (*r's* = .35 to .54), and weak correlations for fathers (*r's* = .20 to .30). Conversely, Hunter et al. (2011) also found weak to moderate correlations for mothers, however, they demonstrated moderate to strong correlations for fathers (*r's* =.43 to .70). This may reflect some cultural differences in their sample in terms of the association between the two variables.

When assessing correlations across different domains of adolescent disclosure, paternal relationship quality was positively correlated with disclosure about all activities except multifaceted, whereas maternal relationship quality only significantly correlated with disclosure about personal issues (Smetana et al., 2009).

Table 4: Study outcomes

Author	Disclosure measure	Parent-child relationship domain	Parent-child relationship measure	Outcome
Berg et al., 2017	**SR**: Modified measure of voluntary disclosure (adapted from Stattin & Kerr, 2000) Daily diary of disclosure to parents	Acceptance	**SR:** Mother–Father–Peer scale (Epstein, 1983); acceptance subscale	Acceptance was positively associated with voluntary disclosure for both mothers (r= .32, p <.01) and fathers (r=.45, p <.01). Daily diary reports were non-significant (r= .08 to .09).
Chan et al. 2015	**SR:** Disclosure about Peers Inventory (DAPI)	Closeness and conflict	**SR and PR:** Network of Relationships Inventory (NRI; Furman and Buhrmester 1985)	**SR:** Closeness with mothers and fathers was positively associated with disclosure about peers (r values between .20 and .54, p < .001). **PR:** Closeness and conflict with the child was not significantly associated with any domain of disclosure about peers.
Darling et al., 2009	**SR:** The Strategic Disclosure Questionnaire	Perceived parental warmth	**SR:** Eight-item scale derived from the Parenting Style Inventory (PSI-II; Darling & Toyokawa, 1997) and a warmth and acceptance scale (Greenberger & Chen, 1996)	Perceived parental warmth was associated with greater likelihood that adolescents would disclose overall across all cultures (r = .22, p <.001). Parental warmth was not significantly associated with disclosure within the Philippines.

Author	Disclosure measure	Parent-child relationship domain	Parent-child relationship measure	Outcome
Dinizulu et al., 2014	**SR:** Reasons for Keeping Things Private scale (RFKTP; McIntosh, 2003)	Trust, communication, and alienation	**SR:** Inventory of Parent and Peer Attachment (IPPA; Armsden and Greenberg 1987)	Parent-adolescent relationship quality was negatively associated with non-disclosure (*r*=-.46, *p*<.*05)*
Everri et al., 2016	**SR:** Modified measure of voluntary disclosure (adapted from Stattin & Kerr, 2000)	Quality of communication	**SR:** Family Communication Scale (FCS) that is based on the Parent-Adolescent Communication Scale (PAC; Barnes & Olson, 1985)	Youth disclosure was positively associated with quality of family communication (p <.001).
Fernandez et al., 2021	**SR:** Adolescent reports of self-disclosure (adapted from Stattin & Kerr, 2000)	Parental support	**SR:** Parent Support subscale from the Child and Adolescent Social Support Scale (CASSS; Malecki & Demaray, 2002)	Child disclosure was positively associated with parental support for both Hispanic (r = .66, p < .001) and non-Hispanic individuals (r = .53, p < .001).
Hare et al., 2011	**Observational task:** Interactions on a supportive behaviour task were coded using the supportive behaviour coding system (Allen et al. 2001)	Maternal acceptance	**SR and MR:** Child Report of Parent Behaviour Inventory (CRPBI; Schaefer, 1965); acceptance subscale	SR of maternal acceptance were not significantly associated with observed disclosure within time points. Higher maternal acceptance at age 13 were predictive of greater observed adolescent emotional disclosure at age 16 (β = .23, p <.01).

Author	Disclosure measure	Parent-child relationship domain	Parent-child relationship measure	Outcome
Hunter et al., 2011	**SR:** General self-disclosure (survey generated from qualitative interviews)	Parental acceptance	**SR:** Child Report of Parent Behaviour Inventory (CRPBI; Schaefer, 1965); acceptance subscale	General self-disclosure had a positive relationship with parental acceptance across genders and cultures (*r*'s ranged between .43 and .70, $p = <$ .001).
Kearney & Bussey, 2014	**SR:** The Teen Overall Level of Disclosure Scale (TOLDS) created for the purpose of the study	Maternal warmth/responsiveness Openness in communication	**SR:** Child's Report of Parent Behaviour Inventory (CRPBI-30; Schludermann & Schludermann, 1970); acceptance subscale.	Maternal warmth/responsiveness was positively associated with disclosure at both T1 ($r = .34$, $p<.001$) and T2 ($r = .38$, $p<.001$). Maternal warmth/responsiveness at T1 predicted disclosure to mothers at T2 ($\beta = .09$, $z = 2.05$, $p = .040$).
Lippold et al., 2015	**MR:** Perceptions of adolescent routine disclosure about their whereabouts and activities (Kerr & Stattin, 2000)	Affective quality	**SR:** Measure of positive and negative interactions in the affective domain of the relationship (Conger 1989; Spoth et al. 1998).	Affective quality of the parent-child relationship was positively correlated with perceived child disclosure ($r = .26$, $p<.001$).
Padilla-Walker & Son, 2019	**SR and PR:** Modified measure of voluntary disclosure (adapted from Kerr & Stattin, 2000)	Parental warmth and autonomy granting.	**SR and PR:** Items from the Parenting Styles and Dimensions Questionnaire (PSDQ; Robinson, Mandleco, Olsen, & Hart, 2001) relating to parental warmth and autonomy granting	**SR:** Disclosure was positively associated with parental warmth and autonomy granting, for both mothers and fathers (*r*'s between .20 and .49, $p < .01$). **PR:** Disclosure was positively associated with warmth and autonomy granting (*r*'s between .28 and .60, $p<.01$).

Author	Disclosure measure	Parent-child relationship domain	Parent-child relationship measure	Outcome
Reidla & Swenson, 2012	**SR and MR:** Self-Disclosure Questionnaire (Rose 2002; adapted from Parker & Asher, 1993)	Perceived parental support	**SR and MR:** Network of Relationships Inventory (NRI) Social Provisions Version (Furman, 1996)	**SR and MR**: Positive relationship quality was positively associated with child disclosure (*r*'s between .25 and .71, *p*<.001).
Roth et al., 2009	**SR:** Adolescent reports of self-disclosure (adapted from Stattin & Kerr, 2000)	Autonomy support	**SR:** Measure of perceptions of mother's autonomy support adapted from Grolnick et al., (1991)	Adolescent self-disclosure was positively associated with perceived parental autonomy support (*r* = .23, *p*< .05).
Smetana et al., 2006	**SR and PR:** Ratings of willingness to disclose on a number of issues (Smetana et. al., 2006).	Trust and parental acceptance	**SR:** Parent-Peer Attachment Inventory (PPAI; Armsden & Greenberg, 1987), trust subscale **PR:** Children's Report of Parents' Behaviour Inventory (CRPBI; Schaefer, 1965a, 1965b; Schludermann & Schludermann, 1970), acceptance/ rejection subscale	**SR:** Trust in parents was positively associated with disclosure across all domains *(r*'s ranged between .40 and .48, *p* = < .01). **PR**: Acceptance was also associated with disclosure across all domains (*r's* ranged between .13 and .29, *p* = <.01).
Smetana et al., 2009	**SR:** Ratings of willingness to disclose on a number of behaviours in a card sorting task (based on Darling et al., 2006)	Trust and parental acceptance	**SR:** Parent-Peer Attachment Inventory (PPAI; Armsden & Greenberg, 1987), trust subscale	Relationship quality was positively associated with disclosure of personal, prudential, and peer issues to mothers (*r's* ranged between .24 and .31, *p* = < .01) and personal issues (*r* = .24, *p* = < .05) to fathers.

Author	Disclosure measure	Parent-child relationship domain	Parent-child relationship measure	Outcome
Villalobos Solís et al., 2015	**SR:** Daily diaries of disclosure and secrecy with mothers	Relationship quality	**SR:** Daily diaries of relationship quality and time spent together with mothers	Relationship quality was positively associated with disclosure of personal (r = .14, p = < .01) and multifaceted (r = .09, p = < .05) activities to mothers.

SR = Self-report; PR= Parental report; MR= Maternal report

Discussion

This is the first review to have examined the association between parent-child relationship quality and adolescent disclosure. We looked at this across sixteen studies in total. Parent-child relationship quality was positively associated with adolescent disclosure in all studies across different domains of disclosure. The study also showed that greater maternal/parental warmth and acceptance were associated with greater disclosure over time. However, this review highlights that the strength of association between relationship quality and disclosure may vary depending on the domain of disclosure and informer.

The findings from this review indicate that better parent-child relationship quality is linked to greater levels of general adolescent disclosure. However, some of the studies reviewed suggested that there are differences in terms of the kinds of issues adolescents are willing to disclose about and, subsequently, the associations between relationship quality and different domains of disclosure. One explanation for this may lie in research embedded in Social Domain Theory (Turiel, 1983; 2006) which suggests that adolescents view parents to have authority to know about some domains of their behaviour but not others (Smetana et al., 2006). Parent-child relationship quality may be less important in facilitating disclosure within domains that adolescents feel parents have more authority to know about. Similarly, as adolescents view disclosure over personal issues as discretionary rather than obligatory (Smetana et al., 2006; 2009), better relational quality may be more important in facilitating disclosure within this domain than others.

Although most studies found a significant positive association between the outcome measures, the majority of these correlations were weak to moderate. This indicated that although there is a relationship between these outcome measures, there are other factors which contribute to child disclosure that warrant further investigation. Some of the cross-sectional studies involved in this review also highlighted associations between other parental factors and

adolescent disclosure, such as parental solicitation of information. Other research has found a link between authoritative parenting and greater disclosure (Darling et al., 2006). Studies have also suggested that individual adolescent factors, such as disclosure self-efficacy and adolescents' perceived communication competence, may offer further insight into factors which facilitate adolescent disclosure (Kearney and Bussey, 2014). As suggested in previous research, family environments which are considered to be warm, trusting, and accepting by both parents and adolescents, appear to play crucial role in increasing the likelihood that adolescents will disclose more information about their lives (Hunter et al., 2011) However, there are other factors at a parenting and individual level, which may also be important in facilitating the process of disclosure. At present, these are under explored.

A number of studies included more than one informer on measures of the parent-child relationship (i.e., an adolescent report and a parental report). Interestingly, the strength of the association with adolescent reported disclosure varied depending on whether the parent or adolescent completed the measure of relationship quality. This suggests that parents and adolescents may vary in terms of their perceptions of relationship quality and the consistency of this should be explored in future research. These between informer differences on outcomes have also been highlighted in previous research with adolescents and parents, which has found that within-informer correlations are generally higher than cross-informer correlations (Achenbach McConaughy, & Howell, 1987; Hartos & Power, 1999).

Most studies were conducted in the USA and included participants from a range of ethnic groups. However, it is noted that participants across studies were predominately White European/American. Of the studies which assessed the relationship between parent-child relationship quality and adolescent disclosure cross-culturally, both consistencies and inconsistencies were found. Hunter et al. (2011) found that relationship quality related to adolescent disclosure across all cultures, however this association was slightly stronger for

fathers than mothers. Overall, study findings suggest that the association between parent-child relationship quality and adolescent disclosure is present across different ethnic groups and cultures. However, further cross-cultural research and research involving participants from different ethnicities is needed to further investigate this.

As the majority of the studies reviewed were correlational, the direction of causation is not entirely clear and warrants further exploration in future research. However, three studies which longitudinally investigated the relationship between parent-child relationship quality, found evidence that greater maternal/parental warmth and acceptance were associated with greater disclosure over time. This suggests that better relationship quality with parents is an antecedent to adolescent disclosure. However, as such limited research has been conducted in this area, it is difficult to draw conclusions.

Strengths and Limitations

Most studies included in the present review used adolescent and parent self-report methods i.e., questionnaires and daily diaries, to assess relationship quality and adolescent disclosure. Self-report measures are commonly used as other methods, such as observational methods, may be time-consuming and expensive with larger samples. However, there are limitations to using self-report measures. As self-report relies on a person's reflective abilities, they may be subject to response bias or demand characteristics. Furthermore, as previously noted, using the same method to collect data within a single time-point may mean that the data is subject to shared method variance, which has been suggested to inflate correlations (Brannick, Chan, Conway, Lance, & Spector, 2010).

Some studies included in the review differentiated between mothers and fathers in adolescent reports of relationship quality, with some studies obtaining a report of relationship quality for both parents individually, and some for mothers only. However, fewer studies

looked at adolescent disclosure to mothers and fathers separately. Examining the relationship between relationship quality and adolescent disclosure for parents separately rather than together may be important given that previous research has highlighted differences between mothers and fathers in terms of adolescents' voluntary disclosure (Smetana et al., 2006; Soenens et al., 2006). Moreover, many of the studies which included parent informer measures, largely recruited mothers. The absence of fathers in adolescent research has historically been highlighted as an ongoing issue (Phares, 1992; Zimmerman, Salem, & Notaro, 2000). Reasons for this may relate to difficulties in recruiting fathers into research. For example, Smetana et al. (2006) noted that a high proportion of participants in their study came from single parent families, nearly all of which involved mothers, therefore recruiting sufficient numbers of fathers was not possible, to draw comparisons.

Finally, this review predominately synthesises studies which have reported on correlations between the parent-child relationship and adolescent disclosure. This is problematic as it assumes a linear relationship exists between these two variables. Although the literature consistently suggests that greater adolescent disclosure is associated with better psychosocial adjustment (e.g., Kerr & Stattin, 2000; Kerr, Stattin, & Burk, 2010), it is also noted that adolescent disclosure has been demonstrated to reduce throughout the period of adolescence, which is considered to serve a developmental function (Finkenauer et al. 2002; Keijsers et al., 2009). For example, research has demonstrated that disclosure to parents and quality of the relationship with parents, contribute negatively to feelings of emotional autonomy in adolescence (Finkenauer et al., 2002). Thus, not all disclosure to parents may be optimal as is suggested by the findings synthesised in this review and appropriate non-disclosure of information may relate to increased autonomy and independence, as young people transition through adolescence. Further research which addresses issues surrounding

appropriate disclosure and appropriate non-disclosure in adolescence is required to further understand the relationship between these two variables.

Clinical Implications and Future Research

Given that research has highlighted that adolescent disclosure is linked with better psychosocial adjustment, more prosocial behaviour, and reduced levels of anti-social behaviours, research into the factors which promote disclosure in adolescents are important. The findings of this review may have clinical implications for parenting interventions, which are aimed at reducing anti-social behaviours or promoting health and wellbeing of adolescents. Indeed, supporting parents to create an environment and relationships, which are considered warm, accepting and trusting by their adolescent child, may increase adolescent disclosure, and subsequently promote better adjustment.

The differences between adolescent and parent ratings highlighted in this review are consistent with other research (Hartos & Power, 1999; Reidler & Swenson, 2012), which suggests the importance of collecting multiple perspectives when conducting research or in clinical practice, with parents and adolescents. Considering the particular informer's perspective individually (i.e., adolescent or parent) can provide valuable insight into the parent-child relationship (Reidler & Swenson, 2012).

Further research using longitudinal designs, involving multiple informer ratings, across cultures, would be beneficial in order to establish evidence for causal relationships between adolescent disclosure and the parent-child relationship. Future research within this area should also attempt to include fathers, given that these are under-represented in current adolescent research.

Conclusion

Parent-child relationship factors, including warmth, acceptance, and trust, are associated with greater disclosure of adolescents to their parents. This has been consistently reported for relationships with both mothers and fathers and in relation to different domains of disclosure, using multiple informant methods. However, the research area is constrained by the majority of these relationships only being explored on a cross-sectional basis. Further research which investigates associations been these two variables over time will provide further evidence regarding the nature of this relationship.

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Chapter Two: Empirical Paper

Information sharing and confidentiality: Exploring the experiences of young people who are accessing a CAMHS service for virtual therapy within the context of COVID-19

Correspondence to be addressed to:

Toni Garner

Department of Clinical Psychology

Whelan Building

Quadrangle

Brown Hill

Liverpool

L69 3GB

Telephone: 0151 794 5534

Email: Toni.Vedmore@liverpool.ac.uk

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Abstract

Background: Whilst previous research has highlighted some of the complexities relating to working with young people and their families in relation to confidentiality and information sharing, the context of remote working and virtual therapy potentially poses new challenges. This study aimed to explore young people's experiences of virtual therapy in relation to confidentiality and information sharing, within the context of virtual therapy.

Methods: Five young people, aged between 13 and 18 years, took part in a semi-structured interview to explore their experiences. Thematic analysis was used to analyse the interviews.

Results: Five master themes were identified, which captured participants' experiences. These were *'Navigating the shift to virtual therapy', 'Therapy at home: A blurring of boundaries', 'Developing and maintaining the therapeutic relationship in the virtual world'; 'The importance of confidentiality and managing this in a virtual space'*, and *'The role of the family'.* Subthemes were also identified within each of the themes.

Conclusions: The findings highlighted the importance of involving young people in decisions about information sharing and parental involvement, however, family involvement can prove beneficial if this is facilitated in a collaborative way. Issues of confidentiality were emphasised and some difficulties relating to maintaining this in the home environment were discussed. Other findings relating to challenges associated with virtual therapy more generally were also identified. The study highlights the importance of working collaboratively with young people to support them to engage effectively in virtual therapy, and manage issues surrounding information sharing and confidentiality within this context. Further research within this area is required to fully capture the experiences of young people and their parents, in relation to issues of confidentiality and information sharing, within this context.

Keywords: *Adolescents; CAMHS; Virtual therapy; Confidentiality, Information sharing*

Introduction

Developing autonomy and individuation from parents is considered critical as young people transition through adolescence (Blos, 1967; Erikson, 1994). This transitional period is also related to changes in terms of parent-child communication, with adolescents being less inclined to share information with their parents during this time (Finkenauer, Engels, & Meeus, 2002; Keijsers & Poulin, 2013). Thus, it is perhaps unsurprising that issues of confidentiality and information sharing between services, young people, and their parents, have been suggested to pose challenges of increased complexity within Child and Adolescent Mental Health Services (CAMHS) settings (Vallance, 2016). Such challenges surrounding information sharing and confidentiality, between adolescents, their parents, and services, can be a barrier to providing person centred care (Gondek et al., 2017).

Within CAMHS settings, therapists endeavour to put young people at the centre of their care and involve them in decisions about their welfare. This is widely acknowledged within legal frameworks and practice guidelines (Children Act, 1989; CAMHS, 2008). However, difficulties pertaining to issues of consent, confidentiality, and competing interests between parents and young people have previously been highlighted as challenges which professionals need to navigate in order to deliver person-centred care (Combe, Short & Stephens, 2006; Koocher, 2008). Although frameworks, such as the Mental Capacity Act (Department of Health, 2005), best practice guidelines, and other legal frameworks (CAMHS, 2008; Cox, Brannigan, Harling, & Townend, 2016) allow young people to exert some power around issues of confidentiality and information sharing, this is not an absolute.

Adolescents are often considered to be a difficult to engage group by mental health professionals (Shirk & Karver, 2003). Young people are often referred to services by parents or other professionals, rather than self-referred, and may disagree around the goals for therapy, which can impact on their motivation to engage (Koocher, 2003; 2008). Thus, research into

how engagement in therapy can be facilitated with this group is particularly important (Freake, Barley, & Kent, 2007). In their review of adolescents' experiences of helping professionals, Freake et al. (2007) reported that confidentiality, trust, and the interpersonal qualities of the therapist, such as them being non-judgemental and caring, were found to be particularly important to adolescents in the context of therapy. Other research has highlighted the role of the therapeutic relationship in facilitating disclosure and young people's engagement in therapy (Day, Carey, & Surgenor, 2006), and the subsequent impact of these on therapeutic outcomes (Day, 2008).

Previous research has also emphasised confidentiality and trust as being important in supporting the development of the therapeutic relationship and thus in facilitating young people's engagement in therapy (Coyne et al., 2015; Freake et al., 2007). Indeed, it is suggested that for the development of an effective therapeutic relationship within mental health settings, adolescents need to feel that their therapist will prioritise confidentiality (Tan, Passerini, & Stewart, 2007; Tebb, 2011). Research which has asked young people about their experiences of mental health services has reported that young people value having a confidential space to speak privately with professionals (Freake et al., 2007; Harper, Dickson, & Bramwell, 2014) and that the presence of parents can sometimes constrain communication (Coyne et al., 2015). Moreover, research has shown that when young people have experienced breaches of confidentiality, and even when they have fears that confidentiality will be breached, they have more negative attitudes toward mental health services and professionals (Wilson & Deane, 2001).

Nonetheless, having the cooperation of parents is also recognised as important when working young people within mental health services (Coyne et al., 2015; Grealish, Tai, Hunter & Morrison, 2013). Working in partnership with parents is considered to enhance engagement in therapy and often considered vital in supporting a young person's wider care (Gross &

Goldin, 2008). Indeed, the sensitive sharing of information between parents, young people and services may enable parents to best support their children (Iachini, Hock, Thomas, & Clone, 2015). Parents' engagement in the therapeutic process can also provide opportunities to help them to support the development of communication in the wider family system (Vallance, 2016). Therefore, there is a need to balance issues surrounding confidentiality with therapeutic interest, which may present a number of challenges and ethical dilemmas in clinical practice (DeSousa, 2010).

The context of virtual therapy

During the COVID-19 pandemic, the way in which CAMHS delivered therapy to young people was transformed rapidly (Bhardwaj, Moore, Cardinal, Bradley, Cross, & Ford, 2021). Social distancing guidelines and restrictions were put into place by the UK Government, to slow down the spread of the virus. Consequently, in person therapy largely ceased and services moved towards completing this through virtual means, i.e., by video or telephone. Both therapists and young people were required to adapt to this new way of working together within a short space of time, often without prior experience of engaging with therapy in this way, and crucially, without choice or discussion (Cliffe, Croker, Denne & Stallard, 2020). For young people already engaged in therapy, this meant an unexpected shift from in person therapy to virtual therapy, whilst for others, this meant that they accessed services for the first time through virtual means.

In order to effectively support young people, services need to create contexts in which young people feel comfortable to disclose information. Previous literature indicates that confidentiality and trust in the therapist are key in this (see Freake et al., 2007), however, there is a paucity of research surrounding these constructs within the context of virtual therapy. Indeed, within this way of working, young people often access support from their own home,

using electronic devices, which potentially raises a number of new challenges with regards to maintaining confidentiality within a shared environment and across shared electronic mediums.

Aims

Given that virtual therapy continues to be offered routinely in CAMHS, it is important that the experiences of young people in relation to this mode of therapy and confidentiality are explored. This may help to guide how virtual therapy is delivered in the future as this may remain the only option for some time, and may still be available once face to face services resume. This research therefore aims to qualitatively explore young people's experiences of information sharing and confidentiality, within the context of virtual therapy, during the COVID-19 pandemic.

Method

Design

A qualitative study design, using semi-structured interviews, was the most appropriate methodology to explore the individual experiences of the participants, with the aim of obtaining in-depth accounts, emphasizing young peoples' personal experiences of confidentiality and information sharing within the context of virtual therapy, whilst also drawing broader patterns of meaning across interviews to provide an overview of experiences. The study aimed to recruit participants with unique experiences of therapy and adopting this methodology allowed for each participant's own experience to be understood individually, before themes across cases are identified.

Input from service users

The Liverpool Experts by Experience group (LExE) and an adolescent service user expert were consulted during the beginning stages of the research, and the documentation, procedures and interview guide were adapted based on their feedback. An adolescent service user also took part in a pilot interview prior to recruitment, to further guide the recruitment and interview process, and refine the interview topic guide. Feedback was also sought from participants as the research progressed. This led to further refinement of the procedure for subsequent interviews.

Ethical considerations

This study was reviewed by the Doctorate in Clinical Psychology Research Committee and awarded University Sponsorship (see Appendix C). Ethical approval was granted by the London and Sussex NHS Research Ethics Committee and the Health Research Authority

(Appendix D). The study was also approved by the research and development team at the participating NHS Foundation Trust.

Recruitment

In line with similar studies, the present study aimed to recruit between five and ten participants (e.g. Bee, Berzins, Calam, Pryjmachuk, & Abel, 2013). Participants were recruited from three NHS Child and Adolescent Mental Health Services (CAMHS) in the North-West of England. Clinicians contacted young people or their parents (depending on whether the young person was considered to be able give consent) via telephone call to determine if they were willing to be contacted by the researcher in relation to the study. The researcher then contacted the young people or parents that consented to be contacted by telephone for an informal discussion about the study and to establish whether they would like to take part. Participant and parental information sheets and consent forms were shared via email, if the young person indicated that they were happy to take part in the study (see Appendix E-I). For those participants under the age of 16 years, consent was obtained from their parents and assent was obtained from the young person. For participants aged 16 years and over, participant consent only was obtained. Those who wished to proceed arranged a date to meet with the researcher for interview by video call. Interviews took place by video call in light of the COVID-19 pandemic and the safety precautions put in place the participating NHS trust at this time. At interview, the participants were given the opportunity to ask any further questions and verbal consent to continue with the interview was obtained. Participants were given a £10 voucher following interview to thank them for their time.

Participants and sampling

Five young people, aged between 13 and 18 years were interviewed between May 2021 and July 2021. One additional participant consented to be contacted and was eligible for

recruitment. However, they did not participate in the interview. All participants were accessing or had accessed virtual therapy (by video or telephone) with CAMHS for mental health difficulties during the COVID-19 pandemic. Participants were excluded if they had accessed CAMHS for assessment only, due to the limited number of sessions that the young person was likely to have engaged with. Due to the reliance on spoken English language, only participants able to communicate in English were accepted into the study. All participants represented a convenience sample, led by clinicians. Demographic information is displayed in Table 1.

Interviews

The interviews followed a semi-structured interview schedule (see Appendix J), which was developed in collaboration with the supervisory team, two of which have extensive experience of working with young people within a CAMHS setting. The schedule was flexibly followed to support the natural flow of conversation and allow the researcher to adopt a curious approach to interviewing (Smith & Osborn, 2008). The researcher transcribed two interviews themselves to support familiarisation with the data and the development of initial coding. The remaining interviews were transcribed by a transcriber affiliated with the University of Liverpool.

Data Analysis

Data was analysed using thematic analysis, following the framework outlined by Braun and Clarke (2006). Thematic analysis was considered to be an appropriate methodology for the analyses, as it is an accessible and theoretically flexible approach to analysing qualitative data, which allows for patterns of meaning across data sets to be identified (Braun & Clarke, 2006). Given that this is a relatively new area of research, there is little existing theory around this topic. The researcher first familiarised themselves with the data and immersed themselves into

this through the process of listening to audio recordings and re-reading transcripts several times. Initial exploratory comments were made for each transcript, focussing on descriptive, linguistic, and conceptual aspects of the participant's narratives. These exploratory comments were used to identify emergent themes, which were then grouped into super-ordinate themes. This process was repeated for each transcript individually, before the researcher moved to the next participant. Finally, patterns across different transcripts were identified and super-ordinate themes across participants were grouped into master themes.

The researcher shared transcripts, initial coding, and emergent themes with their supervision team throughout the development and refinement process of themes, after one participant transcript and again after completion of three participant transcripts. Final master themes were discussed, developed, and refined in collaboration with the researcher's primary supervisor. Following refinement of the themes, a final re-reading of the original transcripts was completed by the researcher to ensure that themes were grounded in participants' accounts prior to writing the analysis (Smith & Osborn, 2003).

Reflexivity

Within qualitative methodology, the researcher is engaged in a double hermeneutic; they are trying to interpret the participants' process of making sense of their world and experiences (Smith & Osborn, 2003). Thus, it is important to acknowledge the active role of the researcher in the research process and the impact of their own conceptions on their interpretation of the participant's narratives. In doing this, the researcher attempts to suspend their existing knowledge and beliefs to adopt a position of reflexivity.

The researcher was completing a Doctorate in Clinical Psychology during the data collection process and was delivering remote therapy with young people as part of their course

placements. Within this context, the researcher had experienced their own challenges relating to virtual working with young people and therefore was aware of how their own experiences had led to their interest in pursuing research in this area. Through discussion with the supervisory team, the researcher was able to reflect on how their own experiences may have the potential to influence their interpretation of participants narratives. A reflexive statement can be found in Appendix K.

Results

Table 1. *Participant demographics*

Name	Gender	Age	Mode of therapy	Previous experience of therapy
James	Male	15	Video	Yes
Oliver	Male	13	Video	Yes
Grace	Female	17	Telephone	Yes
Katie	Female	18	Telephone	Yes
Erin	Female	14	Video/Telephone	Yes

Table 2. *Themes and subthemes*

Main themes	Subthemes
1. Navigating the shift to virtual therapy	• Expectations of virtual therapy • Technical challenges in the virtual space
2. Therapy at home: A blurring of boundaries	• Therapy in my space • Transitioning from therapy back to normal life
3. Developing and maintaining the therapeutic relationship in the virtual world	• Who is this person? • Challenges in connection • The virtual space facilitating openness
4. The importance of confidentiality and managing this in a virtual space	• Therapy as a confidential space to be myself • Struggles with creating a confidential space
5. The role of the family	• The impact of virtual working of family involvement • Collaborative information sharing • The benefits of systemic support

Theme One: Navigating the shift to virtual therapy

All participants had some previous experience of face-to-face therapy however they had not engaged with virtual therapy prior to the COVID-19 pandemic. This theme illustrates

participants' previous experiences of therapy, their expectations surrounding virtual therapy, and the initial practical challenges that they experienced in relation to working in a virtual way.

Expectations of virtual therapy

Although all participants had previous experience of face-to-face therapy, only one participant was actively engaging with face-to-face therapy at the time of the shift to virtual working. For James, the move to virtual therapy was unexpected.

"It kind of came to me as a shock as I remember going to the clinic to speak about virtual therapy and it really instantly shocked me 'cause I never though COVID would impact my therapy. I thought my therapy would be as usual" (James).

James discussed how he experienced the shift to virtual therapy to be *'distressing'.* This change in terms of how he engaged within therapy also came in the context of wider societal changes and restrictions as a result of the COVID-19 pandemic. James commented that *"everything changed like the way we were put into lockdown and stuff",* which left him feeling restricted and isolated across many areas of his life, including therapy. Therefore, participants were situated within a context where they had been required to adapt to numerous unexpected changes to their normal routine and social communication, within a short period of time.

Other participants had more time to adjust to the idea of virtual therapy and noted that virtual communication was also becoming the norm across other areas of life. Grace commented that she *"sort of expected it…(other appointments) have been, erm, like over the phone, it was just getting used to it at that point".* Although some participants had expected therapy to take place virtually, they reported that they did not know what to expect from this and initially experienced it as unfamiliar, confusing, and strange.

"it was a bit strange, like I think everyone found it a bit strange at the beginning" (Katie).

This 'strangeness' appeared to relate to unfamiliarity with the process of online therapy, interpersonal challenges, such as developing a relationship with someone they had not met

before, and contextual factors, such as the physical environment that they were completing therapy in (i.e., their own home).

Technical challenges in the virtual space

When discussing how they were able to navigate the shift to virtual ways of engaging in therapy, four participants discussed the practical challenges of this in relation to technology and technical difficulties. Katie commented, *"we'll be in the middle of a conversation and then it'll just like go dead and then it's like hello, hello, and then like you have to start again".* Difficulties with technology were considered to impact on the flow of therapy, which sometimes resulted in feeling that therapy was disjointed and disconnected, and in some cases, was felt to impact on the quality of therapy.

Erin discussed times when her camera did not work and how this resulted in a loss of non-verbal communication, which she perceived to be important to her: *"When the camera doesn't work, then I think it's a bit difficult because then the therapist can't read my facial expressions".* Erin discussed that young people are often 'closed off' and therefore she felt that non-verbal communication and facial expressions are important in providing the therapist with additional insights into what might be going on for someone. She went on to discuss how this reliance on verbal communication can allow her to avoid discussions and 'brush over' difficulties more easily: *"It was quite easy to just say oh yeah yeah yeah I'm fine".* This subsequently had the potential to impact on the quality of therapy, as Erin did not always actively engage in this process initially.

Despite some of the initial challenges with technology, all participants engaged in therapy through virtual means. Participants talked about adjusting to this new way of working through a process of familiarisation., i.e., they gained more knowledge and understanding of

what virtual therapy was like by direct participation in this, which subsequently resulted in them feeling more comfortable in relation to working in this way.

Theme Two: Therapy at home: A blurring of boundaries

The shift to virtual therapy has created a change in terms of the physical space in which young people engage in therapy. This theme illustrated the lack of separation between therapy and the young person's real life as a consequence of doing therapy in their own home environment, the challenges that were experienced in relation to this, and how these were overcome.

Therapy in my space

"My rooms a place for me" (James)

All participants spoke about the nature of attending therapy in their own environment and how this impacted upon them and the therapy. Young people's narratives reflected some of the challenges posed by the perceived informality and lack of structure around therapy sessions. Grace discussed that waiting for a therapy phone call at home triggered feelings of *'anxiety'* which seemed to relate to the loss of control she experienced around her ability to actively attend therapy and set boundaries around this.

"At least in person you're, you're there and you're in like a clinic or a doctor's office, something like that, and you're there in the place but if you're in your house waiting on that phone call it can be quite…tense in a way" (Grace).

This appeared to trigger feelings of vulnerability and highlight power differentials in terms of the relationship with the therapist, as the therapy was felt to take place on the therapist terms.

Participants talked about the informality of therapy at home and suggested that virtual therapy was not always held in the same regard as face-to-face therapy. Erin commented that, *"it…is a lot harder to kind of have like, almost like the motivation to do it"* when therapy is virtual and Katie noted that she felt it was easier to cancel sessions, compared to attending therapy: *"oh well it's just a phone call, like you can just cancel".* Indeed, the physical space of home did not always facilitate the mental space that participants felt that they needed to be in to get the most out of therapy. *"You're not kind of ready for it or you're not kind of like yeah like engaged"* (Katie).

James discussed feeling *'self-conscious'* and exposed being on camera in his bedroom. He commented how his bedroom is a place for him and he experienced discomfort at the therapist being privy to that space and being able to see it: *"I find it pretty intrusive".*

Interestingly, one participant commented on the impact of the therapist being in their own home environment, which also resulted in a blurring of the personal and professional life of the therapist, which resulted in therapy feeling as though it lacked boundaries.

"You'd hear like his family in the background and it'd just be like, mm, and then…he'd be like oh yeah so I've done this with my son today and then…he'd say oh just give me one minute, I just need to go and give this to my wife" (Grace).

In Grace's account, the nature of the therapy was considered to be both informal and lacking boundaries but also overly rigid and *'scripted'*, which left her feeling unheard, dismissed, and ultimately unable to see the value in the therapy.

Although most participants noted the initial challenges of completing therapy in the home environment, for Oliver this was experienced positively. Oliver commented on how being in a familiar environment facilitated feelings of safety and enabled him to feel more

relaxed: *"You feel a lot more comfortable at home even though it's just the same like it would be…but you think it's better that's all that matters isn't it? That you feel safer"*. Oliver discussed how these feelings of comfort and safety enabled him to be more open with his therapist and subsequently, engage more effectively in the therapy. Oliver was the only participant to comment on the safety of the home environment. This emphasis on safety appeared to be relevant to his past and experiences and why he was subsequently referred for therapy.

Transitioning from therapy back to normal life

Three participants discussed how they experienced difficulties in separating and transitioning from therapy back to their life, when this was taking place in the home. In face-to-face therapy, the structure and processes around therapy were considered to naturally facilitate separation, for example, going to an appointment, therapy taking place in a specific room, and leaving that place once therapy has ended. However, this was not the case in virtual therapy.

"It's this, air of like awkwardness after the session finishes if that makes sense. Cos in person, you have like this erm, oh ok goodbye, let's go get in the car, and oh I don't know, get something to, like, usually we just like go grab something at McDonalds or something you know after a session. But when it just ends and you're sat next to like your Mum and you just don't know what to say." (Erin)

Similarly, Katie commented that *"it's a lot harder to kind of like to switch that off and like do something else cos you're still in the same place"*.

James talked about how the experience of difficulties during sessions could have a greater impact on how he felt after sessions, within virtual therapy. James was engaging in long term psychotherapy at the time of interview and noted that sometimes sessions ended on a silence. He commented that *"when a session would end on a silence it could really impact my day quite negatively".* For James, there was a sense that the atmosphere of the therapy continued to linger in his personal space even after the therapy ended and had lasting effects on him. When the therapy session was experienced positively, this also transferred to the remainder of his day.

Over time, some participants created new ways of facilitating the shift from 'therapy mode' to 'life mode', which helped to develop a structure and allowed them to regain a sense of control and separation. This involved specific activities that allowed them to separate therapy from their life.

"I often try to like go for a walk or do something afterwards that's like, that's completely different to kind of and like move around a bit to kind of, to you know to almost have that like oh, you you're coming home from it" (Katie)

Theme 3: Developing and maintaining the therapeutic relationship in the virtual world

The therapeutic relationship and relational dynamics were intrinsic to all participants' narratives and are considered to be integral to the success of therapy. This theme reflected some of the challenges that participants experienced in terms developing a relationship with the therapist, feeling connected to them, and the impact that this had upon therapy.

Who is this person?

All of the participants, with the exception of James, met their therapist for the first time within the virtual world. Grace discussed how challenging she found it meeting someone for

the first time over the telephone: *"you didn't have like a face to the name or the voice and it was just like you could have been talking to anyone sort of thing"*

Oliver also talked about how he was reluctant to engage with therapy online as he had fears relating to who the person was that he would be talking to and whether they could be trusted. He commented that *"anyone could be behind the screen really"*. There was something lacking and unseen in terms their experience of the therapist within the virtual world, which appeared to impact on his ability to trust the therapist initially. Oliver discussed how he overcame this by arranging a face-to-face meeting with his therapist, which allowed him to see that they were a real person and view him as ultimately *"just a man doing his job"*.

Physically being able to see the therapist, even by video, appeared to allow the participants to feel more connected to the therapist and facilitated the development of the therapeutic relationship.

Challenges in connection

Some participant's narratives reflected upon how feelings of connectedness to the therapist were different in the virtual space. James who, unlike any of the other participants, was engaging in long term psychotherapy, placed significant focus on the relational aspects of the therapy. He discussed how he felt the impact of not physically being with the therapist: *"I wasn't with my therapist, there was like a really large gap".* This gap related not only to physical distance but also to the emotional distance he experienced between him and his therapist within the virtual space. Subsequently, James discussed that he often experienced difficulties communicating what he wanted to communicate when therapy was online.

The importance of connection and the relationship with the therapist was also highlighted by Grace as intrinsic to therapy, however, she also experienced challenges to this virtually.

"it is about making that bond and you've got to be able to like really trust and connect with that person and over the phone I didn't really get that … it was just, like I was speaking to, a, a phone and not a person" (Grace).

Although Grace discussed that she did not manage to reach a point in which she felt a real sense of connection to her therapist within this medium, some participants felt able to achieve a sense of connection and develop an effective therapeutic relationship. Katie commented that managing the relational challenges had *"definitely got a lot easier"* over time.

The virtual space facilitating openness

In some cases, the virtual world and the feelings of disconnection from the therapist actually appeared to facilitate more openness. Despite the difficulties in communication that he identified, James also discussed a time when he shared something with his therapist in the virtual space that he did not think he would have been able to share face-to-face.

"It was something that was really hard to come out with. It was pretty difficult. I'd say like if we were in therapy face to face, it would have made it much harder but with me feeling disconnected from my therapist erm it had like a different atmosphere. Like in a way it was goading me to do it but then a part of me was stopping me" (James)

James described a sense of internal conflict; to share or not to share. This indecision relating to whether or not to share information, in part, appeared to relate to fears around the response of the therapist, which was experienced with a different intensity within the virtual space.

Katie also commented, *"I think it's a lot easier to open up and it's almost like you are just talking to yourself"* when completing therapy on the telephone. She went on to talk about how it feels easier to talk about how you're feeling and that *"you're gonna not be as judged"* within this setting. In these cases, the virtual space appeared to provide a sense of anonymity and distance, and subsequently facilitated feelings of safety and protection.

Theme 4: The importance of privacy and confidentiality and managing this in a virtual space

This theme illustrated the value that participants placed on confidentiality within their narratives and some of the challenges that were experienced in relation to creating a confidential space within the home environment.

Therapy as a confidential space to be myself

Within their narratives, all participants viewed virtual therapy as a confidential space and discussed the importance of this. Oliver reported that this was *"one of the most important things"* to him and knowing the limits of confidentiality within sessions enabled him to feel safe in this space. Participants talked about how they felt able to be open in a space that was just for them and their therapist, which created a sense of freedom to be themselves. This was similar to how they had experienced previous face to face therapy in the past.

"I think it's a lot more…freeing when I'm on my own, because I don't have to, you know, disguise things in front of (parents)" (Erin).

The therapeutic space was viewed as belonging to the young people and they felt that they were able to invite people into this if they wanted to do so or choose to keep this for themselves: *"My meetings are just for like me and (therapist)"* (Katie).

Confidentiality within the context of therapy appeared to support young people to establish a sense of individuation and emotional autonomy, which is associated with the transitional period of adolescence. Participants expressed and normalised a desire to keep some

things private between them and their therapist: *"I mean I think that's quite a general teenager thing, you don't want your Mum and Dad to know everything about your life*" (Erin).

Struggles with creating a confidential space

Four participants discussed the challenges they experienced in trying to create a confidential space within their own home environment as a consequence of family often being in the house when they were engaging in therapy: *"when it's virtual and there's people around it's kind of difficult because people can sometimes not help but to overhear"* (James). In face-to-face therapy, young people would be in a confidential room, outside of the home, which provides a physical barrier between them and their parents. Thus, a confidential space is intrinsic to face to face therapy. However, this was not an absolute within the context of virtual therapy.

Participants attempted to recreate a therapeutic environment which mirrored that of face-to-face therapy i.e., a comfortable, quiet space where they would not be disturbed by other people.

"The majority of the time I did try and make a comfortable, quiet space just because that's what you'd have if you were face-to-face" (Grace).

Katie discussed the value of having a space separate to her house, which created distance from her parents and allowed her the feel safe: *"being able to really…have like that space so I can, I know that like there's nobody there or I'm not worrying oh they're downstairs, I need to be quiet".*

Erin discussed how a therapy room in a clinic provided a physical barrier between her and her parents, that was difficult to recreate at home. She went on to discuss fears about being overheard, in her home therapy space.

"I think it just depends where they are in the house. Depending on how anxious I'd be about it. Cos like they could be like completely downstairs and I'll still be like oh can you hear me?" (Erin).

The struggles in creating a confidential space, at times, led to participants feeling like they were unable to speak openly, which impacted on their experience of therapy. However, James managed to overcome this by adopting the 'chat function' online *"to explain sensitive stuff".* This allowed James to communicate with his therapist using written information, and therefore mitigated the risks of him being overheard by other people in the house. However, this appeared to pose different challenges relating to feelings of discomfort associated with having to type out difficult information.

Oliver was the only participant who did not have concerns around privacy in the home environment. When discussing his mum's presence in sessions, he said, *"she'll just be like in and out and then when like (therapist) asks her to be there she is".* His narrative suggested that he valued mum's presence in his therapy sessions, and that this helped him to make sense of the therapy process. Having mum in the sessions was also viewed as more flexible within the context of virtual therapy. Oliver was the youngest participant who was interviewed.

Theme 5: The role of the family in the therapy process

Finally, the role of the family both within and outside of therapy was discussed across all participant's narratives. This theme related to family involvement in sessions, how this has been managed within a virtual context, and the benefits of having systemic support between sessions.

The impact of virtual working of family involvement

Within the context of virtual therapy, there appeared to be a shift in terms of how family were involved in the therapy process. Young people were no longer reliant on parents to take

them to therapy sessions and for most participants, this had led to increased autonomy around attending sessions.

Some young people were able to maintain family involvement during their virtual therapy sessions. Erin discussed that she has been able to recreate the structure that she had previously adopted in face-to-face therapy, virtually: "*I just shout them up if that's the kind of appointment, you know, or I kind of just go and get them…and then we just sit down in front of the camera together".* This continued involvement of parents appeared to be important in facilitating systemic support outside of her therapy sessions.

However, Grace's narrative suggested that she experienced a loss in terms of parental involvement in her therapy sessions when these took place virtually. She discussed that this lack of parental involvement in her sessions was something that was caused by the structure of virtual therapy, rather than being an active decision on her or the therapist's part. Grace discussed that her mum's lack of involvement in the sessions also had some negative consequences for how she experienced their relationship; *"for me that's maybe made us less close because she can't really be involved with things"*.

Collaborative information sharing

Young people discussed sharing information about their sessions with their family as a collaborative process between them and their therapist. Participants spoke about discussions that they had with the therapist about what information they were happy to share, before this was shared with their parents.

Creating opportunities for information to be shared between young people and their parents opened up new conversations and, in some cases, facilitated more positive relationships.

"my Dad came into a session once and she'd asked me previously oh can I share this, and then, shared it with my Dad. It triggered this like conversation and…. this nice kind of conversation between me and my Dad" (Erin).

For James and Katie, CAMHS did not have any contact with their parents, at their own request, which led to a greater sense of control around what they shared and what they chose to keep private.

"I can decide what like I want to tell them like normally it's, it's everything I tell them like everything that, that like we talk about but like it's more so that I can decide then what…, I want to tell them" (Katie).

Issues relating to consent and information sharing in the context of risk were discussed by two participants. Some young people, who had experienced information sharing in the context of risk, discussed struggling to understand why this had happened at the time and subsequent feelings of anger towards the therapist and the service: *"I got really angry with them telling my parents"* (Erin). Similarly, James discussed finding out that information had been shared with external agencies and subsequent feelings of upset and distress following this. In this context, information sharing was viewed as something which was 'done to' the young person rather than being a process that they had involvement in.

However, both young people who had experienced information being shared without their consent were able to make their own sense of why this happened by reflecting on this over time. Erin commented, *"I came round and I was like…well they should know really, it's best for my sake is that my parents know".* In Erin's narrative, she discussed that at times when she was at risk, she was often unable to see this until further down the line.

One participant felt that it was important that his mum was present during all of his sessions to facilitate information sharing. Oliver talked about how his mum was able to share

information with his therapist about things that had happened in the week that were important, which he would not have otherwise thought to discuss.

"*my mum would take it in and tell (therapist) next time like good things, bad things, questions I'd been asking, if I'd been having a bad time".* (Oliver)

The benefits of systemic support

Four participants reflected on the benefits of having support from family involvement within and/or outside of their therapy sessions. Grace discussed how parental involvement helped to facilitate relationships with the therapist and create a sense of working as a team towards a shared goal. Without the involvement of her family, she felt that her and the therapist were not always aligned.

"it's just nice to have like someone there because, sometimes it might feel like it was a bit, sort of, two split sides, like me and the therapist.., but then like if my Mum's there we're all like sort of a big circle"(Grace).

Similarly, Oliver discussed the value of having mum in sessions and how this helped him to feel *'safer'.* He went on to discuss how this also enabled him to feel more supported throughout the week and reduced his emotional burden, as he did not need to explain what had happened in each session.

"Cause (mum) was present in the sessions she understood what was going on. I didn't need to explain and stuff, you know when I was tired after it and she knew how to help me as well". (Oliver).

This ongoing systemic support outside of the therapy session was also reflected in other young people's narratives. The support appeared to relate to both practical and emotional

support from parents, that was enabled through parents having an understanding of both the therapy process and content.

"…any techniques or whatever it's not just me trying to do it by myself like they can help me, and like kind of encourage me to do it and also like they can understand a bit more about like what's, like what's going on and like how I'm feeling" (Katie).

Although some participants actively made the decision not to involve their family in therapy, James described wanting to share his successes with them.

Discussion

This study used semi-structured interviews to explore the experiences of young people, aged between 13 and 18 years, in relation to confidentiality and information sharing, within the context of virtual therapy and COVID-19. This the first study, to the researcher's knowledge, to explore and make sense of young people's experiences of this phenomenon, within this context. Although the current study aimed to explore young people's experiences of confidentiality and information sharing specifically, themes relating to the wider context of virtual therapy were also consistently identified within young people's narratives. Therefore, these areas also became a focus of the research unexpectedly. The study identified five main themes which will be discussed in relation to existing research, along with the clinical and research implications of this study.

Similar to young people in previous research (Coyne et al., 2015; Freake et al., 2007), all participants discussed the importance and value of having a confidential space in which they felt they were able to be open without fear of information being shared with their parents. This is consistent with Erikson's (1994) model of development, which highlights that young people begin to develop their own identities away from their parents during adolescence. During this stage of development, adolescents begin to explore their own identities and take on increased independence. Information sharing with parents was a collaborative process, involving the young person and the therapist. Therefore, young people valued that it was ultimately them who made decisions about what was shared about their therapy and how this was shared.

However, some young people had some difficulties in terms of creating a confidential space in the home environment, which meant that they did not always view privacy and confidentiality as absolutes within the context of virtual therapy. Research has shown that adolescents are more likely to disclose information to their parents about some issues than

others, for example they are less likely to discuss personal issues than prudential issues (Smetana, Metzger, Gettman, & Campione-Barr, 2006; Kearney & Bussey, 2014). The potential for being overheard at times when family were in the home therefore meant that young people chose not to discuss certain topics when this was the case. This included topics which young people felt were particularly sensitive or personal, which is consistent with those identified within research.

Interestingly, one participant discussed confidentiality only in the context of his information being shared with people he did not know, and his preference was to have his mother present during all of his therapy sessions. Oliver was the youngest participant interviewed and therefore his narrative and preference for having his mother present in all of his sessions may be a reflection of this. Indeed, research surrounding adolescent disclosure of information to their parents has found that disclosure declines as adolescents get older (Keijsers, Frijns, Branje, & Meeus, 2009), with younger adolescents being more willing to share information with their parents than older adolescents (Finkenauer et al., 2002).

The ongoing role of family support, both within and outside of therapy sessions, was highlighted as important by young people and was linked to information sharing. Family members were considered more able to offer effective practical and emotional support when they had some knowledge and understanding of the young person's therapy. Similar to other research in relation to in person therapy (Coyne et al., 2015; Grealish et al., 2013; Iachini et al., 2015), this highlights the benefits of working collaboratively with families to support young people.

Although not all young people discussed wanting parental involvement in the therapy itself, some young people who did wish to involve their parents in their therapy found this difficult, virtually. Young people appeared to have more autonomy around attending virtual

sessions, due to the reduced reliance on parents to physically take them to appointments (as was the case for face-to-face therapy). Subsequently, increased autonomy appeared to be associated with diminished parental involvement for some participants.

As previously discussed, a number of themes were consistently identified across participants' narratives, relating to the wider context of virtual therapy, thus highlighting their potential significance. As such, it was considered important that these were included. In the current study, all participants had previous experience of in person therapy, however none had experiences of engaging in therapy through virtual means. Subsequently, they were unsure what to expect from this and found aspects of this to be strange and confusing. This is similar to findings from studies surrounding in person therapy with young people, which also highlight that familiarisation and engagement with the therapy process takes time to develop (Jones, Hassett, & Sclair, 2017), thus this is likely to be the case regardless of the mode of therapy.

Participants discussed some of the challenges that they experienced in terms of completing therapy within their own home environment, usually in their bedrooms. Young people are often subjected to the rules of their parental home, and their bedroom is the place in which they can exert some control, ownership, and privacy from everyday life (Lincoln, 2015). Thus, having a therapist privy to, and within, this space may feel intrusive and a violation of this privacy. Further difficulties in terms of how young people transition from being in therapy sessions to going back to living their day-to-day life, without the inherent structure in face-to-face therapy of physically leaving a space, were also identified. Some participants overcame these challenges by practicing post-therapy activities, such as going for a walk, which facilitated this transition.

The therapeutic relationship was central to all young people's narratives. Young people had concerns around trust, which related to engaging in therapy with someone that they had

not met in person. They also identified challenges in feeling connected to therapist within a virtual space. Although previous research has demonstrated that effective therapeutic relationships can be developed online (see Berger, 2017), research into this area with young people is very limited. However, it is suggested that the perceived formality of virtual therapy for some young people and the lack of real-life contact with their therapist, may have meant that the 'human aspects' of the therapist, were less apparent and took more time to develop. These therapist factors been highlighted as important for the development of a relationship with young people (Jones et al., 2017), Despite these difficulties, it was noted that young people largely reported that they had formed effective therapeutic relationships over time.

The therapeutic relationship has been extensively researched in relation to therapy with young people and their families (Karver, Handelsman, Fields, & Bickman, 2006). Such research has suggested that the nature of the therapeutic relationship is equally if not more important in working with young people compared to adults, given that young people are often referred to services by parents or other professionals rather than self-referred, and therefore their motivation to engage in therapy may be limited (DiGiuseppe, Linscott, & Jilton, 1996). Therefore, an effective therapeutic relationship is considered to facilitate contexts in which young people feel safe and supported, which subsequently promotes engagement (Shirk & Karver, 2003).

One young person expressed consistently difficult experiences in engaging with virtual therapy, which she felt she was unable to overcome. This experience appeared to relate to perceived power differentials in the therapeutic relationship, which she felt were exacerbated in the virtual context. Other research which has explored adolescents' experiences of in person therapy has highlighted issues of power within the therapeutic relationship, which can preclude young people from asking questions or feeling as though they are unable to challenge their therapist (Bury, Raval, & Lyon, 2007). Bury et al. (2007) discuss that it is therefore important

that power differences are acknowledged by the therapist early on in the relationship, and that by doing so, we may increase engagement.

Clinical implications

The results have several clinical implications that may assist practitioners in providing effective person-centred therapy for young people, who are engaging in virtual therapy within CAMHS.

Participants in this study were engaging with virtual therapy due to the impact of the pandemic on the way in which services were able to deliver therapy. Thus, they had limited power or choice in relation to this, and this loss of control was reflected in their narratives. Services are now adopting a more blended approach to therapy and offering therapy through both in person and virtual means. This research highlights the need to involve young people in decisions about the mode of therapy that they wish to engage with. For some young people in the study, having a combination of face to face and virtual therapy was their preference, and having some in person therapy sessions appeared to be protective against the perceived challenges of virtual therapy. Therefore, it is suggested that open conversations with the therapist, prior to starting therapy, about young people's preferences would be helpful during initial screening appointments.

Navigating the complexities of working with young people and their families within CAMH services can be challenging (Coyne et al., 2015; Vallance, 2016). However, the findings of this research further highlight some of potential benefits of collaborative working with parents as well as young people. The study highlights the need for therapist to consider how families can be better incorporated into the therapy process online, if this is something that is important to the young person, for example, by re-creating in person practices such as having family join at the end of sessions. For young people who do not wish to have family

present in their sessions, this may involve having discussions at the end of sessions about what information they think would be helpful to share with their parents and in what format. Although this is often common practice in face-to-face therapy, it seems that some of these practices have been lost in within the context of virtual therapy.

Finally, this research and the themes identified consistently highlight the importance of working collaboratively with young people to develop services. Working directly with young people accessing services to find adaptive solutions to some of the challenges that have been identified with regards to engaging with therapy through virtual means, may facilitate better engagement, higher quality therapy, and subsequently, better therapeutic outcomes (Shirk & Karver, 2003). This may involve actively discussing how young people can create a confidential space at home which is away from their own personal space if possible, thinking about offering a in person 'get to know you' meeting prior to commencing virtual therapy, and discussing post therapy practices, which may facilitate the young person's transition from therapy back to their normal life.

Strengths and limitations

This study addressed a gap in the literature, by exploring narratives of young people in relation to virtual therapy; a mode of delivering therapy which has now become a more common practice within CAMHS since the COVID-19 pandemic. Guidelines for undertaking and analysing qualitative research were followed throughout the study to ensure that this was of high quality (Smith et al., 2009). The methodology employed and the use of semi-structured interviews, which were flexible and curious in nature, provided rich narratives of people's experiences (Smith & Osborn, 2003).

Nonetheless, the limitations of the current study should be considered. Firstly, this research was exploratory in nature and captured a small number of young people's experiences.

Therefore, it is important to acknowledge that the findings from this study cannot be generalised to the experiences of all young people who have accessed CAMHS for virtual therapy. However, they are able to describe an in-depth account of several individuals, which have important implications for services.

The recruitment process for this study is also recognised as a limitation. Young people were approached through gatekeepers in CAMHS, which may have biased the sample. The motivation for these young people to take part in this study may have been founded on the prior relationship they already had with the individual recruiting them or the challenges that they had experienced in relation to virtual therapy. However, it is important to note that each participant shared a range of experiences within their narratives, which could be characterised as both positive and more negative.

Finally, it is important to acknowledge that the interviews with young people were completed via videoconferencing due to the ongoing face to face contact restrictions within NHS services. Thus, participants did not have any face-to-face contact with the researcher and engaged in the interview within their home environment. This is pertinent given the difficulties that young people reported within their narratives surrounding discussing personal information with someone they had not previously met in person and speaking openly within their home environment. Therefore, it should be considered that the virtual nature of the interviews may have potentially impacted upon participants narratives, in terms of willingness to disclose information.

Future Research

Whilst the move to virtual services occurred unexpectedly in response to the COVID-19 pandemic to protect public health, it is now recognised that some of the changes in terms of how therapy is delivered will be sustained moving forward (Bierbooms et al., 2020). Further

qualitative research is therefore needed to investigate young people's experiences of this and issues of confidentiality and information sharing, to inform how services can best support young people within this mode of therapy. This research focussed specifically on adolescents, however further research with younger children and also parents would be beneficial.

The research also highlights matters relating to virtual therapy more broadly however further research into participants experiences of these would be beneficial. The theme of the therapeutic relationship, and challenges surrounding this within the virtual space, was intrinsic to all participants narratives. Although some previous research has investigated the therapeutic relationship within virtual contexts (see Berger, 2017), research around this remains limited within CAMH services, perhaps due to the limited use of this mode of therapy previously (Cliffe et al., 2020). Given the perceived importance of the therapeutic relationship highlighted in previous research with young people (Karver et al., 2006) and the salience of this in participants narratives, further research around this within the context of virtual therapy is recommended.

Conclusion

This study utilised a thematic analysis to explore young people's experiences of information sharing and confidentiality, within the context of virtual therapy. The importance of confidentiality within therapy was highlighted and some difficulties relating to maintaining this in the home environment were demonstrated. The findings also highlight the importance of involving young people in decisions about information sharing and parental involvement, however, it is suggested that family involvement can prove beneficial if this is facilitated in a collaborative way. The findings also highlighted some challenges for young people as a result of attending therapy in a virtual space, which had the potential to impact upon the quality of therapy and their willingness to engage in this. These included, technical challenges, initial

difficulties in terms of forming a therapeutic alliance, and a blurring of boundaries between their personal space and the therapeutic space. Whilst some young people felt able to adapt and overcome these challenges, for others this proved to be more difficult. Finally, there is a need for more research in this area to fully capture the experiences of young people and their parents, in relation to issues of confidentiality and information sharing, within the context of virtual therapy.

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Smetana, J. G., Metzger, A., Gettman, D. C., & Campione-Barr, N. (2006). Disclosure and secrecy in adolescent–parent relationships. *Child development*, *77*(1), 201-217.

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

Smith, J.A., & Osborn, M. (2003). Interpretative phenomenological analysis. In J. Smith (Eds.), *Qualitative Psychology: a practical guide to research methods (*pp. 53–81). London: Sage.

Tebb, K. (2011). Forging partnerships with parents while delivering adolescent confidential health services: a clinical paradox. *The Journal of adolescent health: official publication of the Society for Adolescent Medicine*, *49*(4), 335.

Tan, J. O., Passerini, G. E., & Stewart, A. (2007). Consent and confidentiality in clinical work with young people. *Clinical child psychology and psychiatry*, *12*(2), 191-210.

Vallance, A. K. (2016). 'Shhh! Please don't tell…'Confidentiality in child and adolescent mental health. *BJPsych Advances*, *22*(1), 25-35.

Wilson, C. J., & Deane, F. P. (2001). Adolescent opinions about reducing help-seeking barriers and increasing appropriate help engagement. *Journal of Educational and Psychological Consultation*, *12*(4), 345-364.

Appendix A: *Author Guidelines of the Journal of Child Psychology and Psychiatry*

General

Contributions from any discipline that further knowledge of the mental health and behaviour of children and adolescents are welcomed. Papers are published in English, but submissions are welcomed from any country. Contributions should be of a standard that merits presentation before an international readership.

Layout

Title: The first page of the manuscript should give the title, name(s) and short address(es) of author(s), and an abbreviated title (for use as a running head) of up to 60 characters.

Abstract

The abstract should not exceed 300 words and should be structured in the following way with bold marked headings: Background; Methods; Results; Conclusions; Keywords; Abbreviations. The abbreviations will apply where authors are using acronyms for tests or abbreviations not in common usage.

Key points and relevance

All papers should include a text box at the end of the manuscript outlining the four or five key (bullet) points of the paper. These should briefly (80-120 words) outline what's known, what's new, and what's relevant.

Under the 'what's relevant' section we ask authors to describe the relevance of their work in one or more of the following domains - policy, clinical practice, educational practice, service development/delivery or recommendations for further science.

Headings

Articles and research reports should be set out in the conventional format: Methods, Results, Discussion and Conclusion. Descriptions of techniques and methods should only be given in detail when they are unfamiliar. There should be no more than three (clearly marked) levels of subheadings used in the text.

Acknowledgements

These should appear at the end of the main text, before the References.

Correspondence to

Full name, address, phone, fax and email details of the corresponding author should appear at the end of the main text, before the References.

References

The *JCPP* follows the text referencing style and reference list style detailed in the *Publication manual of the American Psychological Association* (5th edn.).

References in text

References in running text should be quoted as follows:
Smith and Brown (1990), or (Smith, 1990), or (Smith, 1980, 1981a, b), or (Smith & Brown, 1982), or (Brown & Green, 1983; Smith, 1982).

For up to five authors, all surnames should be cited in the first instance, with subsequent occurrences cited as et al., e.g. Smith et al. (1981) or (Smith et al., 1981). For six or more authors, cite only the surname of the first author followed by et al. However, all authors should be listed in the Reference List. Join the names in a multiple author citation in running text by the word 'and'. In parenthetical material, in tables, and in the References List, join the names by an ampersand (&). References to unpublished material should be avoided.

Reference list
Full references should be given at the end of the article in alphabetical order, and not in footnotes. Double spacing must be used.

References to journals should include the authors' surnames and initials, the year of publication, the full title of the paper, the full name of the journal, the volume number, and inclusive page numbers. Titles of journals must not be abbreviated and should be italicised.

References to books should include the authors' surnames and initials, the year of publication, the full title of the book, the place of publication, and the publisher's name.

References to articles, chapters and symposia contributions should be cited as per the examples below:

Kiernan, C. (1981). Sign language in autistic children. *Journal of Child Psychology and Psychiatry, 22*, 215-220.

Thompson, A. (1981). *Early experience: The new evidence*. Oxford: Pergamon Press.

Jones, C.C., & Brown, A. (1981). Disorders of perception. In K. Thompson (Ed.), *Problems in early childhood* (pp. 23-84). Oxford: Pergamon Press.

Use Ed.(s) for Editor(s); edn. for edition; p.(pp.) for page(s); Vol. 2 for Volume 2.

Tables and Figures
All Tables and Figures should appear at the end of main text and references, but have their intended position clearly indicated in the manuscript. They should be constructed so as to be intelligible without reference to the text. Any lettering or line work should be able to sustain reduction to the final size of reproduction. Tints and complex shading should be avoided and colour should not be used unless essential. Authors are encouraged to use patterns as opposed to tints in graphs. In case of essential colour figures, authors are reminded that there is a small printing charge. Authors will be contacted during the proofing stage of thier accepted paper. Figures should be originated in a drawing package and saved as TIFF, EPS, or PDF files. Further information about supplying electronic artwork can be found in the Wiley electronic artwork guidelines **here**.

Nomenclature and symbols
Each paper should be consistent within itself as to nomenclature, symbols and units. When referring to drugs, give generic names, not trade names. Greek characters should be clearly indicated.

Supporting Information
Examples of possible supporting material include intervention manuals, statistical analysis syntax, and experimental materials and qualitative transcripts.

Appendix B: *Quality assessment tool*

Table 1 Quality assessment tool and scoring guidance notes

Criteria	0 = Not at all	1 = Very slightly	2 = Moderately	3 = Complete
Explicit theoretical framework	No mention at all.	Reference to broad theoretical basis.	Reference to a specific theoretical basis.	Explicit statement of theoretical framework and/or constructs applied to the research.
Statement of aims/objectives in main body of report	No mention at all.	General reference to aim/objective at some point in the report including abstract.	Reference to broad aims/objectives in main body of report.	Explicit statement of aims/objectives in main body of report.
Clear description of research setting	No mention at all.	General description of research area and background, e.g. 'in primary care'.	General description of research problem in the target population, e.g. 'among GPs in primary care'.	Specific description of the research problem and target population in the context of the study, e.g. nurses and doctors from GP practices in the east midlands.
Evidence of sample size considered in terms of analysis	No mention at all.	Basic explanation for choice of sample size. Evidence that size of the sample has been considered in study design.	Evidence of consideration of sample size in terms of saturation/information redundancy or to fit generic analytical requirements.	Explicit statement of data being gathered until information redundancy/saturation was reached or to fit exact calculations for analytical requirements.
Representative sample of target group of a reasonable size	No statement of target group.	Sample is limited but represents some of the target group or representative but very small.	Sample is somewhat diverse but not entirely representative, e.g. inclusive of all age groups, experience but only one workplace. Requires discussion of target population to determine what sample is required to be representative.	Sample includes individuals to represent a cross section of the target population, considering factors such as experience, age and workplace.
Description of procedure for data collection	No mention at all.	Very basic and brief outline of data collection procedure, e.g. 'using a questionnaire distributed to staff'.	States each stage of data collection procedure but with limited detail, or states some stages in details but omits others.	Detailed description of each stage of the data collection procedure, including when, where and how data were gathered.
Rationale for choice of data collection tool(s)	No mention at all.	Very limited explanation for choice of data collection tool(s).	Basic explanation of rationale for choice of data collection tool(s), e.g. based on use in a prior similar study.	Detailed explanation of rationale for choice of data collection tool(s), e.g. relevance to the study aims and assessments of tool quality either statistically, e.g. for reliability & validity, or relevant qualitative assessment.
Detailed recruitment data	No mention at all.	Minimal recruitment data, e.g. no. of questionnaire sent and no. returned.	Some recruitment information but not complete account of the recruitment process, e.g. recruitment figures but no information on strategy used.	Complete data regarding no. approached, no. recruited, attrition data where relevant, method of recruitment.
Statistical assessment of reliability and validity of measurement tool(s) (Quantitative only)	No mention at all.	Reliability and validity of measurement tool(s) discussed, but not statistically assessed.	Some attempt to assess reliability and validity of measurement tool(s) but insufficient, e.g. attempt to establish test–retest reliability is unsuccessful but no action is taken.	Suitable and thorough statistical assessment of reliability and validity of measurement tool(s) with reference to the quality of evidence as a result of the measures used.
Fit between stated research question and method of data collection (Quantitative)	No research question stated.	Method of data collection can only address some aspects of the research question.	Method of data collection can address the research question but there is a more suitable alternative that could have been used or used in addition.	Method of data collection selected is the most suitable approach to attempt answer the research question
Fit between stated research question and format and content of data collection tool e.g. interview schedule (Qualitative)	No research question stated.	Structure and/or content only suitable to address the research question in some aspects or superficially.	Structure & content allows for data to be gathered broadly addressing the stated research question(s) but could benefit from greater detail.	Structure & content allows for detailed data to be gathered around all relevant issues required to address the stated research question(s).
Fit between research question and method of analysis	No mention at all.	Method of analysis can only address the research question basically or broadly.	Method of analysis can address the research question but there is a more suitable alternative that could have been used or used in addition to offer greater detail.	Method of analysis selected is the most suitable approach to attempt answer the research question in detail, e.g. for qualitative IPA preferable for experiences vs. content analysis to elicit frequency of occurrence of events, etc.
Good justification for analytical method selected	No mention at all.	Basic explanation for choice of analytical method	Fairly detailed explanation of choice of analytical method.	Detailed explanation for choice of analytical method based on nature of research question(s).
Assessment of reliability of analytical process (Qualitative only)	No mention at all.	More than one researcher involved in the analytical process but no further reliability assessment.	Limited attempt to assess reliability, e.g. reliance on one method.	Use of a range of methods to assess reliability, e.g. triangulation, multiple researchers, varying research backgrounds.
Evidence of user involvement in design	No mention at all.	Use of pilot study but no involvement in planning stages of study design.	Pilot study with feedback from users informing changes to the design.	Explicit consultation with steering group or statement or formal consultation with users in planning of study design.
Strengths and limitations critically discussed	No mention at all.	Very limited mention of strengths and limitations with omissions of many key issues.	Discussion of some of the key strengths and weaknesses of the study but not complete.	Discussion of strengths and limitations of all aspects of study including design, measures, procedure, sample & analysis.

Appendix C: *University Sponsorship Letter of Approval*

Dr Luna Centifanti
Institute of Life and Human Sciences
University of Liverpool
Brownlow Hill,
Liverpool,
L69 3BX
United Kingdom

Dr Neil French
Research Governance Manager

University of Liverpool
Research Support Office
2nd Floor Block D Waterhouse
Building
3 Brownlow Street
Liverpool
L69 3GL

Tel: 0151 794 8739
Email: sponsor@liverpool.ac.uk

03 March 2021

Sponsor Ref: UoL001531

Re: Sponsor Permission to Proceed notification

Information sharing and confidentiality: Experiences of young people who are accessing a CAMHS service for virtual therapy within the context of COVID-19

Dear Dr Centifanti

All necessary documentation and regulatory approvals have now been received by the University of Liverpool Research Support Office in its capacity as Sponsor, and we are satisfied that all Clinical Research Governance requirements have been met. You may now proceed with any study specific procedures to open the study.

The following REC Approved documents have been received by the Research Support Office. Only these documents can be used in the recruitment of participants. If any amendments are required please contact the Research Support Office.

Document title	Version	Date
Protocol	7	12 December 2020
Participant consent form (16-18)	4	28 December 2020
Participant consent form (Assent Form)	4	12 October 2020
Participant consent form (Parental Consent Form)	2	28 December 2020

Please note, under the terms of your Sponsorship you must;

1. Gain NHS Confirmation of Capacity and Capability from each participating site before recruitment begins at that site;

2. Ensure all required contracts are fully executed before recruitment begins at any site;

3. Inform the Research Support Office as soon as possible of any adverse events especially SUSARs and SAE's, Serious Breaches to protocol or relevant legislation or any concerns regarding research conduct;

4. Approval must be gained from the Research Support Office for any amendments to, or changes of status in the study **prior to** submission to REC and any other regulatory authorities (as per SOP018);

5. It is a requirement that Annual Progress Reports are sent to the NHS Research Ethics Committee (REC) annually following the date of Favourable Ethical Approval. You must provide copies of any reports submitted to REC and other regulatory authorities to the Research Support Office;

6. Maintain the study master file (as per SOP005);

7. Make available for review any study documentation when requested by the sponsors and regulatory authorities for the purposes of audit or inspection;

8. Upon the completion of the study it is a requirement to submit an End of Study Declaration (within 90 days of the end of the study) and End of Study Report to REC (within 12 months of the end of the study). You must provide copies of this to the Research Support Office;

9. Ensure you and your study team are up to date with the current RSO SOPs throughout the duration of the study.

If you have any queries regarding the sponsorship of the study please do not hesitate to contact the Clinical Research Governance Team on 0151 794 8373 (email sponsor@liverpool.ac.uk).

Yours sincerely

Dr Neil French
Research Governance Manager

Appendix D: *Health Research Authority Approval Letter*

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Ms Luna Centifanti
Department of Clinical Psychology
Whelan Building
Liverpool
L69 3GB

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

20 January 2021

Dear Ms Centifanti

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

Study title:	**Information sharing and confidentiality: Experiences of young people who are accessing a CAMHS service for virtual therapy within the context of COVID-19.**
IRAS project ID:	**282194**
Protocol number:	**UoL001531**
REC reference:	**20/PR/0608**
Sponsor	**University of Liverpool**

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

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

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

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report

(including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

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

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

What are my notification responsibilities during the study?

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

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

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

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

Your IRAS project ID is **282194**. Please quote this on all correspondence.

Yours sincerely,
Andrea Bell

Approvals Specialist

Email: approvals@hra.nhs.uk

Copy to: *Mr Alex Astor*

List of Documents

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

Document	*Version*	*Date*
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Insurance certificate]	1	12 October 2020
Interview schedules or topic guides for participants [Interview Schedule]	3	28 December 2020
IRAS Application Form [IRAS_Form_04012021]		04 January 2021
IRAS Application Form XML file [IRAS_Form_04012021]		04 January 2021
Letter from sponsor [Sponsorship Letter]	1	16 March 2020
Organisation Information Document [Organisation Information Document]	2	12 October 2020
Participant consent form [Participant Consent Form (16-18)]	4	28 December 2020
Participant consent form [Assent Form]	4	12 October 2020
Participant consent form [Parental Consent Form]	2	28 December 2020
Research protocol or project proposal [Research Protocol]	7	12 December 2020
Schedule of Events or SoECAT [SoECAT]	1	16 September 2020
Summary CV for Chief Investigator (CI) [CV for Chief Investigator (CI)]		06 September 2019
Summary CV for student [Student CV]	1	12 October 2020

IRAS project ID	282194

Information to support study set up

The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

Types of participating NHS organisation	Expectations related to confirmation of capacity and capability	Agreement to be used	Funding arrangements	Oversight expectations	HR Good Practice Resource Pack expectations
Research activities and procedures.as per the protocol and other study documents will take place at participating NHS organisations.	Research activities should not commence at participating NHS organisations in England or Wales prior to their formal confirmation of capacity and capability to deliver the study.	An Organisation Information Document has been submitted and the sponsor is not requesting and does not expect any other site agreement to be used.	Sponsor is not providing funding to participating NHS organisations.	A Local Collaborator (LC) is expected at participating NHS organisations.	No Honorary Research Contracts, Letters of Access or pre-engagement checks are expected for local staff employed by the participating NHS organisations. Where arrangements are not already in place, research staff not employed by the NHS host organisation undertaking any of the research activities listed in the research application would be expected to obtain a Letter of Access based on standard DBS checks and occupational health clearance.

Other information to aid study set-up and delivery

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.
The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix E: *Participant information sheet*

Participant Information Sheet

Research Study: Information sharing and confidentiality: Experiences of young people who are accessing a CAMHS service for virtual therapy within the context of COVID-19.

We would like to invite you to take part in our research study. Before you decide whether or not you are happy to take part, we would like to explain why the research is being completed and what it would involve for you. The researcher will go through the information sheet with you and answer any questions you might have.

What is the purpose of the study?

This study aims to look at people's experiences of attending virtual therapy at CAMHS, while we have been in the COVID-19 pandemic. It aims to look at how people have experienced sharing information and keeping things private, and some of the challenges that there might have been with this. It is hoped that by understanding more about this, we can support other young people and their families better in the future.

Why have I been invited?

You have been invited to participate in this study because you are between the ages of 13 and 18 years old, and are currently accessing CAMHS, for therapy. We are only inviting young people who are between the ages of 13 and 18 years old, who are accessing CAMHS, to take part in the study.

Do I have to take part?

No. It is your decision whether or not you want to take part in the study. If you decide to take part, you will be asked to sign a consent form. You can decide not to be part of the study at any time without giving a reason by contacting one of the researchers using the details provided at the end of this form. Choosing not to be part of the study anymore would not affect the support that you receive from the CAMHS team. You do not have to answer any questions that you don't want to answer.

What will happen to me if I take part and what will I have to do?

You will be asked to meet with one of the researchers for a chat about your experiences.. The chat will take place virtually, for example by telephone or video call, or face to face at CAMHS or at an alternative location. These meetings will take place in a quiet and private room. The chat will last around one hour and there will be opportunities to take breaks at any time if you need to. At the meeting you will be asked to answer a few questions about your experiences of virtual therapy at CAMHS. This will include questions about what it is like having virtual meetings, how this is different from face to face meetings, and your experiences of keeping information private or sharing information from your sessions with your parents.

The chat will be audio recorded and then typed out by the researcher or someone who works at the University of Liverpool. The audio recording will be destroyed once it has been typed out and the document will be stored in a password protected file. Any identifying information will be removed so that you cannot be identified from the data.

We need around 8 to 10 people to take part in the study. If you decide to take part in the study you will be given a £10 High Street voucher to say thank you for your time, which can be at many different high street stores.

What are the possible risks of taking part?

There risks involved in taking part in the study are small. However, some people may find it difficult or upsetting when answering questions about their experiences. This is normal and the researcher will deal with any distress or difficulties you may experience sensitively. Contact numbers for organisations that may be able to provide extra support will also be provided. You are welcome to contact the research team following completion of the study if you have any further questions.

What are the possible benefits of taking part?

Although there are no direct benefits to taking part in the study, the information we collect will help to better understand young people's experiences of information sharing and confidentiality when attending virtual therapy. This will help professionals to support both young people and their families better in the future.

What about confidentiality?

No information will be shared with anyone outside of the research team without your permission. The only exception to this would be if you informed the researchers of anything which suggested a risk of harm to yourself or somebody else. Should the researcher feel the need to break confidentiality, then this will be discussed with you first whenever possible.

All information collected about you during the study will be kept confidential, and any identifying information about your (e.g. your name) will be removed so that you cannot be recognised. You will not be named or identified in any reports of the study.

All data collected from the study will be kept safely and securely on a password protected computer. Dr. Luna Centifanti will be the custodian of all the study data. The data will be archived and stored at the University of Liverpool for 10 years after the end of this study, with your permission. Your consent form will be stored separately, so that you cannot be identified.

What happens when the research study stops?

When you have completed the chat, you will not be asked to do anything else.

The findings of the research project will be written up as part of the researcher's thesis, as part of their Clinical Psychologist doctorate training. The researchers also hope to publish papers in academic journals following completion of the study. All your information will be made anonymous in these reports so you will not be able to be recognised. You can have copies of these reports if you wish.

How will we use information about you?

We will need to use information from you for this research project.

This information will include your initials, age, and contact details. People will use this information to do the research or to check your records to make sure that the research is being done properly.

People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead.

We will keep all information about you safe and secure.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

What are your choices about how your information is used?

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

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

You can find out more about how we use your information

- at www.hra.nhs.uk/information-about-patients/
- our leaflet available from **www.hra.nhs.uk/patientdataandresearch**
- by asking one of the research team
- by sending an email to **legal@liverpool.ac.uk**
- by ringing us on 0151 794 8373

What if there is a problem?

If you have a concern about any aspect of this study, you should speak to the researchers who will do their best to answer your questions. If you have more questions or have a complaint which you feel you cannot come to us with then you should contact the Research Governance Officer at the University of Liverpool (ethics@liv.ac.uk). When contacting the Research Governance Officer, please provide details of the name or description of the study (so that it can be identified), the researcher(s) involved, and the details of the complaint you wish to make.

Who is organising and funding the study?

The University of Liverpool have provided the funds to carry out this study and the University of Liverpool is the study sponsor.

Who has reviewed the study?

This research has been reviewed by the Research Committee at University of Liverpool. This study was given a favourable ethical opinion for conduct in the NHS and other sectors by an NHS Research Ethics Committee.

Who can I contact for further information this study?

If you have any questions at all, please contact the researchers:

Toni Garner
Trainee Clinical Psychologist
University of Liverpool
Department of Clinical Psychology
Whelan Building
Liverpool L69 3GB
Email: toni.vedmore@liverpool.ac.uk

Dr. Luna Centifanti, PhD
Senior Lecturer and Research Tutor for the Doctorate in Clinical Psychology
Institute of Population Health Sciences, University of Liverpool
Department of Clinical Psychology
Whelan Building
Liverpool L69 3GB
Tel: +44 (0)151 7945658
Email: Luna.centifanti@liverpool.ac.uk

Dr. Peter Lydon
Clinical Psychologist
Halton CAMHS
North West Boroughs Healthcare NHS Foundation Trust
Thorn Road Clinic,

Thorn Road,
Runcorn, Cheshire, WA7 5HQ
Tel: 01928 568162
Email: peter.lydon@nwbh.nhs.uk

Thank you very much for taking time to read this information sheet.

Appendix F: *Parental information sheet*

Participant Information Sheet

Research Study: Information sharing and confidentiality: Experiences of young people who are accessing a CAMHS service for virtual therapy within the context of COVID-19.

We would like to invite your child to take part in our research study. Before you decide whether or not you are happy for your child to take part, we would like to explain why the research is being completed and what it would involve for you and your child. The researcher will go through the information sheet with you and answer any questions you might have.

What is the purpose of the study?

This study aims to look at people's experiences of attending virtual therapy at CAMHS, while we have been in the COVID-19 pandemic. It aims to look at how people have experienced sharing information and keeping things confidential, and some of the challenges that there might have been with this. It is hoped that by understanding more about this, we can support other young people and their families better in the future.

Why has my child been invited?

Your child has been invited to participate in this study because they are between the ages of 13 and 18 years old, and are currently accessing CAMHS, for therapy. We are only inviting young people who are between the ages of 13 and 18 years old, who are accessing CAMHS, to take part in the study.

Do they have to take part?

No. It is their decision whether or not want they to take part in the study. If they decide to take part, you and your child will be asked to sign a consent form. They are free to withdraw at any time without giving a reason by contacting one of the researchers using the details provided at the end of this form. If your child decides that they don't want to take part in the study after they have completed an interview, they can choose for the data they have provided to be destroyed. They will be unable to withdraw from the study once the transcription has been completed as their data will be anonymised. Withdrawing from the study would not affect the support that your child receives from the CAMHS team. They do not have to answer any questions that they don't want to answer.

What will happen if my child takes part and what will they have to do?

Your child will be asked to meet with one of the researchers for an interview. The interview will take place virtually, for example by telephone or video call, or face to face at CAMHS or at an alternative location. These meetings will take place in a quiet and confidential room. The interviews will last around one hour and there will be opportunities to take breaks at any time if needed. At the meeting your child will be asked to answer a few questions about their experiences of virtual therapy at CAMHS. This will include questions about what it is like having virtual meetings, how this is different from face to face meetings, and their experiences of keeping information private or sharing information from their sessions with others.

The interview will be audio recorded and then transcribed by the researcher or a transcriber associated with the University of Liverpool. The audio recording will be destroyed once it is transcribed and the transcription will be stored in a password protected file. Any identifying information will be removed so that they cannot be identified from the data.

We need around 8 to 10 people to take part in the study. If your child decides to take part in the study

they will be reimbursed for their time with a £10 High Street voucher, which can be at many different high street stores.

What are the possible risks of taking part?

There risks involved in taking part in the study are small. However, some people may find it difficult or upsetting when answering questions about their experiences. This is normal and the researcher will deal with any distress your child may experience sensitively. Contact numbers for organisations that may be able to provide extra support will also be provided. You are welcome to contact the research team following completion of the study if you or your child have any further questions.

What are the possible benefits of taking part?

Although there are no direct benefits to taking part in the study, the information we collect will help to better understand young people's experiences of information sharing and confidentiality when attending virtual therapy. This will help professionals to support both young people and their families more effectively in the future.

What about confidentiality?

No information will be shared with anyone outside of the research team without yours or your child's permission. The only exception to this would be if your child informed the researchers of anything which suggested a risk of harm to themself or somebody else. Should the researcher feel the need to break confidentiality, then this will be discussed with your child first whenever possible.

All information collected about your child during the study will be kept confidential, and any identifying information about them (e.g. their name) will be removed so that they cannot be recognised. They will not be named or identified in any reports of the study.

All data collected from the study will be kept safely and securely on a password protected computer. Dr. Luna Centifanti will be the custodian of all the study data. The data will be archived and stored at the University of Liverpool for 10 years after the end of this study, with your permission. Your consent forms will be stored separately, so that they cannot be identified.

How will we use information about your child?

We will need to use information from your child for this research project.

This information will include their initials, age, and contact details. People will use this information to do the research or to check your records to make sure that the research is being done properly.

People who do not need to know who you or your child are will not be able to see your child's name or contact details. Their data will have a code number instead.

We will keep all information about you and your child safe and secure.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that your child took part in the study.

What are your choices about how your information is used?

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

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

You can find out more about how we use you and your child's information

- at www.hra.nhs.uk/information-about-patients/
- our leaflet available from **www.hra.nhs.uk/patientdataandresearch**
- by asking one of the research team
- by sending an email to **legal@liverpool.ac.uk**
- by ringing us on 0151 794 8373

What happens when the research study stops?

When you have completed the interview, your child will not be asked to do anything else.

The findings of the research project will be written up as part of the researcher's thesis, as part of their Clinical Psychologist doctorate training. The researchers also hope to publish papers in academic journals following completion of the study. All your information will be made anonymous in these reports so you will not be identifiable. You can have copies of these reports if you wish.

What if there is a problem?

If you or your child have a concern about any aspect of this study, you should speak to the researchers who will do their best to answer your questions. If you have more questions or have a complaint which you feel you cannot come to us with then you should contact the Research Governance Officer at the University of Liverpool (ethics@liv.ac.uk). When contacting the Research Governance Officer, please provide details of the name or description of the study (so that it can be identified), the researcher(s) involved, and the details of the complaint you wish to make.

Who is organising and funding the study?

The University of Liverpool have provided the funds to carry out this study and the University of Liverpool is the study sponsor.

Who has reviewed the study?

This research has been reviewed by the Research Committee at University of Liverpool. This study was given a favourable ethical opinion for conduct in the NHS and other sectors by the London – Brighton & Sussex NHS Research Ethics Committee.

Who can I contact for further information this study?

If you have any questions at all, please contact the researchers:

Toni Garner
Trainee Clinical Psychologist
University of Liverpool
Department of Clinical Psychology
Whelan Building
Liverpool L69 3GB
Email: toni.vedmore@liverpool.ac.uk

Dr. Luna Centifanti, PhD
Senior Lecturer and Research Tutor for the Doctorate in Clinical Psychology
Institute of Population Health Sciences, University of Liverpool
Department of Clinical Psychology
Whelan Building
Liverpool L69 3GB
Tel: +44 (0)151 7945658

Email: Luna.centifanti@liverpool.ac.uk

Dr. Peter Lydon
Clinical Psychologist
Halton CAMHS
North West Boroughs Healthcare NHS Foundation Trust
Thorn Road Clinic,
Thorn Road,
Runcorn, Cheshire, WA7 5HQ
Tel: 01928 568162
Email: peter.lydon@nwbh.nhs.uk

Thank you very much for taking time to read this information sheet.

Appendix G: *Parental consent form*

Consent form

Title of Project: Information sharing and confidentiality: Experiences of young people who are accessing a CAMHS service for virtual therapy within the context of COVID-19.

Name of Researcher: Toni Garner

Participant Identification Number:

Please initial in the boxes below

	Initial
I confirm that I have read and understand the information sheet for the above study. I have had the chance to consider the information and any questions or concerns that I have about the study have been answered.	
I understand that taking part is voluntary and that my child can change their mind at any time without giving any reason, without consequence. I understand that this will not affect the support that my child receives from the service.	
I understand that the data collected during the study may be looked at by individuals from the University of Liverpool, from regulatory authorities or from the NHS Trust, where it is relevant to my child taking part in this research.	
I understand that the interview with my child will be audio recorded and I consent to this.	
I understand that direct quotes from the interview with my child may be used in the analysis section of the research. These will be anonymised, and any identifiable information will be removed.	
I agree for my child to take part in the above study	
I would like to receive a summary of the findings at the end of study	

Name of parent Signature Date

Name of researcher Signature Date

**1 copy for participant; 1 copy for researcher; 1 copy to be kept in medical notes*

Appendix H: *Young person assent form*

Assent form

Title of Project: Information sharing and confidentiality: Experiences of young people who are accessing a CAMHS service for virtual therapy within the context of COVID-19.

Name of Researcher: Toni Garner

Participant Identification Number:

Please initial in the boxes below

	Initial
I confirm that I have read and understand the information sheet for the above study. I have had the chance to consider the information and any questions or concerns that I have about the study have been answered.	
I understand that taking part is voluntary and that I can change my mind at any time without giving any reason, without consequence. I understand that this will not affect the support that I receive from the service.	
I understand that the data collected during the study may be looked at by individuals from the University of Liverpool, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research.	
I understand that the interview will be audio recorded and I consent to this.	
I understand that direct quotes from my interview may be used in the analysis section of the research.	
I agree to take part in the above study	
I would like to receive a summary of the findings at the end of study	

Name of participant	Signature	Date
Name of researcher	Signature	Date

**1 copy for participant; 1 copy for researcher; 1 copy to be kept in medical notes*

Appendix I: *Participant consent form*

Consent form

Title of Project: Information sharing and confidentiality: Experiences of young people who are accessing a CAMHS service for virtual therapy within the context of COVID-19.

Name of Researcher: Toni Garner

Participant Identification Number:

Please initial in the boxes below

	Initial
I confirm that I have read and understand the information sheet for the above study. I have had the chance to consider the information and any questions or concerns that I have about the study have been answered.	
I understand that taking part is voluntary and that I can change my mind at any time without giving any reason, without consequence. I understand that this will not affect the support that I receive from the service.	
I understand that the data collected during the study may be looked at by individuals from the University of Liverpool, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research.	
I understand that the interview will be audio recorded and I consent to this.	
I understand that direct quotes from my interview may be used in the analysis section of the research.	
I agree to take part in the above study	
I would like to receive a summary of the findings at the end of study	

Name of participant _____ Signature _____ Date _____

_____ _____ _____

Name of researcher Signature Date

**1 copy for participant; 1 copy for researcher; 1 copy to be kept in medical notes*

Appendix J: *Interview schedule*

INTERVIEW SCHEDULE

1. Can you tell me a bit about what it is like coming to virtual therapy sessions?
   Where do you do this?
   What device do you use?
   What happens in a typical appointment?
   Is anyone else present during your therapy sessions? What is this like for you?

2. What did you expect to happen when you first started therapy?
   How did you feel about the referral?
   How did you feel about doing this virtually?
   Did anything help?
   Was anything more difficult?

3. If you've had face to face therapy before, how does virtual therapy compare to this?
   What's different?
   Is anything the same?
   Do you use any therapy apps online?

4. What do you understand about confidentiality/ privacy?
   What does this mean to you?

5. How do you manage any difficulties that may come up during sessions?
   How do these affect you with therapy being online?
   How do you communicate these with people around you?

6. Can you tell me about how information gets shared with your parents about your therapy sessions?
   How has this been different since you started virtual therapy?
   How do you feel about this?
   What information would you like to be shared?
   How does this affect your relationship with the CAMHS team?

7. Can you tell me about the support you get after therapy?
   Do you discuss your sessions with anyone? Who starts those conversations?
   How do you find this?

<u>Debrief</u>

Following the Interview, the interviewer will check on how the interviewee is feeling and discuss how the interview experience was for the interviewee. The Interviewer will also check that if further discussion is required and refer to the study supervisor if needed.

Appendix K: *Reflexive Statement*

Reflexive Statement

As a Trainee Clinical Psychologist, I am interested in supporting young people to maximise their internal and external resources to develop a positive sense of self and promote wellbeing. I would like services to have a better understanding of helpful and unhelpful ways of supporting young people and their families, both within the context of therapy sessions and outside of therapy sessions, by maximising systemic support. I would like young people to have a positive experience of mental health services, meaning they may be more likely to utilise these services for support. I would like to know how we could do things differently and how we could do things better when working with young people and their families.

I come from a position whereby I recognise the importance of young people feeling that therapy is a space in which the therapist will prioritise their confidentiality. I endeavour to first and foremost, work with the young person towards their therapeutic goals and to respect their choices around information sharing. I recognise that during the period of adolescence, young people may choose to exert more control over what information is shared with their parents and I believe that this is an important part of their development and the development of emotional autonomy. I believe that young people should be supported to maximise their autonomy and ability to make choices about their care and support, whenever possible.

However, I also recognise that families can play an important role in the wider systemic support of the young person. I believe that involving families in therapy can provide both practical and emotional support for young people, both within and outside of the therapeutic setting, which subsequently may improve both the young person's experience of therapy and therapeutic outcomes. Thus, I believe that appropriate sharing of information between young people, families and services, can provide a more holistic approach to working with young people who are accessing mental health services.

I have worked in paediatric services with young people and their families during the COVID-19 pandemic and experienced the shift from face-to-face therapy to virtual therapy, from the perspective of a trainee psychologist. During this time, I have recognised that there have been changes to the structure of therapy, which I believe have impacted on some young people's perceptions of how confidential therapy is. For example, I have noticed that some young people have expressed wishes for sessions to take place when family are out of the home, lowered their voice when talking about particularly sensitive information, or expressed wishes to use

the ‘chat function’ on video platforms to ensure that they are not overheard. I have noticed a shift in family involvement in both directions, with family feeling both more present and absent in young people’s therapy. These experiences impacted upon my interest in this area and desire to complete research in this area and led to the development of the research question in this study.

Overall, I believe that young people will have had both positive and negative experiences of virtual therapy, and how issues of confidentiality and information sharing have been managed within this context. I believe that young people who have more positive relationships with their parents and live-in family settings which promote open communication, may actively choose to share more information with their parents. However, I also recognise that regardless of this, young people value having the choice around what information they want to share, therefore creating confidential therapeutic settings remains important. I am interested in how young people have experienced this in the context of virtual therapy and how we can improve this in the future. My views and thinking in relation to issues surrounding information sharing and confidentiality between young people, families, and services, both within the context of virtual therapy and more broadly, have been informed by my experiences of working directly with young people, speaking to colleagues about these issues, and reading academic literature around this topic. These experiences and views impacted on the development of the interview schedule, which explored young people’s expectations and experiences of virtual therapy more broadly and how these compared to previous experiences of face-to-face therapy, in addition to issues of confidentiality and information sharing in this context.

A critical realist epistemological and ontological position was adopted, which assumes that knowledge of reality is mediated by our perceptions, beliefs, and prior learning. I experienced initial apprehension around engaging young people in a single interview via video and wondered if this related to my own experiences of virtual therapy with young people. I was conscious that in my experience, I felt that developing a relationship by video call had been more difficult than in person. I wondered how comfortable participants would be sharing their experiences with me during this single encounter and the impact this would have on the interview process.

During the interview and analysis stages, I was mindful that some young people’s narratives fit with my own conceptions and personal beliefs about virtual therapy more broadly. Challenges in relation to virtual therapy were present across multiple interviews and

subsequently, I felt drawn to ask further questions around this. At times it was challenging to separate the interview encounter from a therapeutic encounter. However, I recognise that an interview relationship does not equate to the therapeutic relationship.

Supervision sessions and reflexive memos were used in order to recognise the potential biases of the researcher and to acknowledge and reduce their impact upon the research process. This was particularly important given that the researcher had prior experiences of delivering virtual therapy within the context of COVID-19. The primary supervisor did not have these experiences therefore they were able support the identification of potential bias in data analysis and ensure that themes were grounded in the data.

Appendix L: *Example participant themes*

Themes	Example participant themes
Theme one: '*Navigating the shift to virtual therapy'*	**James:** Desire for face-to-face therapy. Came as a shock. Change in the context of change. **Oliver:** Feeling worried about privacy online. **Erin:** Discomfort with camera. Technical difficulties. Loss of communication and information. Avoidance and hiding. **Grace:** Adjusting to new ways of accessing support. Lack of choice around mode. Feeling alone. **Katie**: Virtual appointments becoming the norm. The unknown of virtual therapy. Technical difficulties and disruptions to the flow of therapy.
Theme two*:* *'Therapy at home: A blurring of boundaries'*	**James:** Therapy intruding on my space. Blurring the boundaries with personal life. Physical space facilitates mental space. Not feeling ready and being distracted **Oliver:** Home facilitating feelings of safety and comfort. More relaxed. Can be myself. **Erin:** Flexibility of sessions. Lack of structure. Awkwardness after sessions. Transitioning from therapy back to life. **Grace:** Lack of control – waiting for therapist. Anxiety. Therapists personal life encroaching on therapy. Lack of boundaries. **Katie:** Lack of motivation. Lack of separation between home and therapy. Creating new ways of transitioning. Closing the door on therapy.
Theme three: *'Developing and maintaining the therapeutic relationship in the virtual world'*	**James:** Physical and emotional disconnection. Felt distance in the relationship and almost loss of therapeutic relationship. Communication barriers, but disconnection facilitating disclosure. **Oliver:** You could be anyone. Worries about privacy online. Seeing in person helping to view as real person. Developing the relationship. **Erin:** Fear of judgement. Developing trust in therapist.

	Grace: Difficulties forming a therapeutic relationship. Feeling unheard. Being together versus separate. **Katie:** Difficulties building a rapport. Lack of physical contact. Overcoming the difficulties over time.
Theme four: '*The importance of confidentiality and managing this in a virtual space'*	**James:** Value of a confidential space. Alone in therapy but not alone at home. Information sharing in the context of risk; my best interests. **Oliver:** Knowing things are confidential is the most important. Trust in the therapist helping disclosure. **Erin:** Freedom to be myself. Desire to keep something's private from parents. Worry about people listening. Structure of face-to-face therapy facilitating privacy. **Grace:** Lack of control over space. Creating a confidential space. **Katie:** Therapy as my space. Wanting to keep some things for myself. Finding a confidential space away from home.
Theme five: '*The role of the family'*	**James:** Family have no involvement in therapy. Sharing when things are going well. **Oliver:** Desire for mum to be involved in all sessions. More flexible in virtual therapy, in and out. Mum helps me in therapy. Ongoing systemic support. **Erin:** Collaborative information sharing. Information sharing facilitating new conversations with family. Information sharing in the context of risk, from anger to understanding. **Grace:** Impact of COVID on family involvement. Desire for more parental involvement in therapy. We're all a team. Parents as a go between when in conflict with therapist. **Katie:** Choice around what information is shared with family.

Appendix M: *Initial coding excerpt*

Transcript	Initial noting
Interviewer: Is that something that's important to you?	
Respondent: Yeah, yeah. I feel, I feel a bit erm, yeah. I, I, I am close with my family, which means it's quite hard to talk to them about things, and sometimes that's a bit difficult but I don't want them knowing everything, you know, (laughing) erm, but I think it's just even, it accelerates difficulty with erm, having mental health problems as well.	Being close to family means it's hard to talk to them. Protecting them? Need for privacy increased around mental health. Acknowledges difficulties around privacy for teenagers generally but increased in this area?
Interviewer: Does, does any, information get shared with, with Mum and Dad about your therapy sessions?	
Respondent: Erm, yeah. It's erm, as I say, it's the things that means that I may be in danger, or it's things that she's previously discussed with me saying can I share this because she thinks it will help me. Erm, cos when, when it's in person erm, my Dad usually waits erm in the car, out in the thing because you can't wait in there because of COVID and stuff, erm, and erm so I have like a forty minute session and then call him and then we have twenty minutes at the end together, so and then we go over what I've talked about, what (name), what my therapist has said, can I talk, can I say that to your Dad? You know, that kind of thing. Which I think, which I think's very good because she doesn't just say things, you know, it's, she goes, is do you, is that ok for me to tell to your Dad?	Information sharing with parents when in 'danger'. Sharing is protective. Collaborative decision making around what information is shared. Benefits to information sharing with family. Being involved in the decision around information sharing. Feeling more in control of what information is shared. Possibly facilitating more collaborative working with families?
Interviewer: Has that changed since you started doing virtual therapy?	
Respondent: Erm, no, cos usually someone's in the house. So I just shout them up if that's the kind of appointment, you know, or I kind of just go and get them. Erm, and then we just sit down in front of the camera together, erm, and then the same thing kinda just happens. I think it's this, air of like awkwardness after the session finishes if that makes sense. Cos in person, you have like this erm, oh ok goodbye, let's go get in the car, and oh I don't know, get something to, like, usually we just like go grab something at McDonalds or something you know after a session. But when it just ends and you're sat next to like your Mum and you just (laughing) just don't know what to say. Erm, if that makes sense, I don't know. Yeah, it's erm, but, the, the therapy basis doesn't really doesn't change, and I'd even argue that it's erm, you probably get more time, because erm you join at a certain time, and it ends at a certain time. And usually, sometimes the therapy session's gone over with someone else so then your therapist is late and then erm, and then erm you have to go early because they have another se... you know. That kind of thing, and because it's a set time, you probably get more time, like I s... erm, taking out technical issues and stuff like that.	Asking family to join virtual sessions. Inviting family into your therapy and space. Replicating the same structure as face-to-face therapy for family involvement. Awkwardness after sessions. Unable to leave the therapy space. How do we transition from therapy mode to 'normal life'? Routine around leaving face to face therapy. Process to ending therapy face to face. Hard to replicate in virtual therapy Still the same therapy. More time in virtual sessions. Some benefits to therapy being virtual. Technical difficulties

Appendix N: *Sample from 'Katie'*

Theme	Initial noting and coding	Quotes
Navigating the shift to virtual therapy	• Virtual therapy as an unknown. Not knowing what to expect • Expectations of difficulty associated with therapy not being in person • Period of adjustment to virtual therapy • Technical challenges interrupting the flow of therapy	**Katie:** think I really didn't know what to expect like what it would be like or how it would erm, how it would go so, erm yeah, I think that it was quite, it was a little bit, erm, kind of oo how's it gonna be and what's it gonna be like **Katie:** it was a bit strange, like I think everyone found it a bit strange at the beginning cos like it was just so different, erm, I think that I thought that it would be a lot harder, erm, to kind of not talk face-to-face with someone **Katie:** "we'll be in the middle of a conversation and then it'll just like go dead and then it's like hello, hello, and then like you have to start again so I think there's probably a lot more interruptions"
Therapy at home: A blurring of boundaries	• Worries about therapy. Already in the place, waiting. • Not feeling ready for therapy. Not feeling in the 'headspace'. • Perceived informality of sessions • Difficulties switching off after sessions • Physically shifting space helps transition from therapy • Importance of creating new ways of facilitating the mental shift from therapy back to normal life.	**Katie:** I've found it a lot harder to kind of like when I wake, like say in, like it's in the afternoon and then I wake up it's, it's a lot, I do kind of have a lot more worries about it, you know, and kind of like think about it a lot, a lot more, erm, than probably I did when we used to go somewhere **Katie:** you're not kind of ready for it or you're not kind of like yeah like engaged and not thinking like and you're not almost like awake and you don't, probably don't not gonna like take things in as well and like not, not be able to like say like and discuss everything **Katie:** oh well it's just a phone call, like you can, you can just cancel it or like it's a lot easier to think oh well I don't need to do that or like to go, erm, whereas when it was a meeting, you knew that that was like almost more set in stone **Katie:** not being able to like shut it off almost you know cos like if you go somewhere then you would have that and then like you might, we might talk about it in the car but then when we get home it would be like oh, like do something else. Erm and I think it's a lot harder to kind of like to switch that off and like do something else cos you're still in the same place and it's not that physical like movement **Katie:** I often try to like go for a walk or do something afterwards that's like, that's completely different to kind of and like move around a bit to kind of, to you know to almost have that like oh, you you're coming home from it

Developing the therapeutic relationship in the virtual world	• Developing the therapeutic relationship. • Not being able to see the therapist – who is the therapist? • Something lost in terms of relational aspects in the virtual space. • Building a relationship is a process. • 'Like talking to yourself' – reduced relational demands • Sense of anonymity helping to facilitate openness	**Katie:** I think it is difficult like cos it's a lot easier to kind of build more of a like rapport when you can like, when you can see someone and you're talking in person **Katie:** it's quite difficult to like picture who I'm talking to sometimes **Katie:** just not having that like interaction and kind of like the, like the reassurance as much cos you can't see the person **Katie:** sometimes it is a lot easier if you're not talking face-to-face to someone to be more open **Katie:** you don't actually physically see someone, I think it's a lot easier to open up and it's almost like you are just talking to yourself as well, erm, and trying to like so you can be a lot more, more open and it's a lot easier to kind of erm say like how you're really feeling I think, cos like you don't feel like you're gonna like, not, you know like that you're gonna not be as judged
The importance of confidentiality and managing this in a virtual space	• Importance of having a confidential space for therapy. • Meetings for her and the therapist. • 'Just for me'. Something of her own. • Don't want people overhearing. • Creating a confidential space away from others	**Katie:** everything that like is talked about in the meetings is like, is just like stays in the meeting and it doesn't kind of like get discussed outside **Katie:** with (therapist) it's kind of that was just like for me to kind of like not with my Mum and Dad Katie: it being just me and (therapist) it was I could be a bit more like open and you know like talk about whatever I wanted to rather than and not think oo someone's downstairs like listening almost, yeah. **Katie**: it's still the same really that I know that like it's still confidential and, and private **Katie:** I think definitely, obviously for me being able to like come out of like my house and come into the garden instead, that's probably erm a big thing
Family involvement in therapy	• Ongoing conversations and support throughout the week • Having control over family involvement • Working together with family • Family knowledge of therapy can help them provide practical and emotional support • Creating understanding	**Katie:** I think we do definitely talk about things if like I'm struggling a bit **Katie:** (Things) I want to tell them, erm, and like I need to tell them but then other times it's, it's like sometimes it's like oh maybe it'd just be nice just to kind of like have that for me **Katie**: like any techniques or whatever it's not just me trying to do it by myself like they can help me, erm, and like kind of encourage me to do it and erm, and also like they can understand a bit more about like what's, like what's going on and like how I'm feeling