

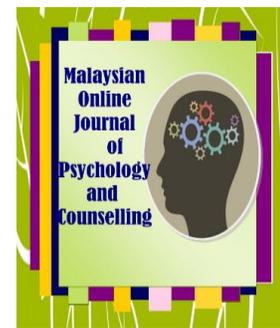
UNDERSTANDING COPING STRATEGIES OF MALAYSIAN PARENTS DURING CHILD PSYCHOTHERAPEUTIC INTERVENTION

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ABSTRACT

Caring for children with Emotional and Behavioural Difficulties (EBD) is associated with elevated stress levels among parents. However, there is little knowledge of how parents cope during participation in their child's psychotherapeutic intervention for EBD. The current study explored the coping strategies adopted by the parents during their contact with their child's mental health services by using a transcendental phenomenological design. Seidman's three-interview series collected detailed data from seven parents (six mothers and one father) in the Malaysian peninsula. The Stevick-Colaizzi-Keen method was used to analyse data collected from individual interviews. Four main strategies were identified from the study: emotion-focused coping, information-based coping, social support, and spirituality-based coping. Additionally, information-based coping included two sub-strategies: (a) means for informed decision-making and (b) access to mental health information. Mental health professionals need to incorporate clinical strategies that could help parents cope better during this challenging time.

Keywords: *Coping strategies, emotion-focused coping, information-based coping, social support, spirituality-based coping.*



**Volume 12 (2),
December 2025**

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INTRODUCTION

Children with Emotional and Behavioural Difficulties (EBD) present a continuum of internalising and externalising behaviours, which range from “normal” misbehaviours to clinically diagnosed psychiatric disorders (Ayers & Prytys, 2002). The surging incidence of EBD in the paediatric population has garnered increasing attention globally (Cui et al., 2021; Van Vuuren et al., 2018). At the international level, approximately 25% of children manifest clinically noteworthy indications of depression, and a substantial 20% of children exhibit symptoms of anxiety that reach clinically elevated thresholds (Racine et al., 2021). Within the Malaysian context, reports show that 424,000 children ranging in age from five to 15 contend with various forms of mental health adversities (National Institute of Health Malaysia, 2020). Notably, the recent National Health and Morbidity Survey highlighted that 26.9% of Malaysian adolescents reported experiencing depression, 9.5% of them admitted to having attempted suicide within the past year, 16% were engaged in physical altercations, and 18.6% reported ever having consumed alcohol (Institute for Public Health, 2022).

Given the rising prevalence of EBD among children and adolescents, it is essential to recognise the critical role of parents in children's mental health services. Throughout their child's psychotherapeutic intervention (ranging from symptom recognition to treatment completion), parents assume multiple responsibilities, serving both as primary caregivers and as informal providers of support. Extensive research indicates that parental engagement in a child's psychotherapeutic intervention substantially improved a child's total clinical symptoms, such as mood and anger difficulties (Foroughe et al., 2019). However, a comprehensive review highlights the numerous challenges parents face while engaging in their child's psychotherapeutic intervention, including the time commitment involved in help-seeking, poor family support network, and long wait time, which often contributes to elevated stress levels (Reardon et al., 2017).

An increasing number of studies have established a strong association between a child's EBD and heightened levels of stress in parents (Jiang et al., 2023; O'leimat et al., 2019). Parenting stress significantly affects various aspects of parents' lives, including their overall quality of life, occupational stability, and financial well-being, particularly when caring for children with mental health conditions (Ambikile & Outwater, 2012). Due to the prolonged course of EBD treatment, parents are at heightened risk of developing psychiatric symptoms, primarily as a consequence of sustained and chronic stress (Middeldorp et al., 2016; Wesseldijk et al., 2018). Ultimately, poor parental mental health can have a profound impact on a child's mental well-being (Wilkinson et al., 2021). These findings suggest a bidirectional relationship between parental mental health and child mental health.

However, research indicates that coping strategies such as an emotion-focused approach, which emphasises emotional validation and helps parents process their own challenging emotions, demonstrate measurable benefits for both parental and child psychological well-being (Ansar et al., 2024). Another study also found that parents manage stress more effectively by adopting religious coping methods, such as reading the Qur'an, attending church, and praying, while caring for children with mental health challenges (Iseselo et al., 2016). Furthermore, strong social support from community networks that value shared parenting responsibilities has also been linked to improved parent-child outcomes (Begle et al., 2012). Similarly, a parenting support programme successfully engaged Somali-born parents of children with EBD, leading to high participation rates and low dropout levels (Osman et al., 2017). Given these findings, a deeper understanding of parental coping is essential for enhancing engagement in psychotherapeutic intervention and improving child mental health outcomes.

In Malaysia, while extensive literature on caregivers' coping strategies has focused on adult children with mental illness (Azman et al., 2017), children with autism (Yaacob et al., 2022), and children with attention-deficit/hyperactivity disorder (Mustafa et al., 2021), research on coping strategies among parents caring for children with EBD remains relatively scarce (Ademosu et al., 2021). This gap is particularly evident in studies examining how caregivers cope specifically during their child's psychotherapeutic intervention. Hence, this study aimed to explore how parents of children with EBD in Malaysia manage their coping strategies throughout their child's psychotherapeutic intervention.

METHODOLOGY

Research Design

Transcendental Phenomenology, a philosophical and research method developed by Edmund Husserl (Husserl, 2012), was selected as the main methodological framework for this study because of its distinctive approach to understanding human consciousness and experience. Transcendental Phenomenology aims to explore the essential structures and conditions that underlie how individuals perceive and interpret the world (Smith, 2013). This method is especially suitable for examining parents' coping strategies in managing their child's EBD because it enables the principal investigator to deeply explore the subjective experiences of these parents and illuminate the lived realities that influence their coping mechanisms (Dahlberg et al., 2007).

Transcendental Phenomenology is done through a series of systematic steps, with the primary goal of accessing the transcendental or a priori aspects of consciousness. The method begins with a process known as the "phenomenological reduction" or "epoché," wherein the principal investigator suspends her preconceived notions and judgments about the phenomenon under investigation. This suspension of assumptions allows for a more direct and unfiltered exploration of participants' experiences (Moran, 2000). The principal investigator engages in a detailed descriptive analysis, examining participants' lived experiences, thoughts, and emotions related to their coping strategies through interviews (Dowling, 2007).

One of the key benefits of employing Transcendental Phenomenology in this study is its capacity to reveal the universal and essential structures of participants' coping strategies (Merleau-Ponty, 1962). By bracketing personal biases and focusing on the fundamental aspects of consciousness, this method enables a deeper understanding of how participants navigate the challenges posed by their child's EBD. Additionally, Transcendental Phenomenology's commitment to objectivity, rooted in the transcendental realm, ensures that the findings are not merely contingent on individual perspectives but offer insights that can be generalised to a broader context (Spiegelberg, 1972).

Research Instruments

This study used semi-structured interviews and drawing protocols. The interview protocol was constructed based on the three-interview series outlined by Dolbear and Schuman, elucidated by Schuman (1982), and subsequently cited in Seidman (2006). To ensure the protocol's validity, a panel of three academics, consisting of two registered counsellors and an educational psychologist, evaluated it. The visual drawing protocol was tailored to capture participants' experiential accounts through visual art, a methodology frequently integrated into phenomenological research endeavours (Cohenmiller, 2018). Upon concluding each interview, participants were asked to draw symbols or images that encapsulated their discussed experiences. After completing their drawings, the principal investigator prompted participants to explain their symbols or images, allowing them to elaborate on experiences that were not fully articulated during the interview. Consequently, this method of documentation enabled the principal investigator to utilise participants' drawings in triangulating the data collected throughout the interviews.

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Participants

The selection of study participants adhered to predefined criteria. They were: (a) parents actively engaged in their child's psychotherapeutic intervention, (b) parents with a minimum of two months of participation in their child's therapy, (c) parents whose child's psychotherapeutic intervention concluded no more than two years before the interview date, (d) parents of children aged between five and 15 years exhibiting EBD, and (e) married parents who are at least 18 years old, the legal age of marriage, residing in Malaysia, with no restrictions related to their racial background, marital status, socioeconomic standing, physical and mental health condition, and employment status. Parents of children diagnosed with neurodevelopmental disorders, as well as those with one child having a neurodevelopmental disorder and another with EBD, were excluded from this study.

Determining the sample size in qualitative research involves considering research goals, inquiries, data collection methods, authenticity, applicability, sample characteristics, and available resources and time. Creswell (1998) suggests a sample size of five to 25 participants for phenomenological studies. In this investigation, a deliberately smaller participant pool of seven was chosen to facilitate an in-depth exploration of diverse experiences. The sample size determination was influenced by the study's scope, data depth, and point of data saturation, wherein no additional information emerged.

The research cohort comprised seven participants (Table 1): six females and one male, with 45.29 average age, and children averaging 13.86 years old. The group was culturally diverse: Malay (1), Indian (2), Eurasian (1), and Chinese (3). Participants' occupations spanned manufacturing, business, and education. Marital status included four married, two divorced, and one widowed. Socioeconomic status was B40 (low income) (2), M40 (moderate income) (2), and T20 (high income) (3). Psychotherapeutic modalities for children included consultation (1), sand tray therapy (1), psychotherapy (1), and counselling (4) with mental health professionals.

Table 1

Background Information of Participants

Participant	P1	P2	P3	P4	P5	P6	P7
Relationship with Child	Father	Mother	Mother	Mother	Mother	Mother	Mother
Parent's Age	50	42	42	57	45	50	47
Child's Age	13	13	13	15	12	16	12
Race	Chinese	Chinese	Indian	Indian	Chinese	Eurasian	Malay
Religion	Buddhist	Buddhist	Catholic	Christian	Buddhist	Catholic	Muslim
Occupation	Manager	Marketing	Factory Operator	Founder of NGO	Research Officer	Freelance Project Coordinator	Academic
Marital Status	Married	Married	Divorced	Married	Widow	Married	Divorced
Income Classification by Household*	T20	T20	B40	B40	M40	M40	T20
Psychotherapeutic Modalities	Counselling, Consultation	Consultation, Drug treatment Counselling	Counselling	Counselling	Sand Play Therapy	Psychotherapy	Counselling
Mental Health Professionals	Counsellor, Psychiatrist	Psychiatrist Counsellor	Counsellor	Counsellor	Counsellor	Clinical Psychologist	Counsellor

*T20 = Top 20% denoting high income; M40 = Middle 40% denoting moderate income; B40 = Below 40% denoting low income.

Before their participation in the research, the principal investigator conducted a screening interview to ascertain the participants' alignment with the predefined inclusion criteria. Upon expressing their concurrence to participate in the study, participants affixed their signatures to the consent form and furnished demographic particulars before the inaugural interview session.

Ethical Clearance

This study was approved by the Institutional Review Board, Universiti Malaya (UM.TNC2/UMRC-1456).

Data Collection

Data collection occurred between October 2021 and June 2022. All participants consented to interview recordings. Due to COVID-19 safety concerns, all participants preferred video conferencing to minimise in-person contact. The study utilised Zoom, a widely recognized platform, for data collection. Before each session, the principal investigator provided Zoom links 24 hours in advance to participants. Interviews followed a sequential structure, with each subsequent session scheduled after completing the preceding one. On average, each interview lasted approximately 60 minutes.

Throughout these interview sessions, the principal investigator provided questions to stimulate participants' reflections concerning their strategies for coping with the stress from challenges experienced during engaging their child's psychotherapeutic intervention. It is pivotal to underscore that the principal investigator followed a sequential and meticulous interviewing and data analysis process for each participant individually.

Analytical Data Procedures

For data analysis, the principal investigator employed the Stevick-Colaizzi-Keen method (Moustakas, 1994), which comprises a systematic eight-step process in depicting the essence of participants' experiences comprehensively. This analysis involved acquiring exhaustive descriptions of participants' experiences and meticulously examining verbatim transcripts. The initial phase encompassed identifying and highlighting pertinent descriptions, from which a catalogue of meaning units was derived. This phase was followed by clustering meaning units into overarching themes and subthemes. Subsequently, the principal investigator connected these meaning units into coherent themes.

In successive stages, the principal investigator crafted individual textural descriptions of the experiences to elucidate the "what" of the investigated phenomenon, grounded in identified themes. Simultaneously, individual structural descriptions were generated through imaginative variation, emphasising the nuanced "how" of each participant's experience. This thorough process was reiterated sequentially for each participant until data saturation. Following this, the principal investigator synthesised composite textural and structural descriptions to overview participants' experiences comprehensively. These synthesised descriptions were amalgamated to understand the essence underlying the investigated experiences comprehensively.

The principal investigator implemented a series of detailed data validation procedures consisting of five distinct steps. Initially, each statement underwent iterative readings to confirm the exclusion of extraneous or irrelevant data accurately. Subsequently, a methodological triangulation strategy was adopted, entailing two diverse data collection approaches. Data derived from interviews was systematically cross-validated with visual art artifacts created by participants after each interview, serving as tangible reflections on the subject matter.

The principal investigator engaged all participants to verify the accuracy of the identified themes, excluding one individual who remained uncontactable during the follow-up phase. Furthermore, two scholarly peers possessing expertise in counselling and psychology undertook an exhaustive audit of the delineated themes. The principal investigator demonstrated transparency and self-reflection by openly acknowledging personal biases before initiating data collection. Lastly, the principal

investigator conducted a debriefing session with a peer to explore and elucidate her own cognitive and emotional responses elicited by the participants' narratives of their experiences.

RESULTS

The analysis of how parents coped during their child's psychotherapeutic intervention revealed four main strategies: (1) Emotion-Focused Coping, (2) Information-Based Coping, (3) Social Support, and (4) Spirituality-Based Coping. Additionally, Information-Based Coping included two sub-strategies: (a) Means for Informed Decision-Making and (b) Access to Mental Health Information (refer to Table 2).

Table 2
Coping Strategies and Sub-Strategies

No.	Coping Strategies	Sub-Strategies	Examples
1	Emotion-Focused Coping	-	<i>P4: "I think that whole experience was so many mixed feelings, pain, brokenness, anger, anxiety."</i>
2	Information-Based Coping	Means for Informed Decision - Making	<i>P1: "You need to understand the nature of the problem first before you can think of what is the solution."</i>
		Access to Mental Health Information	<i>P7: "Every now and then, I'll read something online or maybe a journal article. Maybe just the Psycom, like a psychology website or something."</i>
3	Social Support	-	<i>P5: "This one...the energy source... maybe also from our friends, our family member, my other church members, all of these." P3: "My sister knew I was in depression, and they bring me to Cameron Highlands to release stress... and bring my children all last year to Cameron to relieve stress after the incident."</i>
4	Spirituality-Based Coping	-	<i>P4: "Whatever challenge it is, sometimes you really cannot turn left, right, look anywhere. So, I always feel the only place of hope I can always go to is go to God."</i>

Strategy 1: Emotion-Focused Coping

Some parents in this study employed emotion-focused coping to manage their stress, which included emotional expression (e.g., discussing feelings with professional counsellors) and emotional processing (e.g., engaging in self-blame or wishful thinking). The following are selected statements provided by the participants.

P7 stated:

Sometimes I get so emotionally sucked in that it is kind of difficult to come to solve it because I was so emotional, and the intellectual side all gets jumbled up, and then you don't know what to do and cry. It was so unproductive. But when I started seeing a therapist, I was like ok.

P4 explained:

There was a lot of self-blame. There was a lot of guilt on my side...like how did I not notice it? I think if my son actually went for counselling and then eventually said, "I felt my mom had no time for me, or I was feeling pain because of this," I would then know like I'm not responsible or I'm responsible for his problem...When I went for my own counselling, and I talked about these things, I realised that I was always so angry. So, I begin to just take a step back and ask myself why I am angry. I think all these sessions helped me a lot to understand him and understand me.

P2 narrated:

Probably I am blaming myself for not having the right way or not giving him the right guidance or the time sufficiency that led him in that way.

In summary, this evidence indicates that parents adopted emotion-focused coping strategies to manage overwhelming caregiving emotions during their engagement in their child's therapy.

Strategy 2: Information-Based Coping

Topics related to mental health are seldom openly discussed in public or private circles; however, parents found that this information is essential, especially in helping them to understand their child's problems better and subsequently make decisions on treatment plans. Two sub-strategies emerged from the interviews: (1) means for informed decision-making and (2) access to mental health information.

Means for Informed Decision-Making

Parents consistently reported that acquiring comprehensive information about treatment options enables more confident decision-making about their child's care. The information could be gathered through research on websites or consultation with professionals.

P1 said:

We go to see the psychiatrist, then immediately after, there is a private talk between my daughter and the psychiatrist...She (psychiatrist) said that it's quite serious and got to take medication. And that's the time that I feel that I don't want to go that path...I said can you give me the information about the medicine? I go and Google around and search the information. The medicine is exactly the side effect is exactly the symptoms that we worry. It can cause depression. It can cause suicide tendency. So, I don't feel this is the right path. I decided to ask for a second opinion.

P3 explained:

At first, I thought it's not important for me, but once the counsellor talked to me and after I shared my concerns, I felt released. I knew what to do and what are the next steps to do. Then, only I told the counsellor that my children also needed counselling.

P7 narrated:

I did my reading first before I contacted the therapist. Because I was trying to read up on stuff, and I was trying to diagnose her myself. Every time I find a label or like a journal article or anything that has names attached to it, I feel better because at least I know what I'm dealing.

Taken together, the knowledge parents acquired served as an effective coping strategy for managing caregiving-related stress when making treatment decisions.

Access to Mental Health Information

During the therapy period, parents tried obtaining mental health information from various sources, including online platforms, social networks, and professional consultations. The convenience of accessing this information has helped parents cope better with their child's EBD.

P5 stated:

Because I also don't have all these experiences, so I need to do a lot of study, search a lot of the pictures and photos, then explain to them (children) what the therapist will do in sand play.

P7 recounted:

Every now and then, I'll read something online or maybe a journal article. Maybe just the Psycom, like a psychology website or something...I diversified my sources.

P6 explained:

We (husband and wife) definitely looked online about the company and see who they are. So prior to the first session, we did a lot of that kind of preparation.

Collectively, the resources' accessibility functioned as a critical coping strategy, enabling parents to mitigate uncertainty about their child's EBD through knowledge acquisition.

Strategy 3: Social Support

In the current study, participants received support from friends and family in various ways (e.g., advice, financial assistance, and encouragement). They acknowledged their family's instrumental role in alleviating the challenges, fostering a sense of shared responsibility.

P7 stated:

So, if I don't know anything, I'll think about who's in psychology. I have friends from other faculties, and so I know I'm getting information from the right people.

P6 said:

After that, I went back actually to my friend, just to talk it through as well, and if something I wasn't sure, I guess my friend helped to reassure me that whatever the therapist was suggesting, or her (therapist's) thoughts was along those lines, that he would also have the same. So, I thought that helped to reassure me.

P5 recounted:

The energy source may also come from my friends, my family members, my other church members, all of these are something like the outsource support.

P3 stated:

My sisters and brothers we're all staying in the same area. When this family problem happened, they strengthened me. They are the ones who gave me strength, helping me with my finance. If I don't have them, I don't know how my life would be.

P1 explained:

We always discuss and exchange idea how we can resolve it and support each other. When another one feels no confident, then another one will say, "Well, we always can solve problems together."

These findings indicate that sustained social support functions as a vital psychosocial buffer, mitigating the cumulative physical and emotional stressors of long-term caregiving.

Strategy 4: Spirituality-Based Coping

Many parents consistently turn to spiritual faith for support, from first noticing their child's issues to final treatment. They fully embrace these beliefs when addressing EBD challenges, citing reliance on divine intervention through the following statements:

P3 stated:

So sometimes I have depression because my children are very naughty and stubborn...I talked to God. I like to talk to God. I see Jesus' face and just talk because that's how my attitude is. I like to question Him (God) a lot and I will say now I understand why.

P4 explained:

Whatever challenge it is, sometimes you really cannot turn left, right, look anywhere. So, I always feel the only place of hope I can always go is to God.

P7 said:

I don't count on friends, my mom, or my family. Most of the time, 95% of the time I count on my faith.

These parents' accounts revealed that their steadfast religious faith served as a foundational source of strength and resilience while navigating demanding caregiving responsibilities throughout their engagement in their child's treatment.

DISCUSSION

This study explores how parents of children with EBD cope with challenges throughout their child's psychotherapeutic intervention journey. Given that therapy duration ranges from several months to a year, contingent on symptom severity, parents face sustained challenges requiring coping strategies. The present research identifies and analyses the approaches parents utilise to manage stressors associated with their child's EBD and concurrent psychotherapeutic processes. Through qualitative analysis, four primary coping strategies emerged: emotion-focused coping, information-based coping, social support, and spirituality-based coping. These findings highlight the importance of providing parents with adequate support and information to enhance their engagement in their child's psychotherapeutic intervention journey.

Our findings highlight the importance of emotion-focused coping as one of the strategies utilised in coping with challenges among parents of children with EBD. Despite problem-focused coping helping reduce parental stress (Solem et al., 2011) compared to emotion-focused coping, a recent meta-analysis found that emotion-focused interventions have a small to moderate effect on improving parents' mental health and reducing children's EBD (Zahl-Olsen et al., 2023). Per a study by Yaacob et al. (2022), participants in this study frequently turned to trusted individuals for non-judgmental emotional support. This practice not only alleviated immediate emotional strain but also fosters long-

term resilience. Although not directly reported by participants in this study, professional counselling is widely recognised as a valuable avenue for parents to process emotions in a safe, non-judgmental environment, which can facilitate more structured emotional regulation. Increasingly, programmes that incorporate emotion-focused skills training for parents are gaining recognition for their positive impact on parental mental well-being (Ansar et al., 2021).

However, this adaptive coping approach contrasts markedly with the maladaptive self-blaming patterns identified in the current study. Self-blame is a frequently observed coping mechanism among parents of children with mental health difficulties, often arising from an attempt to understand or rationalise their child's condition (Armitage et al., 2020). In this study, parents who engaged in self-blame expressed heightened feelings of guilt and symptoms of depression, aligning with findings by Marcil et al. (2020), who identified self-blame as a significant risk factor for the onset of depressive symptoms in parents.

The second prominent coping strategy identified was information-based coping. The participants consistently highlighted how acquiring comprehensive knowledge about their child's mental health condition served as a critical foundation for pursuing psychotherapeutic intervention. These observations support established research demonstrating that poor mental health literacy correlates with heightened stigma and diminished help-seeking behaviours (Pullmann et al., 2010). Notably, the data reveal that enhanced mental health awareness empowers parents to (1) make evidence-based treatment decisions, (2) accurately evaluate their child's specific needs, and (3) overcome potential barriers to care.

As parents developed a more nuanced understanding of their child's EBD, they demonstrated a significantly greater propensity to both seek and actively engage with professional support. This finding directly corroborates Girio-Herrera et al.'s (2013) longitudinal study, which shows strong positive relationships between parental mental health literacy and therapeutic engagement. The inverse relationship was also significant, and limited understanding consistently predicted treatment hesitancy, especially among parents of at-risk children. This pattern manifested clearly in our sample, with better-informed parents showing markedly higher motivation to initiate and sustain their child's psychotherapeutic intervention.

Moreover, this study revealed that easy access to mental health information has significantly streamlined the process for parents to acquire knowledge about EBD, owing to the convenience of internet use. This finding is consistent with the study by Croucher et al. (2020), which highlighted the growing reliance on web-based platforms, such as Mumsnet, as a valuable resource for mental health information, general guidance, and emotional support for parents of children with mental health challenges.

These findings underscore the need for collaborative efforts and alignment across health, education, and social networks to enhance mental health literacy. Strengthening public awareness initiatives is crucial for reducing stigma, promoting early intervention, and enhancing societal understanding, as supported by Hurley et al. (2020).

Additionally, the availability of strong social support emerged as a critical factor in mitigating parental distress. This finding supports Lakey and Orehek's (2011) stress-buffering hypothesis, which posits that quality social interactions can significantly attenuate psychological stress. Parents actively engaged in family support systems reported improved well-being and enhanced resilience. These observations support previous research showing that spousal support enhances psychological

well-being – a key factor in maintaining parental optimism and resilience during therapy (Berli et al., 2021).

Finally, spirituality-based coping emerged as another important strategy. Some parents found that faith, prayer, and religious teachings helped them manage stress during their child's psychotherapeutic intervention. This data reinforces existing research on the role of spirituality in mental and emotional well-being (Ilias et al., 2017; Isa et al., 2017). While spirituality can influence mental health both positively and negatively (Weber & Pargament, 2014), parents in this study predominantly employed positive religious coping strategies, drawing strength and guidance from their faith.

LIMITATIONS AND RECOMMENDATIONS

This study's exploration of parental experiences highlights the importance of recognising its limitations. Using a relatively homogeneous sample restricts the generalisability of findings to a broader range of parental encounters. To develop a more comprehensive understanding of service and knowledge gaps, future studies should include diverse participants, such as mental health professionals, child clients, and other key stakeholders in child mental health services. Furthermore, to address the lack of standardisation, future research should adopt purposive sampling to ensure participants receive the same psychotherapeutic modality, promoting consistency in parental experiences regarding intervention type and duration.

THEORETICAL AND PRACTICAL IMPLICATIONS

In supporting parents during their child's psychotherapeutic intervention, forming robust relationships within their support networks is crucial. Mental health professionals should strengthen this system through community mobilisation, involving volunteer training in emotional support and mental health. This empowers volunteers to provide practical assistance, fostering an environment where parents feel recognised and supported by those with similar experiences (Klein et al., 2019). Furthermore, practitioners should integrate digital platforms into therapy to address parents' reliance on online mental health information. This approach requires developing accurate, accessible content about EBD and psychotherapeutic intervention for digital dissemination.

Furthermore, parental spirituality improved coping greatly, which highlights how significant nurturing a spiritual bond with a higher power from childhood is. This observation underscores how developing a strong belief system requires sustained, long-term engagement. Therefore, mental health professionals are encouraged to guide parents in tapping into this spiritual resource, aiding them in coping more effectively during their child's psychotherapeutic intervention.

CONCLUSION

This study highlights the diverse coping strategies adopted by Malaysian parents as they navigate their child's psychotherapeutic journey for EBD. Four coping strategies were identified: emotion-focused coping, information-based coping, social support, and spirituality-based coping, each contributing significantly to reducing parental stress and promoting resilience. While emotion-focused coping proved beneficial when supported by professional services, it also revealed maladaptive patterns such as self-blame, emphasising the importance of interventions aimed at reframing parental guilt. Information-based coping enabled parents to make more informed

treatment decisions; however, uneven levels of mental health literacy and limited access to reliable information remain challenges. Social support from family and community networks functioned as a protective factor consistent with stress-buffering theory. Spiritual faith provided a meaningful framework for emotional regulation and coping, particularly in culturally relevant contexts. In conclusion, supporting parents during their engagement in their child's psychotherapeutic intervention requires a collaborative approach acknowledging their lived experiences. By meeting parents' emotional and social needs, mental health professionals can empower parents to steer their caregiving roles effectively, ultimately improving outcomes for families and children.

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