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The Experience of Parenthood in Clinical Psychology

A thesis submitted in partial fulfilment of the requirements for the

Doctorate in Clinical Psychology

By Sharla Lawrence

Coventry University, Faculty of Health and Life Sciences

and

University of Warwick, Department of Psychology

May 2013

Table of Contents

Appendices

Lists of Tables and Figures

List of Abbreviations

AAMFT – American Association for Marriage and Family Therapy

APA – American Psychological Association

BPS – British Psychological Society

CSI – Coping Strategies Inventory

GP – General Practitioner

IPA – Interpretative Phenomenological Analysis

NHS – National Health Service

REC – Research Ethics Committee

SWLS – Satisfaction with Life Scale

UK – United Kingdom

USA – United States of America

Acknowledgements

I would like to express my appreciation to the nine psychological therapists who took time out from their busy schedules to complete the research interviews. Without their honesty and open-ness this research would not have been possible.

I would also like to thank my research supervision team Jacky, Jo and Lisa, who have supported me at each stage of the research process. I will always be grateful for their expertise, encouragement and time.

Finally, I would like to thank Luke and my wonderful children Ewan, Francesca and Haydn for distracting me with fun and generally keeping me sane!

Declaration and Authorship

This thesis was carried out under the supervision of Jacky Knibbs, Jo Kucharska and Dr Lisa Summerhill, all of whom were involved in the initial formulation of ideas, development of the research design and the drafting of papers. Jo Kucharska provided a co-ordinating role, Jacky Knibbs facilitated the recruitment of participants and Dr Lisa Summerhill provided supervisory guidance during the research process.

Apart from these collaborations this thesis is all my own work. These chapters have been prepared for submission to journals and authorship of any papers derived from this research will be shared with the supervision team as appropriate. This thesis has not been submitted for a degree at any other university. The empirical paper has also been written up as a research poster, which will be presented at future conferences.

Literature Review (prepared for submission to the British Journal of Clinical Psychology)

Lawrence, S., Knibbs, J., Kucharska, J. & Summerhill, L.

Protective Factors and Barriers to Achieving Work Life Balance as a Psychologist

Empirical Paper (prepared for submission to the British Journal of Psychology)

Lawrence, S., Kucharska, J., Knibbs, J., & Summerhill, L.

Motherhood and the impact on the therapeutic relationship: A qualitative study of psychological therapists in Child and Adolescent Mental Health Services

Reflective Paper:

Lawrence, S., Summerhill, L., Kucharska, J. & Knibbs, J.

Reflections on the challenges of being a trainee clinical psychologist and a mother

Summary

Being a parent is generally accepted to be a difficult but rewarding job. For those individuals who combine parenthood with an emotionally demanding career, such as clinical psychology, this experience may be magnified. Exploring the experiences of parents who also work in the field of clinical psychology offers a meaningful insight into the challenges and positive rewards inherent in managing work and family life.

Chapter I consists of a narrative review of the literature exploring the issues of balancing work and family life for psychologists. The barriers apparent in the literature, as well as the positive factors for achieving effective work life balance are considered. Barriers cited in the literature include the difficulties in meeting the demands of multiple roles, the influence of gender and negative individual factors. Positive influences on achieving effective work life balance included engagement in leisure activities, positive relationships, organisational support and positive individual factors. The clinical implications of this literature are discussed.

Chapter II presents an empirical study conducted with psychological therapists who work within a Child and Adolescent Mental Health Service (CAMHS) and are also mothers. Nine psychological therapists were interviewed during the research. Following the use of the Interpretative Phenomenological Analysis (IPA), three superordinate themes emerged from the data. The findings consider the implications of shared experience when working with parents and the dilemma of managing the multiple demands of work and family life. The sense of re-evaluation of one's own self-concept following becoming a mother is also discussed. Clinical implications are considered alongside suggestions for future research.

Chapter III offers a reflective account of the challenges inherent in undertaking doctoral level training in clinical psychology whilst raising a young family. The implications for the role of clinical psychology as a discipline are considered as well as the impact on my own personal and professional development.

Chapter One: Literature Review

Protective Factors and Barriers to Achieving Work Life Balance as a Psychologist

This paper has been prepared for submission to the British Journal of Clinical Psychology

Word Count: 6183 (exclusive of figures, tables and references)

This paper has been broadly prepared in accordance with the requirements of the British Journal of Clinical Psychology (See Appendix 1). Supplementary information is presented within the thesis chapter to aid overall cohesion; this will be removed prior to journal submission in order to reduce the word count

1.1 Abstract

Objectives:

The objective of this narrative literature review was to critique the literature whilst considering the barriers and protective factors to implementing an effective work life balance. The implications for United Kingdom (UK) clinical psychologists working within the National Health Service (NHS) are also considered.

Methods:

A narrative review of the literature was completed with an emphasis on critiquing the evidence. Five databases were searched using a variety of search terms sourced from an as yet unpublished review of literature (Eib, McDowall, Kinman, & Allan, 2009) as well as searches of reference lists to identify relevant articles.

Results:

This literature review identified a number of themes related to the issue of work life balance, which could be broadly grouped into barriers and protective factors to achieving this. Barriers to work life balance included difficulties in meeting the demands of multiple roles, the influence of gender and negative individual factors. Protective factors to achieving work life balance included engagement in leisure activities, positive relationships, organisational support and positive individual factors.

Conclusions:

Research in this area is varied in terms of methodology, lack of up to date findings and its limited focus on certain groups of individuals and settings. As the majority of the studies have been completed in the USA and Canada in primarily academic settings, future research would be well placed in investigating the perspective of UK clinical psychologists working in the NHS. This is particularly pertinent given the current economic and political climate surrounding organisational change within the NHS.

1.1.1 Practitioner Points

Clinical Implications:

There are demonstrated clinical benefits to individuals being able to effectively manage work and home life demands including stress reduction, improved wellbeing and organisational productivity amongst others (Lee, Reissing & Dobson, 2009; Burke et al., 2003). This review highlights the importance of engaging in self-care behaviours as one strategy for maintaining an effective work life balance. From an organisational perspective, this review suggests that organisations could do more to be supportive to those employees who are managing multiple demands.

Limitations

There has been limited research conducted outside of the USA and no evidence of the perspective of UK clinical psychologists. Many of the research studies have been completed with psychologists who work within an academic setting. The quality of the literature in this area is also variable. There is a focus on the female perspective in the literature, which highlights the assumption of traditional gender roles.

1.2 Introduction

Achieving balance between one's professional and personal life is often used as a positive way to reduce life demands and ensure emotional resources are available for all areas of an individual's life (Rupert & Kent, 2007). Within the literature there are many varied definitions of work life balance. Essentially, effective work life balance provides the "fulfilment of work roles without the loss of personal life" (Lee, Reissing & Dobson, 2009, p. 75). Individuals who work within the field of psychology use their emotional resources to help clients with poor mental health and as a result may experience difficulties with work life balance (Kircaldy & Siefen, 1991). Managing different emotionally charged roles can make maintaining satisfactory work life balance a challenge (Matheson & Rosen, 2012).

However, the notion of balancing work and family roles suggests that the two areas are mutually exclusive, with an individual perhaps only being

able to fully commit themselves to one aspect of their life (Kinman & McDowall, 2010). A more useful concept may be that of work life effectiveness, which has been defined as a mutually beneficial relationship between work and home life where the individual is able to manage effectively their necessary multiple roles and responsibilities (Koppes & Swanberg, 2008; Burke, Oberklaid & Burgess, 2003). Within the literature, the majority of the studies utilise the term work life balance and this will be the term that is used throughout this review.

One element of work life balance is the notion of taking care of oneself while managing competing demands. Within the field of psychology, despite the expanding knowledge of self-care and awareness of our own limitations, Canning (2011) believes that practitioners do not always engage in self-care practices. Very often the emphasis for action is placed firmly at an individual level and not at a more systemic level (Burke et al., 2003). Yet individuals do not always take responsibility for acting on this.

There is very little research on the use of positive work life balance strategies by practising psychologists and yet the challenge of combining family life with a psychological career has been present virtually since the beginnings of psychology (Furumoto & Scarborough, 1986). A narrative approach to the reviewing the literature was chosen; this was to enable the inclusion of the historical perspective. The literature in this area utilises a wide variety of research methods and a narrative approach will

also allow the inclusion of all relevant literature regardless of methodology.

This narrative literature review will focus on historical literature regarding managing multiple demands before considering our current understanding of the barriers and protective factors that impact on achieving effective work life balance.

1.3 Historical Overview

At the beginning of the twentieth century, a small number of female psychologists had been pioneering the role of women within the field of academic psychology. These women were often expected to forego the traditional roles of women, including marriage and children, to experience career success and recognition. It was considered that the idea of balancing the multiple roles of wife, mother and psychologist was impossible (Furumoto & Scarborough, 1986). Indeed one early female psychologist, Ethel Howes, spoke out about her own struggles in this area and believed that perhaps attempting to maintain a family life and a psychology career was simply not possible without some alteration to existing work practices (Furumoto & Scarborough, 1986). Her early attempts at promoting flexible work schedules were not successful (Milar, 2000) but provide an indication of the length of time that managing multiple life roles has been a challenge.

Research studies into the women who pioneered the field of psychology suggest that they were less committed to the traditional female roles of wife and mother and were perhaps, therefore, less interested in balancing different life roles (Campbell & Soliman, 1968; Bachtold & Werner, 1970). However, this may have been symptomatic of the career disadvantages afforded to women who attempted to manage both work and family roles (Furumoto & Scarborough, 1986; Milar, 2000). Personality profiles of early female psychologists suggest that they were less likely to experience stress from environmental pressures, due to high levels of self-confidence and low levels of anxiety. So perhaps they were less concerned about tradition and were able to pursue their academic interests rather than conform to traditional female stereotypes (Bachtold & Werner, 1970).

Pendergrass (1974) surveyed male and female psychologists working within private practice and found that they had very different reasons for wanting to work within the independent sector. Men often cited the opportunity to work most effectively whereas women believed the flexibility of schedule was the most important consideration for working in this way (Pendergrass, 1974). This may reflect the notion that to the present day, women maintain the greater responsibility for family and home commitments (Matheson & Rosen, 2012; Lee, Reissing & Dobson, 2009; Bryant & Constantine, 2006; Burke et al., 2003; Kirkcaldy & Siefen, 1991).

These studies are very dated and focused primarily on female experience within American academic institutions, however this kind of research has not been replicated with a more current sample of psychologists. However recently, increasing numbers of men are considering ways to effectively balance their home and work commitments in favour of spending more time at home with their families (Duan, Brown & Keller, 2010). Increased male involvement in child rearing can be encouraged through challenging societal expectations and supporting the equal sharing of family roles (Lee, Reissing & Dobson, 2009). There has been limited attention paid to psychologists who work within non-academic settings, and studies into achieving work life balance when employed within UK institutions such as the NHS are non-existent.

1.4 Aims of the Literature Review

The aim of this narrative literature review is to critique the literature and consider how things have progressed for male and female psychologists in maintaining work life balance. It is hoped that this will provide some clarity of thinking for UK psychologists working within health settings such as the NHS, who have so far been a neglected group in terms of research.

The specific aims are:

- To critique the body of literature on work life balance in psychologists

- To consider the barriers and the protective factors to achieving effective work life balance while working within the field of psychology
- To consider the implications for psychologists working within public health settings such as the NHS in the UK

1.5 Method

This literature review will use a narrative approach. Narrative literature reviews provide an overall perspective of the literature and this can include the historical development of knowledge within a particular subject area. Articles within a narrative literature review are summarised and critiqued with the overall themes discussed to provoke thought and discussion (Baumeister & Leary, 1997; Green, Johnson & Adams, 2006).

The literature in the area of work life balance for psychologists is varied in terms of the research methodologies utilised, the date the research was completed and the populations sampled. Therefore, the area would benefit from a narrative overview of the current themes that underpin the potential challenges and protective factors of maintaining an effective work life balance within the field of clinical psychology.

1.5.1 Search strategies

The literature reviewed in this paper were extracted from five databases including Academic Search Complete, Allied and Complementary Medicine database, CINAHL, MEDLINE and PsychInfo. Key words searched were “work life balance”; “work family balance”; “work family conflict”; “work life conflict”; work family facilitation”; “work life facilitation”; “work family enrichment”; “work life enrichment”; “family friendly”; “flexible work”; “self care” and “resilience”. These search terms were sourced from an as yet unpublished review of literature on work life balance (Eib et al., 2009) and combined with the search term “clinical psychology” to source papers with relevance to work life balance within the field of clinical psychology. No limit was set on the date that the articles were published. This was to enable the inclusion of a historical perspective on work life balance.

1.5.2 Inclusion and Exclusion Criteria

Inclusion Criteria

- The methodology of the article reported a participant sample of clinical or counselling psychologists, psychological therapists or psychotherapists.
- Articles published in peer-reviewed journals.

Exclusion Criteria

- Articles that were not available in the English language were excluded.

1.5.3 Results of Literature Searches

Using the search terms listed, literature searches were completed between December 2012 and February 2013. Initial searches identified 1438 articles. These articles were examined for relevance, exclusions and duplicates. Reference lists of appropriate articles were also searched, which resulted in a total of 23 articles being included within the review (See Figure 1.1 for a consort diagram of this process).

These studies used a variety of methodologies included quantitative methods and surveys (eleven papers), position papers (four papers), qualitative methods (five papers), three literature reviews and one mixed methods paper. Eight of the papers reviewed used a sample of academic psychologists and seven used practising psychologists, who were involved in providing therapy. Other studies used samples of psychotherapists, family therapists, counsellors, counselling psychologists and mental health professionals. Twelve of the papers used both male and female participants; eight used solely female participants and one used only male participants. Some of the papers reviewed were position papers or literature reviews and therefore did not utilise a participant sample. The majority of the papers (seventeen) were

completed in the USA, as well as two in Canada, two in Australia and one in Germany.

1.5.4 Quality Assessment

The literature selected using the above methods and the inclusion/ exclusion criteria were examined for methodological rigour. The Quality Assessment framework from the Critical Appraisal Skills Programme (Green et al., 2006) was slightly adapted due to the range of methodologies used in the literature. Question two was adapted from “Is a qualitative methodology appropriate?” to “Did the research use appropriate methodology?” to cover the mixed methodologies used by the studies included in this review. The appropriate use of research methodology was considered in the context of the size and type of the population studied and the aims of the research. A numerical coding system was also applied to the framework to quantify the results of the quality assessment. A value of one was given for a positive answer and zero for a negative answer. This allowed for a simple overview of the quality of the literature as well as considering the evidence on a more qualitative, in-depth level. A copy of the quality assessment framework and the results obtained can be viewed in Appendix 2 and 3.

The ratings from the quality assessment framework varied from four out of ten to nine out of ten, suggesting that the literature was of variable methodological quality. The variable quality of the literature in this subject

area will impact on the generalizability of the conclusions of this review and indicates that further methodologically sound research would expand the knowledge base in this area.

Searches were completed between December 2012 and February 2013.

Due to the paucity of research in this area, all literature covering work life balance issues within the field of clinical psychology, counselling psychology, psychological therapy and psychotherapy was considered. This included all published work to date, including both quantitative, qualitative and mixed method papers.

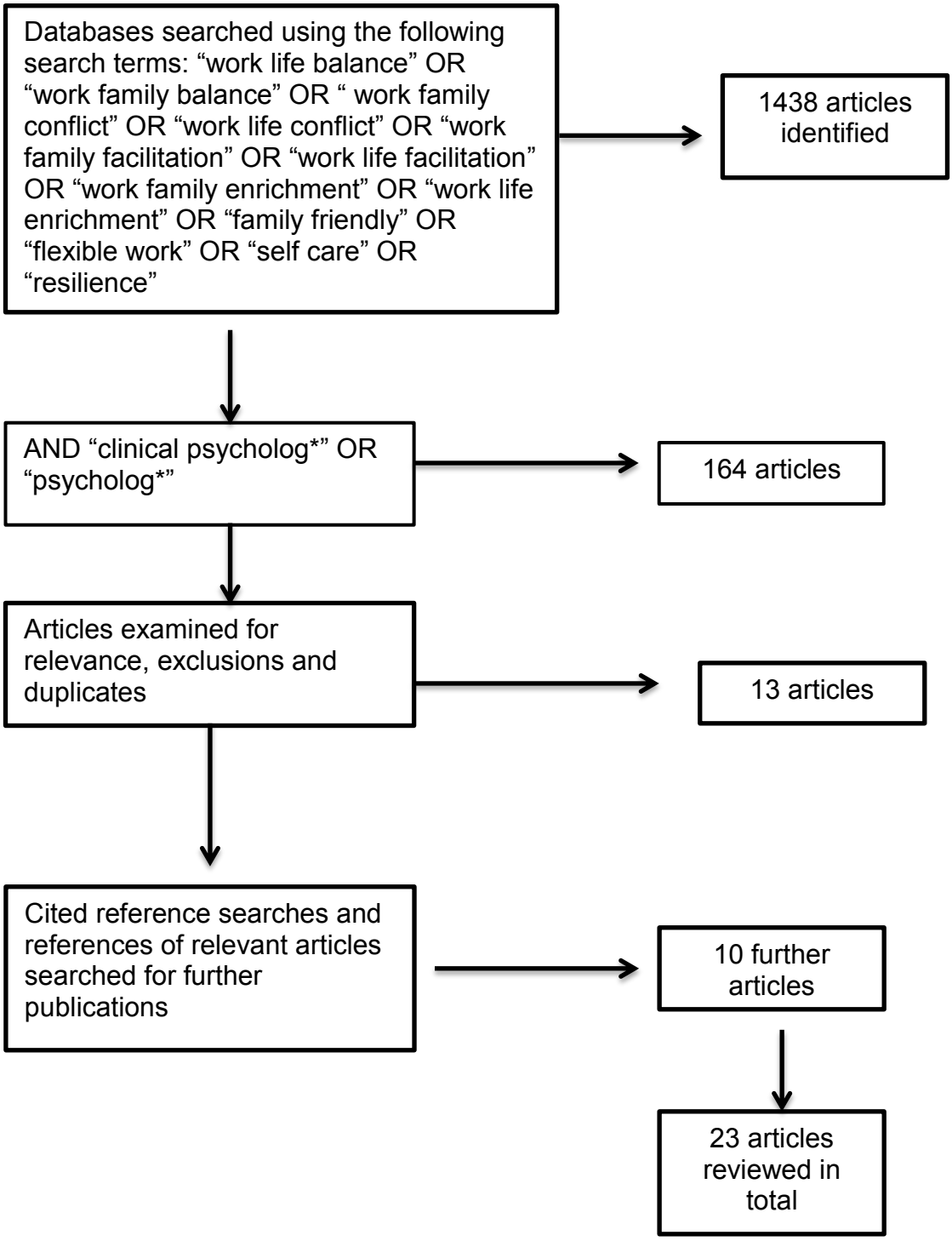

Figure 1.1: Consort diagram of search strategy for literature review paper

Table 1.1: Summary of articles covered in the literature review

Authors	**Methodology**	**Sample**	***N***	**Quality Framework score**
Bachtold & Werner (1970)	Questionnaire	Female psychologists who were members of the American Psychological Association (APA)	Posted to 296 potential respondents and this resulted in 124 returned questionnaires	6/10
Brown & Duan (2007)	Survey: Validated measures ('Self Efficacy Expectations Role Management' scale, 'Coping Strategies Inventory' (CSI), 'Satisfaction with Life Scale' (SWLS) And one scale developed and validated for the study ('Role Orientation Scale')	APA members who had obtained PhD degree in Counselling Psychology and were currently employed in an academic setting	524 surveys were posted and this resulted in a 33% return rate	8/10
Bryant &	Questionnaires: 'Role Balance	Female school counsellors	Posted to 250 potential	8/10

Constantine (2006)	Scale', 'Satisfaction With Life Scale', 'Job Satisfaction Blank-Revised' and a demographic questionnaire		respondents with a 54% response rate	
Burke, Overlaid & Burgess (2003)	Questionnaires	Australian psychologists working full time	Posted to 658 potential participants with a response rate of 18%	7/10
Campbell & Soliman (1968)	Questionnaire	Female psychologists who had previously completed the same measure in 1942 Comparison with current (1966) female psychologists listed in APA directory	1942 sample – 178 posted – 81% response rate 1966 sample – 397 posted – 72% response rate	7/10
Canning (2011)	Reflective paper	Author is Associate Professor of Psychology and Behavioural Health Provider	Not applicable	4/10
Dlugos &	Interviews and self report measures	Psychotherapists who had worked for	12 psychotherapists who	8/10

Friedlander (2001)		more than 10 years and spent at least 50% of their working week engaged in psychotherapy related activities	received 3 or more peer nominations for being passionately committed to their work	
Duan, Brown & Keller (2010)	'Survey of Work and Family Roles' was developed Written answers to short open-ended questions were analysed	APA – Society of Counselling Psychology male members who had obtained a PhD and were currently employed in an academic setting	Posted to 304 potential participants and received 83 responses (36%)	8/10
Furumoto & Scarborough (1986)	Review	First American female psychologists	22 women identified as psychologists in 1st edition of American Men of Science publication	4/10
Grananaki et al. (2005)	Semi-structured interviews	Practicing counsellors and psychologists	10	8/10
Hoeksma, Guy,	Survey:	Randomised sample of psychologists	Posted to 500 potential	7/10

Brown & Brady (1993)	The 'Maslach Burnout Inventory'; the 'Leisure Satisfaction Scale' and a demographic questionnaire	from the APA	participants and 201 surveys returned with a response rate of 40%	
Kinman & McDowall (2010)	Working group	Occupational psychologists	Not applicable	7/10
Kinman & McDowall (2011)	Conference report	Academics and practitioners	Not applicable as conference report	5/10
Kirkcaldy & Siefen (1991)	Questionnaires	Medical and allied health staff (including 8 psychologists)	111 participants (6.9% psychologists)	6/10
Koppes & Swanberg (2008)	Introduction to Special Issue	Not Applicable	Not Applicable	6/10
Lee, Reissing & Dobson (2009)	Review of literature	Not Applicable	Not Applicable	5/10
Matheson & Rosen (2012)	Quantitative web-based questionnaire followed by qualitative in-depth telephone interview	Participants recruited from American Association for Marriage and Family Therapy (AAMFT)	43 participants responded to on-line survey and 16 of these were interviewed on telephone	9/10

Milar (2000)	Literature & evidence review	First generation of female psychologists	Not applicable	4/10
Pendergrass (1974)	Questionnaires	Psychologists working clinically in South Eastern Psychological Association in the USA	44.9% response rate totalling 111 respondents	6/10
Rupert & Kent (2007)	Survey looking at career satisfaction, potential for burnout, career-sustaining behaviours, spiritual issues, and demographic information.	Licensed clinical or counselling psychologists who worked within a clinical setting were randomly selected from members of the APA	1200 participants were randomly selected and 595 were returned with a 49.6% response rate	8/10
Scott et al. (2012)	Focus group	Members of a graduate school of psychology including graduates, faculty members and current students	6	8/10
Stevanovic & Rupert (2004)	Survey – non-validated measures	Practising psychologists randomly selected from those licensed to practice in Illinois	Out of a potential 600, 286 responses were received	8/10
Walfish &	Survey:	Psychologists in independent practice	Sent to 350 members of APA	8/10

Walraven (2005)	Non-validated measure and a demographic questionnaire	Division of Independent Practice and 179 returned (51% return rate)

1.6 Discussion

Table 1.1 shows the range of literature reviewed in the course of this paper.

1.6.1 Barriers to achieving work life balance

Throughout the literature there has emerged a number of themes regarding the barriers to achieving optimal work life balance. These have included difficulties in meeting the demands of multiple roles, traditional assumptions about gender roles, individual factors and increasing demands. The literature supporting each of these themes will be considered in turn.

1.6.1.1 Difficulties in meeting the demands of multiple roles

Much of the literature is concerned with the on-going struggle of maintaining the professional and family roles. Burke et al. (2003) surveyed Australian psychologists working in therapeutic practices and found that they reported often feeling pressured into making a choice between home and work roles. Respondents to the survey were primarily female full-time employees and they may have felt particularly under pressure due to also taking responsibility for most domestic duties (Matheson & Rosen, 2012; Lee, Reissing & Dobson, 2009; Bryant & Constantine, 2006; Burke et al., 2003; Kirkcaldy & Siefen, 1991). The

results of this survey should be interpreted cautiously due to a response rate of just 18%. Female academic psychologists in a focus group of six participants reported similar difficulties when attempting to balance the conflicting demands of home and work life (Scott et al., 2012). This qualitative study supports the findings of the above survey.

A male perspective was gathered from eighty-three male counselling psychologists working within an American academic setting. Their responses to short written questions were qualitatively analysed. Participants reported conflict between home and work roles as a result of three issues:

- Experiencing high workplace demands
- Experiencing ambiguous professional role expectations
- Believing they were unable to manage these roles effectively

(Duan, Brown & Keller, 2010)

The participants within this study were predominantly Caucasian, aged over fifty and experienced within their career. These factors would limit the validity of the findings to other groups.

The above studies were all of good methodological quality, due to the use of appropriate methods of research design, recruitment and analysis. Through the use of quantitative survey and qualitative approaches both male and female psychologists are reported to experience similar difficulties in meeting multiple roles. Similar findings in each study suggest that the results are reasonably robust and although male and

female psychologists may report differing reasons for their struggles, there is little doubt that they struggle to manage the demands of their differing work and family roles.

1.6.1.2 The influence of gender

One of the reasons for the difficulties in managing multiple demands could be linked to prevailing assumptions about traditional gender roles. The majority of the literature reviewed makes reference to family obligations remaining primarily the domain of the woman (Matheson & Rosen, 2012; Lee, Reissing & Dobson, 2009; Bryant & Constantine, 2006; Burke et al., 2003; Kirkcaldy & Siefen, 1991). The historical literature makes reference to marriage, motherhood and a career as a psychologist being incompatible (Furumoto & Scarborough, 1986). This continues to be an issue as in a recent study of sixteen family therapists in an American academic setting, the women interviewed stated that one of the primary challenges to effective work life balance was an overload of domestic responsibilities in a "boundaryless career" (Matheson & Rosen, 2012, p.412). This study uses a small homogeneous sample of experienced white American academic psychologists but perhaps is indicative of the overwhelming struggle some women experience in balancing demanding work and home roles.

In a qualitative focus group study female academic psychologists also reported similar struggles with the demands of family life and potential

career progression (Scott et al., 2012). The historical literature is of questionable methodological quality (largely due to limited data being reported in the articles), however more recent robust qualitative findings support the idea that women continue to struggle with managing demands, potentially more than men, however this does require further investigation.

Despite the apparent continuing prevalence of traditional gender roles, a survey of Australian psychologists found that men in the psychology profession are expressing their desire to maintain an effective work life balance (Burke et al., 2003). This study had a poor response rate of just 18% and so these findings are limited in their generalizability. A recent report from a British Psychology Society (BPS) conference on work life balance suggested that fathers believe they remain somewhat invisible within the workplace environment (Kinman & McDowall, 2011). Eighty-three male counselling psychologists were surveyed and 77% rated family as more important than work commitments. Of those, 60% would prioritise family needs. Participants also acknowledged that often success at a psychology career was only achieved at the expense of personal relationships (Duan, Brown & Keller, 2010) perhaps confirming the perspective of the historical literature. This is a relatively small male sample in a methodologically sound survey, due to the appropriate use of research design, recruitment and analysis. The results support the findings of a literature review that suggested men also recognise the

benefits for their families of increased involvement in domestic responsibilities (Lee, Reissing & Dobson, 2009).

In a survey of male and female counselling psychologists in academia, it was found that both men and women were similarly committed to work and family roles (Brown & Duan, 2007). In a separate study of family therapists, men reported feeling more confident in their ability to balance these roles (Matheson & Rosen, 2012). While these studies had relatively poor response rates or small samples, the results highlight gender differences within the management of multiple roles.

Male counselling psychologists also reported a greater expectation to engage in activities that encourage self care (Brown & Duan, 2007). It is suggested that this may be linked to training in a specific therapeutic modality. However, it could be implied that this would equally apply to the female participants in the study. It is not clear from this research whether men actually do complete more self-caring activities than women or simply have a greater perception of the importance of such activities. In contrast Stevanovic and Rupert (2004) found that, in a robust survey of practising psychologists in the USA, female psychologists reported greater use of behavioural strategies that sustained their general wellbeing. Given the varying results of studies it would be beneficial to pursue further research in this area.

Female psychologists in therapeutic settings also appear to benefit more from working within organisations that provide practical support and policies that promote work life balance. This may be due to the prevailing gender stereotypes that exist within organisational culture making it more difficult for men to benefit from similar policies (Burke et al., 2003).

1.6.1.3 Negative Individual Factors

Other individual factors, alongside gender have been considered to hinder or improve attempts at balance. A robust mixed methods study, that utilised both quantitative and qualitative methodologies to appropriately address their research aims, found that some family therapists reported the development of pervasive negative behaviours. These were related to their own self-care and attempts to manage multiple roles. Participants reported that values attained through social modelling during childhood were often used to evaluate perceived levels of coping, although these were not always helpful (Matheson & Rosen, 2012). Other participants reported that the inability to contain work stress resulted in an impact on their personal lives (Matheson & Rosen, 2012). In a reflective paper Canning (2011) suggests that perhaps psychologists do not always engage in healthy attitudes and self-care practices as much as they ought. It appears that engaging in self-care behaviours can be affected by an individual's pervasive negative behaviours, ability to contain work stresses and pre-existing family scripts.

Emotional factors can also play a part; negative work esteem can impact on an individual's ability to manage multiple roles. This is a general feeling of not being valued by one's colleagues and can be linked with individual expectations of perfectionism as well as perceived organisational pressures (Matheson & Rosen, 2012). Mental health professionals, including psychologists, in Germany were surveyed about levels of occupational stress. They reported that guilt is prevalent about numerous aspects of work and home life but particularly with regard to not maintaining perceived social responsibilities (Kircaldy & Siefen, 1991). Although it could be argued that this paper offers a European perspective there were only a small number of psychologists included within the sample and the emphasis of the study was on the nursing perspective. Additionally much of the demographic data was not reported.

Male counselling psychologists in academia reported that suffering difficult personal life events, ineffective time management and experiencing depression or anxiety were all detrimental to the maintenance of work life balance. Men also reported being more likely to draw on intrapersonal resources, such as increasing assertiveness or reprioritising goals, to combat high levels of stress. Experiencing negative life events or emotions could therefore affect men's resilience and ability to manage multiple roles due to their tendency to rely on intrapersonal resources (Duan, Brown & Keller 2010).

1.6.2 Protective factors in achieving work life balance

Protective factors identified within the literature as being beneficial to achieving effective work life balance included engagement in leisure activities; positive relationships; organisational support; spiritual beliefs and individual factors. The presence of these protective factors provides individuals with self-efficacy and the belief they can manage multiple roles (Dlugos & Friedlander, 2001).

1.6.2.1 Engagement in leisure activities

Grafanaki, Pearson, Cini, Godula, McKenzie, Nason and Anderegg (2005) interviewed practising counsellors and psychologists in therapeutic settings and found that engaging in meaningful leisure activities allowed participants to successfully maintain balance with other areas of their lives. Meaningful leisure activities allow the individual to enter a state of mind that is free from demands, worries and pressure. Psychotherapists were interviewed about ways to maintain 'passionate' commitment to their work life and it was found that attending to life outside of work was crucial. Leisure interests were discussed with considerable enthusiasm, often more so than work interests. It is suggested that leisure interests contribute to the development of a balanced life (Dlugos & Friedlander, 2001). These studies used qualitative methodology that adequately addressed the research aims. The samples while small, utilised practising psychologists or psychotherapists, which is perhaps more similar to the

NHS clinical psychologists role within the UK, due to the intervention-based nature of their work. Grafanaki et al. (2005) found that participating in leisure activities allows psychologists to replenish their emotional resources and provides a counterbalance to the difficult issues faced in their working lives. This in turn allowed the psychologists to be more present and emotionally available for the clients in their working lives as it deepened their own self-connections and increased their empathy (Grafanaki et al., 2005; Dlugos & Freidlander, 2001).

However, engaging in leisure activities is not always easy. Kircaldy and Siefen (1991) surveyed mental health professionals, including psychologists and found that mothers were significantly less likely to participate in structured exercise than women without children when controlled for age. This finding could be linked to the notion that as women take the primary responsibility for domestic duties, mothers have less time for structured exercise. This issue does require further investigation.

1.6.2.2 Positive relationships

Most of the literature emphasises the importance of positive social relationships in maintaining an effective work life balance. Beneficial relationships with partners, friends and colleagues all impact in a positive way (Rupert & Kent, 2007; Kircaldy & Siefen, 1991). Affirmative relationships outside of work provide an opportunity for psychologists to

remain emotionally grounded and offer an alternative to the difficult realities that are often encountered within therapeutic work (Grafanaki et al., 2005). Maintaining work life balance allows individuals to be both physically and emotionally available within their family lives too (Lee, Reissing & Dobson, 2009). Rupert & Kent (2007) surveyed practising psychologists and found that for women particularly the availability of a positive social network can help with stress reduction. Women were more likely to utilise relational or support seeking strategies to overcome strain and tension (Rupert & Kent, 2007). Female psychologists were also more likely to seek support from clinical supervision and tended to receive more supervision time in comparison to male psychologists (Rupert & Kent, 2007). These studies and literature reviews were of good methodological quality, due to the appropriate use of methodology, recruitment and analysis. Therefore it can be concluded that a supportive social network can provide an individual with positive effects including the reduction of work related stress and tension (Kircaldy & Siefen, 1991).

1.6.2.3 Organisational support

A literature review of work life balance of newly qualified psychologists in Canadian academic settings suggested that workplaces that promote values that are family friendly and supportive of encouraging work life balance in turn optimise employee wellbeing. They have also been shown to improve productivity (Lee, Reissing & Dobson, 2009). Unfortunately to

date there has been no direct research into work life balance for psychologists working within the NHS.

The benefits for employees of working within an organisation that is supportive of work life balance are many and varied. Female psychologists reported improved levels of emotional and physical wellbeing whereas male psychologists reported fewer psychosomatic symptoms, increased engagement in positive lifestyle behaviours and higher levels of emotional wellbeing (Burke et al., 2003). This survey utilised validated measures, however, did not provide operational definitions for all of the measures administered. Nevertheless the results do suggest a number of positive benefits. Participants rated their organisations as only moderately supportive, and did not report that they were particularly accommodating of personal life. Despite this the employee benefits were apparent. Overall the aim of organisational policies supporting work life balance should be to encourage the development of a reciprocal relationship between home and work lives (Koppes & Swanberg, 2008; Burke et al., 2003).

While most organisations will have administrative policies that address the issue of work life balance, the presence of this kind of policy is not sufficient for the perception of a supportive organisation. In a survey of Australian psychologists participants wanted to feel satisfied with the opportunity presented by the policies to implement real changes in terms of their abilities to work in a more balanced way (Burke et al., 2003). For

many such organisations there are a number of barriers that can inhibit employee perceptions of support. The organisational culture can provide one of the largest barriers to change.

Burke et al. (2003) provide an insight into the impact of the role of the employing organisation on an individual's ability to maintain work life balance. However despite using a large initial sample size, the response rate for this study was poor. The psychologists surveyed worked within small independent practices, this highlights a difference to larger corporations, such as the NHS, present in other countries. A general lack of outcome or evaluation data on the impact of work life policies does not help supervisors in tackling these issues from a management perspective (Burke et al., 2003). The ability to generalise from these studies to other work environments is limited. They do however provide direction for further research in this area.

There is much made within the literature with regard to flexible working, suggesting that the ability to utilise flexible working schedules is beneficial in maintaining work life balance (Matheson & Rosen, 2012; Duan, Brown & Keller, 2010). The majority of these studies have been conducted in the USA where independent practice is a more typical work environment, opportunities for flexible working within larger organisations may be more difficult to secure. The opportunity for flexible working is cited as one of the emotional benefits of working within independent practice in a survey of practising psychologists (Walfish & Walraven, 2005). It is difficult to

generalise this to UK clinical psychology within the NHS but perhaps points to one of the key elements in developing organisations supportive of work life balance.

1.6.2.4 Positive Individual Factors

Feelings of self-efficacy and ability to manage time effectively were positive influences on male psychologists capacity to manage their work life balance (Duan, Brown & Keller, 2010). Overall in a survey of female counsellors, when participants reported being able to manage their multiple roles effectively, this also resulted in improved levels of self-efficacy and the potential for positive mental health outcomes (Bryant & Constantine, 2006). The greater the perception of an individual's ability to successfully balance multiple roles is positively associated with a greater satisfaction with life in general (Bryant & Constantine, 2006). This is beneficial to an overall sense of wellbeing. Effective balancing of roles can also reduce levels of stress (Rupert & Kent, 2007). Achieving work life balance can promote a greater sense of commitment to the professional role providing that the work, home and leisure roles are all effectively in balance (Dlugos & Friedlander, 2001; Kinman & McDowall, 2010).

Psychologists tended to use their clinical skills of self-awareness to identify times when their work life balance was not adequate and they were feeling under pressure (Rupert & Kent, 2007). They reported the

use of both internal signs, such as the quality of their health and their sense of contentment alongside external signs from their work and home environment, such as setting healthy boundaries and using flexible work schedules to aid them in this process (Matheson & Rosen, 2012). Positive messages about the importance of work life balance from family members, particularly during early childhood can help feelings of self-efficacy with maintaining work life balance as can setting healthy work and personal life boundaries and having a positive sense of work esteem (Matheson & Rosen, 2012).

One final protective factor cited by clinical psychologists as important in maintaining effective work life balance was maintaining a sense of humour (Rupert & Kent, 2007).

1.6.3 Limitations with the current evidence base

Overall the current evidence base for work life balance within the field of psychology is variable. The quality of that evidence was also variable with articles scoring between four and nine out of ten on the Quality Framework adapted from the Critical Appraisal Skills Programmes (Green et al., 2006).

One of the clear limitations of the current evidence base is the lack of evidence conducted outside of the USA. Although some comparisons can be drawn with American group practices or Australian psychological

practices, generalizability is limited. This is particularly pertinent for clinical psychologists working in the UK within the NHS, as this work environment is relatively unique. Due to the relative lack of research the samples utilised in the studies reviewed varied between clinical psychologists, counselling psychologists, counsellors and academic psychologists, with a significant proportion of the research being conducted within academic settings. Again this provides difficulties with generalizability to those working in non-academic settings (Lee, Reissing & Dobson 2009).

Many of the studies were completed with small sample sizes due to the qualitative methodology or were large-scale surveys of all psychologists working within a pre-defined area but with disappointing response rates. Again this limits the generalizability of the findings, however a number of the studies do report similar results. Research methods within the field of work life balance either focus on concerns in large population samples or on the individual perspective. This often determined the type of methodology utilised by the researchers and explains the reason for the different methodologies used.

There is also an emphasis on the female perspective within the literature, which only serves to highlight the prevailing assumptions regarding traditional gender roles. It is crucial that both male and female perspectives are considered to develop understanding in this area (Duan, Brown & Keller, 2010).

1.6.4 Clinical Implications

Effective work life balance is an essential part of managing the multiple demands that have become part of busy, everyday lives. However, it seems very little attention has been directed at how individuals can achieve work life balance in the most optimal way. Within the field of clinical psychology in the USA, Australia and Canada this work is beginning but so far research in the UK and Europe is lacking. Consideration for how NHS employees can maintain work life balance is timely given the current political and financial climate in the NHS, particularly the national changes that are impacting on development and capacity. The papers described above suggest the benefits of work life balance. These include: stress reduction; increased job satisfaction (Rupert & Kent, 2007); improved sense of wellbeing (Bryant & Constantine, 2006) and improved organisational productivity (Lee, Reissing & Dobson, 2009).

From an organisational perspective, research evidence shows that simply producing family friendly policies is insufficient to make a real difference for employees (Burke et al., 2003). Prevailing negative attitudes and assumptions surrounding the notion of work life balance need to be challenged so that organisations are perceived to be authentically supportive. The overall aim is to create a workplace climate that will allow employees to address issues of work and family balance and influence the implementation of policy changes, where necessary.

Particularly pertinent to working as a clinical psychologist is the finding that taking part in meaningful leisure activities away from the work environment allows the psychologist to be more emotionally available for their clients (Grafanaki et al., 2005). This research also highlights the importance of self-care, which is a concept that while widely acknowledged as important, may not be practiced to its full extent by clinical psychologists. Male and female psychologists report varying difficulties with adopting behaviours that encourage taking care of oneself (Brown & Duan, 2007). It has been suggested that practising psychologists do not engage in self-care behaviours and activities to the extent that they ought (Canning, 2011).

Work life balance, or lack of it, can impact on clinical practice as psychologists, particularly those working within the NHS, who are increasingly asked to do more, with less resource, alongside increasing service pressures and constantly changing targets. Six years ago, with an American sample Rupert and Kent (2007) found that there was no evidence of an increase in stress levels of psychologists working within the current healthcare environment. It is not clear whether this finding could be applied to clinical psychologists working within the NHS today. This gap in evidence needs to be addressed to facilitate a current understanding of the challenges in implementing and maintaining effective work life balance for clinical psychologists in the UK.

Male psychologists views have also been neglected in the research and are essential for a complete understanding of how psychologists face the challenges inherent in implementing work life balance. Without the male perspective the evidence base is in danger of confirming the prevailing traditional gender assumptions regarding home roles and responsibilities, seeing childcare and domestic duties as predominantly the role of the female (Burke et al., 2003).

Finally, existing work life balance organisational policies would benefit from objective outcome data to allow organisations to make informed decisions about the most effective way of supporting their employees to maintain work life balance.

1.7 Conclusion

Overall the literature reviewed is of variable quality, some studies are very dated and there are clear gaps in the evidence base. There also exists a geographical bias in the literature. While work life balance practices have developed in a positive way since the beginnings of academic psychology in the USA, there still exists a traditional gender assumption about domestic responsibilities.

This narrative literature review was able to identify barriers and positive influences on the development of effective work life balance. Difficulties in managing multiple roles; the influence of gender and negative individual factors all contribute to the challenges of maintaining work life balance. In contrast, engaging in leisure activities; positive relationships;

organizational support and positive individual factors all enhance attempts at maintaining work life balance. While there is a distinct absence of research conducted within the UK, the above influences on work life balance may have implications for clinical psychologists working within the NHS. This review provides directions for future thinking in this area but further research is warranted to understand the key influences on maintaining work life balance for UK clinical psychologists.

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Chapter Two: Empirical Study

Motherhood and the impact on the therapeutic relationship: A qualitative study of psychological therapists in Child and Adolescent Mental Health Services

Word Count: 7082 (Exclusive of tables and illustrative extracts)

This paper has been broadly prepared in accordance with the requirements of the British Journal of Psychology (See Appendix 4). Tables are presented within the thesis chapter to aid overall cohesion; these will be moved to the end of the paper prior to journal submission as per the author guidelines.

2.1 Abstract

Pregnancy in psychological therapists has been extensively researched, however the on-going impact of motherhood on the development of therapeutic relationships within Child and Adolescent Mental Health Services (CAMHS) has been largely neglected. Semi-structured interviews were conducted with nine psychological therapists who were employed within CAMHS and results were analysed using an Interpretative Phenomenological Approach (IPA). Three superordinate themes emerged including 'Common Ground' relating to a connectedness with families and young people; 'Looking at Myself Differently' highlighting a re-evaluation of self and 'Feeling Torn' between work and home demands. These themes appear to impact on the therapeutic relationships developed with families in CAMHS. The clinical implications of these results and directions for future research are also considered.

2.2 Introduction

Pregnancy, childbirth and motherhood can be considered as a major event in a woman's life (Darvill, Skirton & Farrand, 2010). The necessary physical, emotional and psychological changes inherent in becoming a mother cannot be underestimated. The maternal transition can take many months and the psychological impact of this transition is significant (Darvill et al., 2010). For any woman pregnancy and early motherhood can be a time of psychological vulnerability and it has the potential to be emotionally challenging (Nelson, 2003; Tinsley, 2000; Fenster, Phillips and Rapoport, 1986). However, many psychological therapists become mothers while also providing emotional support to clients. Much of the research conducted has only examined the impact of therapist pregnancy and to date has failed to acknowledge the impact of motherhood as a whole.

2.2.1 The psychological impact of pregnancy and motherhood

Pregnancy has been referred to as a "psychological crisis" for the new mother (Dyson & King, 2008 p.28) and it is suggested that this emotional struggle is especially potent for first time mothers. Darvill et al. (2010) interviewed new mothers about the impact of the transition to motherhood in their own lives. They found that the maternal transition began early on in pregnancy and continued until the woman perceived she was again in control of her body and her environment. Participants reported that throughout their pregnancy and early motherhood they often felt intense

vulnerability and emotional turmoil as well as feeling out of control. Cultural pressures to be able to manage pregnancy, a career and motherhood may lead to the woman denying the impact of her pregnancy as a “Superwoman fantasy” becomes challenged by the demands of the progressing pregnancy (Tinsley, 2000 p.106). The impact of social support from others who had experienced similar events appears to ease this transition (Darvill et al., 2010).

For pregnant therapists it is well documented that this sense of psychological vulnerability and feelings of increased anxiety can impact on the therapeutic relationship (Nadelson, Notman, Arons & Feldman, 1974; Imber, 1995). These feelings can fluctuate throughout the pregnancy, leaving the therapist to cope with their own emotional lability as well as the impact that this has on their relationship with clients (Rubin, 1980). Candib, Steinberg, Bedinghaus, Martin, Wheeler, Pugnaire and Wertheimer (1987) interviewed general practitioners (GP’s) and found that pregnancy and motherhood strengthened their perceived ability to provide nurturing and caring relationships for their clients. They suggested that these therapeutic relationships enhanced their understanding of the client’s perspective and replicated the mothering of their own children.

Fenster et al. (1986) has suggested that the peak time for emotional stress in mothers is the early postpartum period. Therefore changes in the therapeutic relationship as a result of the emotional experience of

pregnancy and new motherhood may persist beyond the birth of the child and not be a temporary state as has been suggested by Candib et al. (1987).

2.2.2 Emotional availability in motherhood

The current emotional concerns and anxieties of a psychological therapist can impact on their empathic capacity (Dyson & King, 2008). The concept of primary maternal preoccupation (Winnicott, 1978) would suggest that the pregnant therapist is increasingly likely to be distracted by their own concerns about their pregnancy and impending motherhood. The pregnant therapist may become preoccupied with narcissistic concerns and consequently spend a lot of time focussing on their own role as a parent, perhaps leaving less emotional space for their clients needs (Underwood and Underwood, 1978). As the pregnancy progresses the therapist becomes increasingly aware of the impending birth of their child and may feel the need to withdraw emotionally (Rubin, 1980). Therefore, the ability to remain empathically available for clients can be challenged by pregnancy, especially first pregnancies (Dyson & King, 2008).

However, in their study of GPs, participants believed that clients viewed them as more available for long-term doctor-client relationships if they returned to clinical practice after maternity leave as it demonstrated their commitment to medicine (Candib et al., 1987).

More recent literature has also found that empathy can be positively affected following pregnancy and motherhood. Hodges, Kiel, Kramer, Veach and Villanueva (2010) investigated the impact of having shared life experiences on empathy. They interviewed pregnant women and new mothers and found that, while the women in this study were not therapists, sharing similar experiences to another person does result in greater empathic concern and greater understanding. They found that perceived empathy was affected by the belief that others had shared the same experience. However, simply sharing an experience did not improve empathic accuracy, with the presumption of similar experiences resulting in pregnant women being less accurate than women without children. Hodges et al. (2010) conclude that although there are core similarities in the experience of pregnancy and child rearing, stereotypical responses should only be used as a basis for further exploration of an individual's experience.

2.2.3 Therapist self-disclosure in pregnancy and motherhood

Being pregnant destroys anonymity for the therapist, allowing her clients to be aware of the presence of a personal life and a sexual life (Dyson & King 2008). The therapist may also take on the role of the patient, as her relationships with pregnancy-related medical professionals develop. They may also begin to address emotional concerns relating to their pregnancy and impending motherhood through supervision or personal therapy (Rubin, 1980). Perhaps most obvious are the physical changes that occur

as a result of pregnancy, providing a constant reminder of the impending termination of therapy.

The client will often use pregnancy as an opportunity to express interest in the therapist and contribute to their relationship, resulting in a shift in the power differential within the therapeutic relationship. If the client is also a parent the shared experience of parenthood can result in the relationship feeling more equal and affect the pre-existing therapeutic relationship (Candib et al., 1987). However, self-disclosure of personal information may have a beneficial effect on therapeutic outcome and encourage the development of a trusting and positive therapeutic relationship (Rubin, 1980). Inevitably for pregnant therapists the physical changes that occur as a result of pregnancy provide a constant reminder of the impending termination and the impact of this on the therapeutic relationship needs to be carefully monitored (Tinsley, 2000). For new parents the relatively invisible nature of parenthood allows the therapist to make their own decisions about self-disclosure.

2.2.4 Implications for clinical practice

Boland (2008) describes the challenges of working with families, parents and children and the emotional impact this can leave with the therapist. Combining the roles of mother and therapist can be a challenging time and often women require additional support from colleagues and supervisors (Darvill et al., 2010). It would seem essential that the pregnant therapist becomes aware of any obstacles within themselves

that could affect the therapeutic process (Imber, 1995). They also need to feel able to deal with their own responses to their pregnancy and impending motherhood (Underwood & Underwood, 1974) and acknowledge the impact of those feelings so therapeutic gains can be maximised (Cullen-Drill, 1994).

There is clear evidence for good, supportive and containing supervision (Dyson & King, 2008). The challenges likely to be faced by the pregnant therapist include struggling to balance the demands of a career and a family (Tinsley, 2000) and opposition from resentful colleagues (Candib et al., 1987). On a more positive note, it has been found that working through the emotional challenges of pregnancy and motherhood enhances both personal and professional growth (Korol, 1996).

Therapists have also reported an increase in their credibility in the eyes of their clients and felt they were better able to understand the challenges of parenthood after the birth of their child (Candib et al., 1987).

2.2.5 Critique of the literature

Much of the research has focused on pregnant therapists and has used the client perspective to evaluate any potential impact on the therapeutic relationship. A substantial amount of the literature was written in the 1980s from an American perspective. Much of this research has been conducted using first time mothers; there has been very little attention on

the impact of motherhood or subsequent pregnancies on continued levels of empathic availability.

There are a limited number of studies available that document the therapist's experience of her own pregnancy. It has been suggested that the lack of available literature is due to therapists denying the true impact of their pregnancy on the therapeutic relationship (Wedderkopp, 1990) or remaining reluctant to take responsibility for the changes in the therapeutic environment (Clementel-Jones, 1985).

Much of the literature considers only the impact of pregnancy itself and seems to suggest that any impact is temporary and transient, disappearing once a therapist returns from maternity leave (Candib et al., 1987). For therapists who are also mothers it is not clear whether they can maintain their focus on work whilst ignoring maternal preoccupations (Winnicott, 1987; Fenster et al., 1986; Underwood & Underwood, 1978). It may be possible that the effects persist as they begin to integrate the roles of therapist and mother (Tinsley, 2000; Rubin, 1980). The therapist's own vulnerabilities as a result of being a new mother may well impact on the therapeutic relationship built during therapy (Dyson & King, 2008; Imber, 1995; Nadelson et al., 1974) although research has yet to specifically focus on this.

2.3 Research Aims

The main aim of this study is to focus on the therapist's own experience of motherhood and its impact on the therapeutic relationship.

The research questions arise directly out of gaps in the literature, which has tended to focus on pregnancy as a temporary influence on the therapeutic relationship. The study aims to look beyond the period of pregnancy and focus on the impact of motherhood on the therapeutic relationship:

1. What are the therapist's experiences of being a mother and how has this impacted on their therapeutic relationships with clients?
2. Has their clinical practice changed as a result of becoming a mother?
3. How have they sought support and promoted self-care?

2.4 Methodology

2.4.1 Ethical Approval

The research proposal was submitted to the Coventry University Research Registry Unit and ethical approval was granted (See Appendix 5). Ethical approval was also sought from the West Midlands (South) Comprehensive Local Research Network (See Appendix 6). As participants were staff within the National Health Service (NHS), ethical

approval from the Research Ethics Committee (REC) was not required (See Appendix 7).

2.4.2 Design

Nine psychological therapists were interviewed about their experiences of motherhood and working within CAMHS. The intention was to continue to recruit participants until theoretical sufficiency was achieved. This occurred after nine interviews. Interpretative Phenomenological Analysis (IPA) was deemed the most appropriate method of analysis as it aims to examine how people make sense of major life experiences (Smith et al., 2009).

IPA is a qualitative methodology that is influenced by the theories of phenomenology, hermeneutics and idiographic approaches. Phenomenology is concerned with the individuals experience and how that experience is afforded significance within an individual's life. Hermeneutic theory recognises that individuals attempt to make sense of their experience, and acknowledges that the researcher in turn will attempt to understand the individual's sense making processes. Finally, an idiographic approach involves focusing on the individual perspective as it incorporates the line-by-line analysis of a participants account. Broader themes are then developed as the data is analysed as a whole (Smith et al., 2009). These approaches provide the broad theoretical basis for IPA and facilitate the researcher in understanding how a person

interprets a major life transition. As the transition to motherhood is often viewed as one of the most significant changes in a woman's life (Darvill et al., 2010) then IPA would seem appropriate to explore the meanings that this has for the therapist and the potential impact on the therapeutic relationship.

2.4.3 Researcher Position

The lead researcher was employed by a local NHS Trust during the time of the interviews. The researcher had completed a placement in a local CAMHS service as well as a placement working with children under the age of six with complex developmental and medical needs. The researcher is also a mother.

A bracketing interview to help determine the researchers preconceived ideas and values in relation to the research topic was completed with a fellow trainee clinical psychologist who was also using an IPA approach in their own research. A reflective research journal was also kept to draw out any thoughts or influences on the research process and analysis.

The bracketing interview and enabled the researcher to manage their subjectivity through an increased awareness of their own position and values. For example the researcher held the assumption that participants would answer in a particular way when asked by families whether they had children. Due to the increased awareness the researcher was able to attempt to put aside this assumption while conducting the research

interviews and the analysis process. In a similar way the researcher held pre-conceived ideas about the most challenging elements of parenthood, however attempts were made to place this aside during the research interviews and subsequent analysis. Supervision was an essential process in helping the researcher to highlight their own position and pre-existing values.

2.4.4 Participants and Recruitment

Inclusion criteria required participants to be mothers and also be working as clinical psychologists, psychological therapists, or psychotherapists in CAMHS. Participants in this study had been qualified for between ten and thirty-two years, with a mean of 18.7 years. They had between one and three children, with a mean of 2.1. Their children were aged between six and twenty-three with a mean age of 13.5 years. Participants described working with either an equal number of males and females (five participants) or predominantly male clients (four participants) with an age range of two to seventeen. Six participants lived within the same geographical area that they worked.

Ethical approval permitted access to three CAMHS departments within the Trust. The lead researcher met with the Head of Department for CAMHS in the Trust and information about the research study was cascaded through staff meetings. Staff were asked to register their interest by agreeing to an interview, for which nine participants registered.

Interviews were conducted between November 2012 and March 2013 and each lasted an average of twenty-five minutes.

Participants were allocated participant numbers during the interview process to preserve anonymity. However, it was agreed that any direct quotation from individual transcripts could be used in the final report. Participants were also made aware that they could withdraw from the study up to the point of publication without it impacting on their employment in any way. Interview transcripts were stored in a lockable cabinet. The researcher used password-protected data back up to ensure the safe storage of all electronic data.

2.4.5 Materials

A semi-structured interview schedule was developed to specifically address the research aims and sought to explore the experiences of mothers who also work as psychological therapists within CAMHS (See Appendix 10). The schedule was developed following a review of the literature and adapted after the completion of a pilot interview with a trainee clinical psychologist alongside consultation with supervisors. Amendments were made to the question order following feedback from the pilot interview. Other materials used included the participant information sheet (see Appendix 8), consent form (see Appendix 9) and a basic demographic questionnaire (see Appendix 11).

2.4.6 Analysis

The transcripts were analysed according to the principles of IPA (Smith et al., 2009). These guidelines were followed closely as described in Table 2.1. Excerpts from the transcripts are provided to demonstrate the analysis conducted (see Appendix 12); emergent participant themes are also presented (see Appendix 13). Potential subthemes were developed from the emergent themes (see Appendix 13), before being organised into broader categories and becoming superordinate themes (See Table 2.3).

2.4.7 Credibility of Analysis

The subjective nature of qualitative analysis requires attempts to ensure the credibility of analysis (Smith et al., 2009). The data analysis was audited at various points throughout the process as outlined in Table 2.2. Recurrence of themes was also monitored to ensure that final themes were an accurate representation of the whole data set (Smith et al., 2009).

Table 2.1: The Analysis Process (Based upon Smith et al., 2009)

Reading and re-reading transcripts	Each interview transcript was repeatedly read to allow oneself to become immersed in the data. Repeated listening to the audio recording was also completed to enhance familiarity with the data.
Initial noting	Transcripts were then annotated with initial notes and exploratory comments about the content of each interview. Initial notes were written on the transcripts in pencil & exploratory comments were written in the left hand margin in black.
Developing emergent themes	The researchers interpretations of the participant's original words are then developed into emergent themes. These were written in the right hand margin in blue. (See Appendix 13 for emergent themes for all participants).
Searching for connections across emergent themes	All of the emerging themes are then drawn together in a meaningful way that highlights all the important and interesting parts of the original transcript. These were noted in the right hand margin in red.
Moving onto the next case	The process was then repeated for the remaining eight participants. New themes emerged with an attempt to 'bracket off' the previously established themes. A total of 532 emergent themes were identified and 14 potential subthemes were

	developed (See Appendix 13).
Looking for patterns across cases	Subthemes were then laid out on ‘post-it’ notes and organised into broader categories. These then formed the final superordinate themes and represent a meaningful account of all of the data collected (See Table 2.3).
Identifying recurrent themes	Care was taken to ensure the final superordinate themes were representative of the whole data set. Transcripts were checked as the themes developed and quotations were extracted from all participants

Table 2.2: Credibility of Analysis: Auditing the Process

Stage	**Audit Process**	**Amendments made**
First level of analysis for the first interview	Analysis checked by peer who was also using IPA in their research	Discussion of initial noting to ensure consistency
Emergent themes of all interviews	Briefly discussed with clinical supervisor	
First level of analysis of all interviews	Extracts from each interview reviewed by a peer	Emergent themes were discussed and felt to be accurate of the overall data set
	Discussions with supervision team about developing themes	More interpretative aspects of the analysis were discussed and this informed the development of potential subthemes (See Appendix 13).
Establishing final superordinate themes	Researcher developed overarching superordinate themes from the potential subthemes and these were discussed with academic supervisor	The superordinate themes were felt to be an accurate representation of the data

2.5 Results

Analysis of the interviews using IPA established three superordinate themes and associated subthemes. In most cases these were present in half of all transcripts, however some of the subthemes were only present in four transcripts out of nine, not quite meeting the IPA guidelines (Smith et al., 2009; Table 2.3). The implications of this will be considered within the discussion section.

The first superordinate theme 'Common Ground' was an important theme across all data sets and was identified at both an explicit and an interpretative level of analysis. Participants discussed their experiences of shared understanding with the families that they are working with, although underlying this was a sense of being cautious of 'Assuming Shared Experience'. This became a subtheme along with 'Experiencing Negative Feelings', which occurred when this shared experience became uncomfortably close to the participants own experiences. These subthemes were not present in exactly half of the transcripts but it was believed that this was an important element of the superordinate theme and was therefore included within the overall analysis. The final subtheme was 'We as Parents'; participants reported that they often alluded to their role as mother, despite describing explicit boundaries between their professional and personal lives.

The second superordinate theme is entitled ‘Looking at Myself Differently’ and is concerned with the ‘Re-evaluation of Self’ that all participants reported following becoming a mother. This became the first subtheme and considers the many changes reported by participants in relation to their own self-concept. The second subtheme is experiencing ‘Feeling Challenged by Parenting’ and the majority of participants reported this as they transitioned to the role of mother.

The third superordinate theme was ‘Feeling Torn’; participants reported difficulties in managing the multiple demands in their lives. They also reflected on the ‘Reciprocal Role of Mother and Psychological Therapist’, which also became a subtheme.

Table 2.3: Superordinate Themes and Subthemes

Superordinate Themes	Subthemes	Present in at least half the sample?
'Common Ground'	Connectedness	In all transcripts
	Assumption of shared experience	In 4 transcripts
	Experiencing negative emotions	In 4 transcripts
	'We as Parents'	In 6 transcripts
'Looking at Myself Differently'	Re-evaluation of self	In all transcripts
	Feeling challenged by parenting	In 8 transcripts
'Feeling Torn'		In all transcripts
	Reciprocal role of mother and psychological therapist	In 5 transcripts

2.5.1 Superordinate Theme 1: 'Common Ground'

Each of the participants spoke about perceiving common ground with the parents that they work with due to their own experiences as a mother. This included feeling an emotional connection to other parents; a sense that they understood their struggles alongside an awareness of the difficulties inherent in assuming shared experiences. Some participants also experienced negative feelings towards certain parents; this was particularly evident when participants own experiences mirrored the experiences of the families that they were working with.

2.5.1.1 Connectedness

Participants described their feelings of an emotional connection to other parents since becoming a mother themselves. They believed that this emotional connectedness resulted in an increased understanding of the struggles of parenting:

> *"I've got more empathy and understanding about parents that might be feeling that sort of pressure about well that trapped-ness"* (P4 lines 57-58)

There was a sense from the participants that experiencing motherhood had resulted in an emotional connectedness that was subjectively different from theoretical learning:

"I guess I'm wondering whether it's just the emotional connection that you've got that puts you in a slightly different place, regardless of everything you know" (P3 lines 245-247)

This emotional connectedness also extended to the children that participants worked with. They reported experiencing an improved understanding of the perspective of the child and an increased awareness of the issues raised at different ages and developmental stages:

"So you know if they talk about a certain television programme, you think yeah I know that or what a certain game…and you've got a way in, you've got an understanding, you've got some common ground when you're working with a child" (P6 lines 120-123)

Overall, participants felt that the experience of emotional connectedness was beneficial to the development of a therapeutic relationship:

"Parents as having the depth of knowledge around their own child, but as a clinician we have that breadth…parents come along and they've got the depth of knowledge and it's about putting those two ideas together" (P6 lines 147-151)

However, alongside the positive aspects of experiencing emotional connectedness with families, there was also an awareness that

experiencing a strong emotional connection can sometimes be unhelpful. It is possible for the connectedness to impede the development of the most effective therapeutic relationship:

> *"Parents will then say, well it's alright for you, all your children must be wonderful…or well you know the answer to everything I bet your children are…fantastic or great. So it does get in the way"* (P1 lines 205-207)

2.5.1.2 "We as parents"

This subtheme is related to the issues raised by many participants about whether psychological therapists should let clients know whether they had children or not. What emerged was that some participants believed it was important to remain honest with their clients and would always respond accurately to the question if raised by families. However, the other participants discussed the importance of keeping therapeutic boundaries in place. If asked whether they had children, they report they would have shifted the focus of the question by attempting to understand why the client felt that it was important to know.

What was not widely acknowledged by the participants was the use of the term "we as parents":

"Sometimes they just pick up, because often it's very helpful to say we as parents" (P1 lines 147-148)

Typically the participants who reported the use of the term "we as parents" would have described themselves as someone who kept therapeutic boundaries in place, yet they did not acknowledge the tension that this could produce. Very often it appeared that an overwhelming urge to let their clients know that they had a shared experience overshadowed the relative importance of tight therapeutic boundaries:

"I don't think that I would necessarily say it outright but maybe some of my answers would allude to the fact that I have children. I might say something like oh yes as Mums we might do this" (P6 lines 35-37)

2.5.1.3 Assumption of shared experience

Some participants described the difficulties inherent in having a shared experience with a family that they were working with. Although this subtheme was not present in over half of the participant accounts (four participants did report this subtheme) it was believed to be an important aspect of the overall theme. Often the participants reporting shared experience had also experienced their own struggles in parenting and explicitly linked this to their assumption of shared experiences:

"Projecting your own…feelings about motherhood onto other people and I suppose that's something you just have to be very mindful of" (P8 lines 321-323)

The majority of participants did acknowledge that parenthood was not a necessary requirement to working with children and families and recalled a number of colleagues who were not parents but continued to be effective and positive therapists:

"Is the only way to empathise with the experience to have had the experience?" (P9 lines 20-21)

2.5.1.4 Experiencing negative emotions

Linked to the assumption of shared experience was the experience of associated negative emotions towards those families with whom participants shared similar experiences:

*"This is where I mentioned frustration with parents…very often I'm thinking, I know that you're not an academic and you don't know about the theory of child development but can you not see what your child needs from you as a parent" (*P3 lines 132-137)

Negative emotions towards the education system and teaching staff were also discussed, again in the context of participants having experienced similar situations with their own children's schools:

> *"It's emphasised some of my concerns about nursery and education provision and how I don't feel that they're necessarily always appropriate and geared around the child…whether they're realistic in their expectations"* (P5 lines 154-156)

In each account that included this subtheme there was an explicit awareness of the existence of these negative emotions:

> *"But that's where supervision comes in, isn't it really?"* (P8 lines 323)

Supervision and personal reflection were believed to be the mechanisms most often used for dealing with these negative emotions and the potential impact on the therapeutic relationship:

> *"Sometimes you have to be, the need for your own insight and reflections becomes quite high"* (P9 lines 89-90)

2.5.2 Superordinate Theme 2: 'Looking at myself differently'

The second theme of 'Looking at Myself Differently' explores issues relating to changes to the perception of self that were experienced by all

participants. They reported that they believed that these changes were related to becoming a mother.

2.5.2.1 Re-evaluation of self

Participants reported changes to both their professional and personal selves as a result of becoming a parent. Evaluation of theoretical models was considered in the light of increasing knowledge of the experience of being a parent:

> *" [Parents] just had to follow the theory and that everything would be fine. And then of course I had my own children and I know that theory's nice and it helps but it doesn't always work"* (P7 lines 63-65)

Participants also reported changes to the way that they now practice clinical psychology as a direct result of being a parent:

> *"I think again in my initial training it was very much about working with parents whereas increasingly I've…focused on the voice of the child"* (P2 lines 149-150)

However, some participants felt that their belief in the effectiveness of theoretical knowledge to help parents who are struggling had not altered;

instead what had changed was their emotional reaction to the use of those models with families:

> *"The intellectual thinking about it doesn't [change] but actually emotionally it becomes a lot more complex"* (P9 lines 251-252)

Due to many of the participants being experienced clinicians they reflected on the impact of taking on more senior roles within their organisation on their perception of their professional self:

> *"I'm now a manager…and a supervisor and I do a lot of taking care of people, meeting people's needs, there are a lot of people who rely on me, so there's a lot of looking after people…and that's very draining"* (P5 lines 345-360)

Some participants also reflected on the impact of ageing as well as becoming more experienced in the clinical role. They believed that unpicking the impact of becoming a mother alongside the impact of becoming older and more confident in their professional role was extremely difficult:

> *"Maybe it's because I'm getting older as well as having older children, I feel more comfortable in just being a bit more human about things and being more warm and trying to understand children and very often using humour"* (P3 lines 356-359)

Changes in practice were also linked to the emotional connectedness reported by participants. They discussed how attempts to make sense of their emotional reaction to their clinical work had resulted in re-evaluating their own personal history:

> *"You link it back to being parented yourself, don't you? You link it back to your own relationship with your own parents as well I think it's sort of quite a complex thing"* (P8 lines 197-198)

Very often participants reported using emotional support to help them to cope with the difficulties associated with the on-going process of re-evaluating the self as a result of being a mother. It was believed that this helped to reduce the emotional impact associated with their clinical role on their personal lives:

> *"Just surround yourself by people you know who will support you…I mean my husband does so I think often it's just…enough to know that he's there and he will support me and I've got good friends also"* (P7 lines 320-322)

2.5.2.2 Feeling challenged by parenting

Linked to the re-evaluation of the self associated with being a parent, was a gradual realisation that parenting is hard. Narrative elements extracted

from all the participant accounts demonstrated the use of negative language associated with the parenting role. Words such as: *"difficulties"* (P1 line 6), *"distress"* (P9 line 49), *"emotionally very drained"* (P3 line 39) and *"the strain"* (P6 line 7) are testament to the very normal struggles of parenthood experienced by the participants.

When describing the difficulties they had experienced as parents, participants also used humour in an apparent attempt to reduce the impact of the struggles they had experienced:

> *"But actually you're thinking I might actually, is it possible to die from lack of sleep?"* (P9 lines 350-351)

Participants apparently found it difficult to admit the difficulties they had experienced as a parent. This may be due to the perception that as experienced, well-educated clinical psychologists they should be able to manage the role of mother effectively. It may also be indicative of the fact that admitting difficulties with parenting remains a taboo subject within our society and this is also a challenge that faces the families that present to CAMHS departments. However participants were able to acknowledge that despite the challenges they had experienced, they remained able to continue to with their parenting role:

> *"My feeling about a lot of these issues is yes it's tough but you do it anyway"* (P5 lines 76-77)

2.5.3 Superordinate Theme 3: 'Feeling Torn'

The theme of 'Feeling Torn' emerged following discussions around managing the competing demands of mother and psychological therapist. Participants reported the emotional dilemma between balancing work commitments and the needs of their children:

> *"The idea that you are making yourself available for somebody else's children when your own child is…not desperately unwell, but if you weren't doing the job that you do, you might have given them a duvet day. I think that, the guilt kicks in hard"* (P9 lines 287-290)

Participants also discussed the sense of having made a choice between work and family, and believed that their career progression had been affected by their decision to work reduced hours:

> *"That has it's drawbacks because you don't really get anywhere in your career because you are working so part-time but it is a choice you make and my personal choice was I'd rather have the children than some fancy career"* (P1 lines 293-296)

Participants also acknowledged the impact of their work on their children; they believed that their children often had their needs prioritised beneath the needs of their mother's clients:

"When she was in her earlier adolescence was really grumpy about what I did and she said one day when she was quite cross with me, I suppose compared to somebody who's going to go off and drink bleach, I'm not that troubled am I? And a lot of it was adolescent door slamming but there was something very real in that" (P9 lines 300-304)

2.5.3.1 Reciprocal role of mother and psychological therapist

Participants reported that the roles of mother and psychological therapist were reciprocal in nature, in that each role impacted on the other. Participants were divided about whether the reciprocity of the relationship was a positive or negative influence. It also contributes to the emotional reactions associated with 'Feeling Torn' between numerous demands.

Some participants reported that each role impacted positively on the other, resulting in improved empathy and understanding for their clients and a sense of self-assurance when managing their own children:

"The working with children here has also enriched my experience with my own children" (P1 lines 479-480)

"Although I'm convinced that being a Mum has made a better clinician and you know a better psychologist" (P7 lines 219-220)

However, others believed that they were not necessarily completing either role to the best of their ability, therefore contributing to feelings of self-doubt and emotional dilemmas:

> *"I feel I'm not doing as good a job at home as I could be and I think to myself I should be better than this, I should know because I'm a clinical psychologist who works with children…so I sometimes feel quite deskilled…both at work and at home"* (P3 lines 216-218)

2.6 Discussion

This study was interested in the subjective experiences of psychological therapists who are mothers and work with children and families. It explored the participant's experiences of being a mother and how this may impact on their therapeutic relationships with their clients. It also considered how their practice may have changed as a result of being a mother as well as how they ensured sufficient levels of emotional support. Nine interviews were completed with psychological therapists who worked within CAMHS and were also mothers. IPA analysis established three superordinate themes that emerged from the interview transcripts: 'Common Ground', 'Looking at Myself Differently', and 'Feeling Torn'. The findings will now be explored in the context of the literature and the research aims.

2.6.1 The impact of being a mother on the therapeutic relationship

Experiences of having 'Common Ground' with parents was cited by all participants as being one of the main influences that being a parent had on their clinical work. Participants believed that increased empathy and understanding of the parent perspective had a positive impact on the development of therapeutic relationships. This is consistent with the findings of other research (Candib et al., 1987). However, this increased empathy was not always considered to be a positive experience. Participants reported the difficulties in assuming shared experience, particularly when their own personal experience paralleled that of their clients. This is consistent with the findings of Hodges et al. (2010) who found that sharing an experience did not always result in more accurate levels of empathy.

Participants reported that inaccurately assuming shared experience with a client often resulted in negative emotions being experienced and inevitably had a detrimental impact on the therapeutic relationship. The experience of difficult emotions in relation to being a parent is consistent with Nadelson et al.'s (1974) finding that for pregnant therapists psychological vulnerability can impact on the therapeutic relationship. This finding suggests that this impact can persist beyond pregnancy.

2.6.2 Therapist's experience of being a mother

The superordinate theme of 'Looking at Myself Differently' encompasses the many different ways that participants believed that being a mother had led to changes in their perceptions of themselves. Despite the suggestion that the psychological impact of pregnancy is a transient state (Candib et al., 1987) the results of this study indicate that motherhood continues to have an emotional impact beyond the birth. Some participants in this study had adult children and yet could still identify ways in which being a mother impacted on the way they thought about themselves.

The participants in this study described fundamental changes to the way that they viewed themselves after becoming a mother. They highlighted the importance of being aware of their own struggles and being able to reflect upon the impact of these in their clinical work (Imber, 1995). Participants cited the crucial role of supervision in this process (Dyson & King, 2008), as well as relying on supportive colleagues (Darvill et al., 2010).

Many participants experienced the challenges inherent in parenthood. This is indicative of the emotionally challenging nature of becoming a mother (Nelson, 2003; Tinsley, 2000; Fenster et al., 1986) accompanied by the challenges of working psychologically with families and children (Boland, 2008). This subtheme was developed from the narrative

structure of many of the transcripts. The use of negative descriptions of parenthood in the absence of any positive adjectives and the defensive use of humour to lessen the impact of their struggles indicate that experiencing anything other than positive feelings around parenthood continues to be a taboo subject amongst many parents.

Many participants reported ‘Feeling Torn’ between the competing demands of home and work life. Attempting to manage both roles and the expectation that this should be relatively straightforward resulted in many participants feeling challenged by parenting. Tinsley (2000) describes a “Superwoman fantasy” (p.106), which may underpin this attempt to manage it all. The concept of narcissistic concerns was not evident in this study (Underwood & Underwood, 1978). Instead participants spoke of the emotional dilemma of wanting to meet the demands of both work commitments and their children’s needs and the inevitable feelings of guilt if this was not possible.

Participants in this study spoke not of a primary maternal preoccupation (Winnicott, 1978) but instead of the reciprocal relationship between their work and mother roles. The positive elements of this relationship appear to contribute to both personal and professional growth as suggested by Korol (1996).

Changes to clinical practice that were reported by participants were often linked to self-disclosure. Some participants reported being honest with

their clients about their parent status and felt that this was beneficial to the therapeutic relationship. This is consistent with findings of other research (Rubin, 1980). The subtheme of “We as Parents” encompasses the range of reactions to the questions posed by families about whether the therapist has children. Candib et al. (1987) reported that the shared experience of parenthood can place the therapeutic relationship on an equal level and may be one explanation to why participants often felt the need to allude to their parent status, rather than address it directly.

2.6.3 Accessing support and self-care

Participants who reported experiencing negative emotions in response to an assumption of shared experience cited supervision as crucial in identification and self-awareness (Dyson & King, 2008). The availability of social support was also considered important in managing the on-going demands of parenthood and working as a psychological therapist (Darvill et al., 2010)

2.6.4 Methodological Considerations

2.6.4.1 Choice of methodology

The results generated by this research suggest that psychological therapists are interested in reflecting on their experiences of being a mother while working with children and families. There are no known

studies of psychological therapists who are mothers and work in CAMHS departments in the UK. It was, therefore, important to use a qualitative methodology. IPA was deemed most appropriate because of it's commitment to capturing individual experience and this was important given the expected variety of perspectives in this sample.

Commitment and rigour to the IPA process was demonstrated via thorough analysis of the data and in the researcher's attempt to develop their own personal competencies in using IPA. All parts of the process have been documented and findings shared in a transparent way. Clinical implications have been considered to meet the requirements of impact and importance to the clinical psychology field.

2.6.4.2 Methodological Limitations

There are a number of limitations to this study that should be reflected upon. Firstly, due to the nature of the recruitment process of this study, the sample were self-selected. It is possible that those who agreed to take part had already acknowledged the impact of their motherhood on their clinical practice, hence their interest in the study.

Secondly the participants were all experienced clinicians, and the majority were parents to adolescent children. It would have been useful to also gather the thoughts of both newly qualified clinicians as well as new

mothers or mothers to younger children, to determine whether they hold similar views.

Thirdly as this is a relatively under researched area, it was decided that this research study would focus on the mother's viewpoint. However research on the impact of fatherhood for those working in CAMHS settings would also be of benefit.

Additionally, some of the subthemes included in the final analysis did not quite meet the IPA guidelines for recurrent themes (Smith et al., 2009). The subthemes of 'Assumption of Shared Experience' and 'Experiencing Negative Emotions' were only present in four transcripts, rather than the recommended half of all transcripts. It was believed that these subthemes represented an important aspect of the superordinate theme and were discussed by those participants who shared their own parenting struggles. This may explain the reason that the subthemes were only present in some participant accounts, as other participants may not have experienced related difficulties or chose not to share these during the interview.

Finally, while this study achieved its aim of exploring the experiences of psychological therapists who work within CAMHS departments and who are also mothers, such findings cannot be generalised to a wider population.

2.6.4.3 Clinical implications

The clinical implications of this study involve the improved awareness and understanding of the psychological impact of motherhood in those who also provide emotional support to others. The importance of acknowledging conflicting demands in supervision (Dyson & King, 2008) and encouraging personal reflections around these issues (Imber, 1995) is crucial. It would appear that this is particularly important in regard to the issue of assuming shared experience and the negative emotions that can occur as a result. The results of this study also contradict previous findings that the impact of motherhood is transient (Candib et al., 1987). It would appear that experiencing motherhood is one element of the evolving process of developing a therapeutic relationship.

The difficulties in managing the emotionally challenging roles of mother and psychological therapist can result in participants 'Feeling Torn' between work and home demands (Boland, 2008; Darvill et al., 2010). Inevitably this is a fluid and constantly changing process however the importance of being able to access positive support within their employing organisation will be essential at those times when home demands became unworkable. An improved awareness of the potential emotional impact of motherhood for new parents alongside predetermined organisational structures for accessing additional supervision or support would help to ease the transition to parenthood for new mothers. For those psychological therapists who are already parents, any attempt to

reduce the apparent stigma of experiencing difficulties with parenting would have benefits not only the for the individual clinician, but also for the families that they work with.

2.6.4.4 Recommendations for future research

There remain large gaps in the evidence base for the impact of motherhood on the therapeutic relationship for psychological therapists, as there are no other known studies in this area.

Future research could focus on understanding the experience of newly qualified clinicians, new mothers, as well as psychological therapists who are fathers. It may also be worth considering how this experience changes over time as parenthood progresses. It is possible that these groups of psychological therapists could have differing experiences from the participants in this study and it would be important to understand their views to contribute to the findings of this study.

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Chapter 3: Reflective Paper

Reflections on the challenges of being a trainee clinical psychologist and a mother

Word Count: 3337 (Excluding references)

3.1 Introduction

Clinical psychology training courses at United Kingdom (UK) universities consist of three years of academic learning alongside supervised clinical placements in the core professional areas of adult mental health, older adults, children and families and learning disabilities as well as one or two elective specialist placements. All courses in the UK are accredited by the British Psychological Society (BPS) and therefore are broadly similar in terms of their approach to learning and the core competencies that trainees have by the end of the course. In terms of the 'typical' clinical psychology trainee, the majority of the 2011 cohort were female (83%) were aged between twenty-five and twenty-nine (53%) The majority were single (64%) and just 12% reported having dependents (Clearing House for Postgraduate Courses in Clinical Psychology Equal Opportunities Data, 2011). Being part of the 12% of UK trainee clinical psychologists who attempt to manage the dual roles of trainee and parent I was curious about the literature.

3.2 The psychological impact of clinical psychology training

For many working parents, attempting to balance work and home priorities results in inevitable feelings of guilt (Laine, 1998). There are times when home priorities result in having to change work commitments or vice versa. In my own experience, simple everyday problems such as unwell children, unavailable child minders or school concerts scheduled

during the working day each present their own challenges and a consideration of where priorities lie for that day. While this is a dilemma for many working parents, it has been suggested that for those parents who work within the caring professionals, the work ethic that accompanies their chosen profession makes their experience different from many other professional groups (Laine, 1998). Professional carers, such as doctors, psychologists and nurses feel a responsibility not only towards their families but also towards their patients (Laine, 1998), perhaps resulting in elevated levels of guilt.

As well as feelings of guilt, perhaps another over-riding emotion often experienced during clinical psychology training is that of stress. Trainee clinical psychologists often experience high levels of stress at some point during the three-year training course (Cushway, 1992) and this can have a detrimental effect on their personal and professional development (Pakenham & Stafford-Brown, 2012; Cherniss, 1995). The challenge for trainee clinical psychologists, who are also parents, is that there may be an increased potential for experiencing high levels of stress. Kuyken, Peters, Power, Lavender and Rabe-Hesketh (2000) interviewed trainee clinical psychologists on UK training courses about psychological adaptation and found that over the length of the training course, trainees reported increasing difficulties in the important role functioning areas. While this study did not address the demands of being a trainee clinical psychologist and a parent, it could be assumed that managing multiple roles could be affected during the training course. Brookes, Holttum and

Lavender (2002) found that trainee clinical psychologists reported difficulties in maintaining social roles, parenthood (although not addressed directly) could be considered as one potential area of difficulty. Completing a clinical psychology training course coupled with the demands of raising a young family and the potential for additional stressors, it would not be surprising for trainees who are also parents to experience additional psychological pressure.

I began clinical psychology training in 2010 when my eldest child was 6 years old and my youngest two children (a set of twins) were almost two. In my own experience I found that, despite having been cautioned by course staff against having any significant life events during the three years of training, life often has other ideas. I experienced the diagnosis of serious health conditions for both my daughter and my father and the death of two members of my close family, within two weeks of each other, during the second and third years of my training. This is also widely acknowledged as being the most stressful time period of the course (Cushway, 1992). This was alongside everyday stressors of training and family life. During these difficult times, without doubt I believe that my ability to function effectively as a clinician was significantly compromised as my own internal resources became overwhelmed. I believe that my emotional availability for my clients was significantly limited due to a preoccupation with the demands of my personal life. During this time supervision was crucial in helping me to reflect on my difficulties and find effective solutions for managing my current demands.

3.3 Cognitive appraisals and expectations of training

Using a trainee sample, a study found that appraising events as being out of an individuals control was significantly associated with poorer psychological adaptation over time (Kuyken, Peters, Power and Lavender, 2003). Psychological adaptation can be described as a balance between the demands placed upon an individual and the individual's appraisal of intrapersonal and situational resources for managing those demands (Kuyken et al., 2003). The accumulation of the stress of clinical training as well as additional life stressors can negatively impact on perceptions of self-efficacy and role functioning (Kuyken et al., 2000). The experience of receiving devastating diagnoses for my daughter and my father as well as the unexpected deaths of my family members were events that were out of my control and as a consequence had a direct influence on my psychological adaptation at that time.

Having realistic expectations of the impact that clinical psychology training may have on other aspects of life has been found to protect against poor psychological adaptation (Brooks, Holttum & Lavender, 2002). They emphasis the importance of trainee clinical psychologists being prepared in a realistic way for the demands and stressors of clinical training, prior to commencing a course.

Having spent several years during pregnancy and motherhood working as an Assistant Psychologist locally in a part-time capacity, beginning a

full-time training post was approached with trepidation and a considerable amount of reflection on the potential impact for my family and me. I believed that I had a reasonably realistic expectation of the demands of clinical training, through previous exposure to trainee clinical psychologists, however the reality was even more challenging than I had expected. There were times during the difficult periods of what felt like overwhelming stress in my personal life when I did not feel that I had sufficient resources to manage those stressors alone. At these times therefore I sought additional support to help me manage my short-term difficulties from both university appraisal tutors and clinical supervisors.

3.4 Protective factors in managing the challenges of being a trainee and a mother

Given my growing awareness of the emotional and psychological impact of the difficulties of managing the demands of being both a trainee clinical psychologist and a parent, I now turn my attention to the different things that I have found useful while managing these challenges.

3.4.1 The positive impact of sufficient support

The literature identifies a number of areas in which support is important for trainees. Areas of note are social support (Myers, Sweeney, Popick, Wesley, Bordfeld & Fingerhut, 2012; Kuyken et al., 2003; Cohen & Willis, 1995; Kahn & Byosiere, 1992); support at home (Kuyken et el., 2003) and

a supportive working environment (Laine, 1998). Further there were some forms of support such as personal therapy (Kumari, 2011) and support from course staff (Kuyken et al., 2003) that provide mixed results. Therefore it may be that having access to a variety of types of emotional support is what is essential.

In my own experience I found that having positive social networks to provide on-going encouragement, both at difficult times as well as when things were more bearable, was incredibly important. This support came from a variety of sources, and each provided unique encouragement. Support from friends and family provided a welcome escape from the realities of studying and clinical placements. Although some of my friends are working parents themselves, there was often a sense that they didn't really understand the demands of being a 'student'. Colleagues, tutors and supervisors on placement provided considerable levels of emotional support, as they understood both the experience of the clinical course as well as being able to manage working in the profession whilst often also being a parent. Finally, my peers on the training course had a real appreciation of the stress 'in the moment'. None of my fellow trainees, however, were parents themselves and this resulted in feelings of isolation as I was often left with a sense that they did not truly understand my difficult experiences. What seems to be clear is that having different social support networks that provide different functions is key to building adequate interpersonal resources.

Working within the National Health Service (NHS) as a trainee clinical psychologist provides an insight into the demands of qualified clinical psychologist from a very well-protected vantage point. What I discovered was that it is possible to combine a clinical psychology career with parenthood, providing this was supported by flexible working practices and effective supervision. NHS policies relating to parental leave are very supportive of family life, however in the context of current financial pressures and sweeping organisational change, this does not seem to be a particularly secure position for working parents. From a course perspective, the arrangements for supporting trainees emotional needs are very robust and provide alternative arrangements should there be a need for longer-term support.

3.4.2 Implementing effective boundaries

The development and maintenance of home and work boundaries is particularly pertinent when considering that participating in a clinical psychology training course had a greater than expected impact on life experiences (Brookes, Lavender & Holttum, 2003). Addressing directly the demands of academic work as opposed to engaging in avoidance coping has the potential to have a positive effect on mental health, including depression, anxiety and self-esteem (Kuyken et al., 2003). Avoidance coping is one way individuals may choose to manage stressful experiences through avoiding those demands as much as possible and ignoring the consequences.

Having worked for thirteen years within an NHS clinical psychology environment, nine of those as a working parent, I have become accustomed to implementing effective boundaries between my home and work life. This was something that I had managed to continue throughout the first two years of my training course. I always had the words of a previous supervisor ringing in my ears, that it was perfectly possible to complete all the necessary academic work that accompanies training within the allocated study time, and tried my best to stick to this. However, since entering the 'writing block' for my thesis I have become aware of the deadline looming large, and have worked in the evenings and at weekends, often to the detriment of my family. A passing comment from my daughter of "Mummy, why are you always working?" made me keenly aware of how far these boundaries have slipped.

3.5 Managing the multiple demands of trainee clinical psychologist and parent

Working mothers often see their struggle to achieve an effective performance at both work and home as "trade-off" for their choices in life (Laine, 1998 p. 580). An alternative view of this process would be the reciprocal nature of the relationship between being a psychologist and a parent (Laine, 1998). Often trainee psychologists are expected to focus solely on their training, while putting other aspects of their life on hold (Bacon, 1995) and yet it has been shown that this can be to the detriment of their own psychological well-being (Guse, 2010)

During the process of completing my interviews for my empirical paper, I explored the difficulties of work life balance. My literature review was also concerned with work life balance for psychologists. These experiences made me even more aware of my own difficulties with work life balance and what particularly resonated was the sense that I was not fulfilling either role as well as I would have liked. Without having to consider the needs of my family, I believed I could have devoted more time to the process of learning and developing as a clinical psychologist. Even though I feel tremendous guilt at admitting this, at times I envied my childless peers who could devote all their energies to developing their career whereas my resources had to include my children. There were also times when I dropped the children off at the crack of dawn, or the little ones cried because I was going to work 'again' when I would have cheerfully quit the course to end their distress, all the while wishing I could achieve my expectations of being the perfect mother.

Now that the course is coming to an end and I can see the finishing line, these struggles feel slightly less oppressive. The idea of having a (part-time) job that fits neatly around my children has become the ultimate aim. Although I still feel sad that having Mummy pick them up from school is met with squeals of delight and the promise of this happening all the time has become an unimaginable joy. I also acknowledge that my youngest children have benefited hugely from high quality child-care, growing into independent confident little people. My eldest child has been far more aware of the changes that occurred as a result of the training course and

has been extremely resentful at times, although the idea of Mummy writing a ‘book’ (thesis) has been intriguing to him, with a daily word count update being required. My only hope is that by striking the right balance between work and home life, through part time work will help to redress his feelings of resentment and my associated feelings of guilt.

During my research interviews many participants discussed the dilemma of managing multiple challenging roles. This provided validation of my own experiences and made me aware of the shared experiences inherent in managing varying demands.

3.6 The influences on me as a practitioner

Much of the literature regarding trainee clinical psychologists focuses on the adaptation to stress (Kuyken et al., 2003; Kuyken et al., 2000) and acknowledges that clinical training is a stressful experience (Cushway, 1992; Pakenham & Stafford-Brown, 2012). More positively, research also shows that on the whole trainees are typically psychologically resilient and use varying personal and professional resources to cope with the demands of training (Kuyken et al., 2000).

As part of my personal development over the past three years I have noted a considerable change in the way that I approach potentially challenging, anxiety-provoking situations. Prior to training my default response was to use avoidance coping for as long as possible. However

by acknowledging this difficulty and through positive support from supervisors and tutors I feel I have managed to overcome this and while I still often wish to avoid difficult situations, I now will attempt to face the anxiety with a more solution focused approach. This is in turn has made me a more confident parent, especially when dealing with education and healthcare professionals in acquiring the most appropriate health-care and support for my daughter who has a serious health condition.

I also had preconceived notions that I would find working with children and families challenging, as I was concerned that my own experiences would interfere with my ability to remain objective and professional. What transpired was that my experiences of being a parent enabled me to understand and empathise with the concerns and anxieties of parents and children who were struggling. While I remained aware of the potential for inaccurately assuming a shared struggle, I found that having my own children only deepened and enhanced my understanding. Through the interviews that I have conducted for my empirical paper, I have come to realise that I am not alone in this belief. Many psychological therapists working with children also believe that being a parent has enhanced their understanding of parenting, child development and their theoretical knowledge (Laine, 1998).

On a more practical level I have learned important work skills such as effective time management and implementing clear effective boundaries between work and home life. I have also developed an understanding of

my own stress levels and the most effective strategies for dealing with this. Finally, as a result, I have also learned the importance of not being stubbornly independent and letting others know when I am struggling.

3.7 Clinical Implications

Trainee clinical psychologists who are also parents are a small minority of the hundreds of individuals who commence clinical psychology training each year. However, as the competition for places increases in the face of potential reductions in funding, it is possible that individuals will no longer put their personal lives on hold while waiting for that elusive place on a clinical training course. This could result in the number of parents applying to clinical training gradually increasing. Consideration is also needed for those individuals who become parents part-way through their training as many of the same challenges will also apply to them.

From my own experience it would seem that ensuring that trainees have sufficient emotional support will help them to cope with the challenges inherent in raising a family while studying and completing clinical placements (Myers et al., 2012; Brookes, Holttum & Lavender, 2002; Kuyken et al., 1998; Kahn & Byosiere, 1992; Cohen & Willis, 1985). It is important that support is available from course tutors, while acknowledging that other sources of support, such as supervisors, peers and personal therapy can all be utilised when required (Kuyken et al., 2003; Laine, 1998).

Another aspect of my clinical training that proved to be extremely helpful was the consideration from course staff to ensure that my clinical placements were not always geographically distant from my home address. While travel is an inevitable part of clinical training, the ability to be flexible with start and finish times, for example, helped with this potentially stressful element of training (Laine, 1998).

Finally, given the lack of other parents within my training cohort, it would have been helpful to attempt to connect trainee clinical psychologists who are also parents either within other year groups or across local courses. This would enable the sharing of experiences and provide another source of support to promote an improved sense of wellbeing (Jordaan et al., 2007).

3.8 Influences on the role of clinical psychology

Clinical psychologists are in a unique position within the world of working parents. Working parents often experience similar struggles and difficulties. However, the influence of the clinical psychologists' training model and their ability to reflect on their own experiences and emotional reactions places them at an advantage for promoting change within organisations (Pakenham & Stafford-Brown, 2012). They could provide understanding at a corporate level of the strategies that enable working parents to continue to balance their home life with their commitments to their professional caring role (Laine, 1998).

From a training course perspective, course staff should continue to provide sufficient emotional and psychological support to those trainees who are balancing the unique demands of training and parenthood (Kumari, 2011; Kuyken et al. 2003). Opportunities for flexibility within the training model also helps with the demands of training while raising children (Laine, 1998).

Conclusion

Completing a three-year pre-qualification training course in clinical psychology whilst simultaneously raising a family is not without its difficulties. The opportunity for personal reflection has been helpful for me in considering the most effective way to cope with these challenges. Ensuring sufficient levels of emotional support, implementing effective boundaries and learning ways to manage multiple demands have all been positive ways of meeting these challenges. This is not to suggest that I have managed to completely prevent the emotional impact of these difficulties. However, improved self-awareness as a result of personal development has minimised the impact of the emotional overspill between personal life events and my professional life.

Clinical psychologists who are involved in the training of future clinicians can help trainees who are also parents by ensuring adequate, timely support and flexibility within their working lives. On a management level, clinical psychologists could also provide psychological knowledge to

inform future policy level changes that will continue to support trainee clinical psychologists who are also parents, as well as other working parents within the professional caring world.

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Appendices

Appendix One

Author Guidelines: British Journal of Clinical Psychology

Author Guidelines

The British Journal of Clinical Psychology publishes original contributions to scientific knowledge in clinical psychology. This includes descriptive comparisons, as well as studies of the assessment, aetiology and treatment of people with a wide range of psychological problems in all age groups and settings. The level of analysis of studies ranges from biological influences on individual behaviour through to studies of psychological interventions and treatments on individuals, dyads, families and groups, to investigations of the relationships between explicitly social and psychological levels of analysis.

The following types of paper are invited:

• Papers reporting original empirical investigations

• Theoretical papers, provided that these are sufficiently related to the empirical data

• Review articles which need not be exhaustive but which should give an interpretation of the state of the research in a given field and, where appropriate, identify its clinical implications

• Brief reports and comments

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

Papers should normally be no more than 5000 words (excluding abstract, reference list, tables and figures), although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

3. Submission and reviewing

All manuscripts must be submitted via http://www.editorialmanager.com/bjcp/. The Journal operates a policy of anonymous peer review. Before submitting, please read the terms and conditions of submission and the declaration of competing interests.

4. Manuscript requirements

• Contributions must be typed in double spacing with wide margins. All sheets must be numbered.

• Manuscripts should be preceded by a title page, which includes a full list

of authors and their affiliations, as well as the corresponding author's contact details. A template can be downloaded from here.

• Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.

• Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi.
• All papers must include a structured abstract of up to 250 words under the headings: Objectives, Methods, Results, and Conclusions. Articles, which report original scientific research, should also include a heading 'Design' before 'Methods'. The 'Methods' section for systematic reviews and theoretical papers should include, as a minimum, a description of the methods the author(s) used to access the literature they drew upon. That is, the abstract should summarize the databases that were consulted and the search terms that were used.

• All Articles must include Practitioner Points – these are 2–4 bullet points to detail the positive clinical implications of the work, with a further 2–4 bullet points outlining cautions or limitations of the study. They should be placed below the abstract, with the heading ‘Practitioner Points’.

• For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full and provide DOI numbers where possible for journal articles.

• SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.

• In normal circumstances, effect size should be incorporated.

• Authors are requested to avoid the use of sexist language.

• Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright. For guidelines on editorial style, please consult the APA Publication Manual published by the American Psychological Association.

5. Brief reports and comments

These allow publication of research studies and theoretical, critical or review comments with an essential contribution to make. They should be limited to 2000 words, including references. The abstract should not exceed 120 words and should be structured under these headings:

Objective, Method, Results, and Conclusions. There should be no more than one table or figure, which should only be included if it conveys information more efficiently than the text. Title, author name and address are not included in the word limit.

6. Supporting Information

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11. The Later Stages

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12. Early View

British Journal of Clinical Psychology is covered by the Early View service on Wiley Online Library. Early View articles are complete full-text articles published online in advance of their publication in a printed issue. Articles are therefore available as soon as they are ready, rather than having to wait for the next scheduled print issue. Early View articles are complete and final. They have been fully reviewed, revised and edited for publication, and the authors' final corrections have been incorporated. Because they are in final form, no changes can be made after online publication. The nature of Early View articles means that they do not yet have volume, issue or page numbers, so they cannot be cited in the traditional way. They are cited using their Digital Object Identifier (DOI) with no volume and issue or pagination information. E.g., Jones, A.B. (2010). Human rights Issues. *Human Rights Journal*. Advance online publication. doi:10.1111/j.1467-9299.2010.00300.x

Further information about the process of peer review and production can be found in this document: What happens to my paper?

Appendix Two

Quality Assessment Framework

Adapted from the Critical Appraisal Skills Programme –
Making sense of evidence about clinical effectiveness
http://www.phru.nhs.uk/casp/critical_appraisal_tools.htm

Screening Questions (Score 1 for yes and 0 for no for overall score out of 10)

1. **Was there a clear statement of the aims of the research?**

   Consider:

   - *What was the goal of the research?*
   - *Why is it important?*
   - *Is it relevant?*

2. **Did the research use appropriate methodology?**

   Consider:

   - *If the research seeks to interpret or illuminate the actions and/ or subjective experiences of research participants*

Detailed Questions

3. **Was the research design appropriate to address the aims of the research?**

   Consider:

   - *If the researcher has justified the research design (e.g. have they discussed how they decided which method to use)?*

4. **Was the recruitment strategy appropriate to the aims of the research?**

   Consider:

- *If the researcher has explained how the participants were selected*
- *If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study*
- *If there are any discussions around recruitment (e.g. why some people chose not to take part)*

5. **Were the data collected in a way that addressed the research issue?**

   Consider:

   - *If the setting for data collection was justified*
   - *If it is clear how the data were collected (e.g. focus group, semi-structured interview etc.)*
   - *If the researcher has justified the methods chosen*
   - *If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how the interviews were conducted, or did they use a topic guide)?*
   - *If methods were modified during the study. If so, has the researcher explained how and why?*
   - *If the form of data is clear (e.g. tape recorder, video material, notes etc.)*
   - *If the researcher has discussed saturation of data*

6. **Has the relationship between researcher and participants been adequately considered?**

   Consider:

   - *If the researcher critically examined their own role, potential bias and influence during:*
     - *Formulation of the research question*

    - *Data collection, including sample recruitment and choice of location*
- *How the researcher responded to events during the study and whether the considered the implications of any changes in the research design*

7. **Have ethical issues been taken into consideration?**

Consider:

- *If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained*
- *If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)*
- *If approval has ben sought from the ethics committee*

8. Was the data analysis sufficiently rigorous?

Consider:

- *If there is an in-depth description of the analysis process*
- *If thematic analysis is used. If so, is it clear how the categories/ themes were derived from the data?*
- *Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process*
- *If sufficient data are presented to support the findings*
- *To what extent contradictory data are taken into account*
- *Whether the researcher critically examined their own role, potential bias and influence during the analysis and selection of data for presentation*

9. Is there a clear statement of findings?

Consider:

- *If the findings are explicit*
- *If there is adequate discussion of the evidence both for and against the researchers arguments*
- *If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)*
- *If the findings are discussed in relation to the original research question*

10. How valuable is the research?

Consider:

- *If the researcher discussed the contribution the study makes to existing knowledge or understanding e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature?*
- *If they identify new areas where research is necessary*
- *If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used*

Appendix Three

Results of the Quality Assessment

Table A1: Results of the quality assessment completed for the literature review

Reference:	1	2	3	4	5	6	7	8	9	10	Total
Bachtold & Werner (1970)	✓	✓	✓	✓	✓	X	X	✓	X	X	6/10
Brown & Duan (2007)	✓	✓	✓	✓	✓	X	X	✓	✓	✓	8/10
Bryant & Constantine (2006)	✓	✓	✓	✓	✓	X	X	✓	✓	✓	8/10
Burke, Oberklaid & Burgess (2003)	✓	✓	X	✓	✓	X	X	✓	✓	✓	7/10
Campbell & Soliman (1968)	✓	✓	✓	✓	✓	X	X	✓	✓	X	7/10
Canning (2011)	✓	X	X	X	X	✓	X	X	✓	✓	4/10
Dlugos & Friedlander (2001)	✓	✓	✓	✓	✓	X	X	✓	✓	✓	8/10
Duan, Brown & Keller (2010)	✓	✓	✓	✓	✓	X	X	✓	✓	✓	8/10
Furumoto & Scarborough	✓	X	X	✓	✓	X	X	X	✓	X	4/10

(1986)											
Grafanaki et al. (2005)	✓	✓	✓	X	✓	✓	X	✓	✓	✓	8/10
Hoeksma et al. (1993)	✓	✓	✓	✓	✓	X	X	✓	X	X	7/10
Kinman & McDowall (2010)	✓	✓	✓	✓	✓	X	X	X	✓	✓	7/10
Kinman & McDowall (2011)	✓	✓	✓	X	X	X	X	X	✓	✓	5/10
Kircaldy & Siefen (1991)	✓	✓	✓	X	X	X	X	✓	✓	✓	6/10
Koppes & Swanberg (2008)	✓	X	✓	✓	✓	X	X	X	✓	✓	6/10
Lee, Reissing & Dobson (2009)	✓	✓	✓	X	X	X	X	X	✓	✓	5/10
Matheson & Rosen (2012)	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	9/10
Milar (2000)	✓	X	✓	X	✓	X	X	X	✓	X	4/10
Pendergrass	✓	✓	✓	✓	✓	X	X	X	✓	X	6/10

(1974)											
Rupert & Kent (2007)	✓	✓	✓	✓	✓	X	X	✓	✓	✓	8/10
Scott et al. (2012)	✓	✓	✓	X	✓	✓	X	✓	✓	✓	8/10
Stevanovic & Rupert (2004)	✓	✓	✓	✓	✓	X	X	✓	✓	✓	8/10
Walfish & Walraven (2005)	✓	✓	✓	✓	✓	X	X	✓	✓	✓	8/10

Appendix Four

Author Guidelines: British Journal of Psychology

Author Guidelines

The Editorial Board of the British Journal of Psychology is prepared to consider for publication:

(a) reports of empirical studies likely to further our understanding of psychology

(b) critical reviews of the literature

(c) Theoretical contributions

Papers will be evaluated by the Editorial Board and referees in terms of scientific merit, readability, and interest to a general readership.

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

Papers should normally be no more than 8000 words (excluding the abstract, reference list, tables and figures), although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

3. Submission and reviewing

All manuscripts must be submitted via http://www.editorialmanager.com/bjp/. The Journal operates a policy of anonymous peer review. Before submitting, please read the terms and conditions of submission and the declaration of competing interests.

4. Manuscript requirements

• Contributions must be typed in double spacing with wide margins. All sheets must be numbered.

• Manuscripts should be preceded by a title page which includes a full list of authors and their affiliations, as well as the corresponding author's contact details. A template can be downloaded from here.

• Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.

• Figures can be included at the end of the document or attached as separate

files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi.

• All articles should be preceded by an Abstract of between 100 and 200 words, giving a concise statement of the intention, results or conclusions of the article.

• For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full and provide DOI numbers where possible for journal articles.

• SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.

• In normal circumstances, effect size should be incorporated.

• Authors are requested to avoid the use of sexist language.

• Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright. For guidelines on editorial style, please consult the APA Publication Manual published by the American Psychological Association.

5. Supporting Information

BJOP is happy to accept articles with supporting information supplied for online only publication. This may include appendices, supplementary figures, sound files, videoclips etc. These will be posted on Wiley Online Library with the article. The print version will have a note indicating that extra material is available online. Please indicate clearly on submission which material is for online only publication. Please note that extra online only material is published as supplied by the author in the same file format and is not copyedited or typeset. Further information about this service can be found at http://authorservices.wiley.com/bauthor/suppmat.asp

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Authors for whom English is a second language may choose to have their manuscript professionally edited before submission to improve the English. A list of independent suppliers of editing services can be found at http://authorservices.wiley.com/bauthor/english_language.asp. All services are

paid for and arranged by the author, and use of one of these services does not guarantee acceptance or preference for publication.

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10. Author Services
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11. The Later Stages

The corresponding author will receive an email alert containing a link to a web site. A working e-mail address must therefore be provided for the corresponding author. The proof can be downloaded as a PDF (portable document format) file from this site. Acrobat Reader will be required in order to read this file. This software can be downloaded (free of charge) from the following web site: http://www.adobe.com/products/acrobat/readstep2.html. This will enable the file to be opened, read on screen and annotated direct in the PDF. Corrections can also be supplied by hard copy if preferred. Further instructions will be sent with the proof. Hard copy proofs will be posted if no e-mail address is available. Excessive changes made by the author in the proofs,

excluding typesetting errors, will be charged separately.

12. Early View

The British Journal of Psychology is covered by the Early View service on Wiley Online Library. Early View articles are complete full-text articles published online in advance of their publication in a printed issue. Articles are therefore available as soon as they are ready, rather than having to wait for the next scheduled print issue. Early View articles are complete and final. They have been fully reviewed, revised and edited for publication, and the authors' final corrections have been incorporated. Because they are in final form, no changes can be made after online publication. The nature of Early View articles means that they do not yet have volume, issue or page numbers, so they cannot be cited in the traditional way. They are cited using their Digital Object Identifier (DOI) with no volume and issue or pagination information. E.g., Jones, A.B. (2010). Human rights Issues. *Human Rights Journal*. Advance online publication. doi:10.1111/j.1467-9299.2010.00300.x

Further information about the process of peer review and production can be found in this document: What happens to my paper?

Appendix Five

Letter of Ethical Approval

(Research Registry Unit, Coventry University)

Coventry University
Priory Street
Coventry CV1 5FB
Telephone 024 7688 7688

Professor Ian M Marshall
Pro-Vice-Chancellor (Research)

Coventry University

TO WHOM IT MAY CONCERN

RRU/Ethics/Sponsorlet

28 May 2012

Dear Sir/Madam

Researcher's name: Sharla Lawrence
Project Title: Motherhood and the impact on the therapeutic relationship: A qualitative study of therapists in Child and Adolescent Mental Health Services

The above named student has successfully completed the Coventry University Ethical Approval process for her project to proceed (ref: P3789).

I should like to confirm that Coventry University is happy to act as the sole sponsor for this student and attach details of our Public Liability Insurance documentation.

With kind regards

Yours faithfully

Professor Ian Marshall
Deputy Vice-Chancellor, Academic

Enc

Pro-Vice-Chancellor's Office
Direct Line 024 7679 5293
Fax 024 7688 8030

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Appendix Six

Letter of Ethical Approval

(West Midlands (South) Comprehensive Local Research Network)

Coventry and Warwickshire NHS
Partnership Trust

West Midlands (South) Comprehensive Local Research Network
Fourth Floor, West Wing (ACF40002)
University Hospitals Coventry & Warwickshire NHS Trust
University Hospital
Clifford Bridge Road
Coventry
CV2 2DX

20th July 2012

Mrs S Lawrence
St Michaels Hospital
St Michaels Road
Warwick
Cv34 5QW

Dear Mrs Sharla Lawrence

Project Title: Motherhood and the impact on the therapeutic relationship
R&D Ref: 101844 PAR 110712

I am pleased to inform you that the R&D review of the above project is complete, and the project has been formally approved to be undertaken at Coventry and Warwickshire Partnership NHS Trust. Your research activity is now covered by NHS indemnity as set out in HSG (96) 48, and your trial has been entered onto the Trust's database.

The following documents were reviewed:

Document	Version	Date
NHS R&D Application Form	101844/332071/14/954	25th May 2012
NHS Site Specific Information Form	101844/332066/94/147923/245967	4th July 2012
Research Proposal		3rd October 2012
Participant Information Sheet	3.0	May 2012
Interview Schedule	2.0	
Demographic Questionnaire	2.0	February 2012
Consent Form	1.0	July 2012

Your responsibilities are set out in the attached agreement, which must be signed and returned to the R&D Office. You should keep a copy for your records.

All research must be managed in accordance with the requirements of the Department of Health's Research Governance Framework (RGF) and to ICH-GCP standards. In order to ensure that research is carried out to these standards, the Trust employs the services of an external monitoring organisation to provide assurance. Your study may be randomly selected for audit at any time, and you must co-operate with the auditors.

The duration of Trust approval extends to the date specified in the R&D application form. Action may be taken to suspend Trust approval if the research is not run in accordance with RGF or ICH-GCP standards, or following recommendations from the auditors. Research must commence within two years of the REC approval date and within six months of NHS Permission.

I wish you well with your project. Please do not hesitate to contact me should you need any guidance or assistance.

Yours sincerely

N Embury

Natassia Embury
RM&G Facilitator

Enc: PI Agreement

Cc: Dr Helen Rostill, Head of Psychological Services for CAMHS

Appendix Seven

Ethical approval guidelines when conducting research with staff

Does my project require review by a Research Ethics Committee?

National Research Ethics Service

Research involving staff

REC review is not normally required for research involving NHS or social care staff recruited as research participants by virtue of their professional role.

Exceptionally, the Research Ethics Service may accept an application for review of research involving staff at the request of the sponsor, chief investigator or host organisation, where it agrees that the proposal raises material ethical issues. Agreement should be sought from the responsible operational manager for the local REC centre prior to submission of the application. Requests should be sent by email, including a summary of the research proposal (maximum one page) and explanation of why the project raises significant issues, which cannot be managed routinely in accordance with established guidelines and good practice, and requires ethical consideration and advice from a REC.

Contact points for REC operational managers are at http://www.nres.nhs.uk/contacts/nres-office-and-departmental-contact-details/

Appendix Eight:

Participant Information Sheet

Coventry University
Priory Street, Coventry CV1 5FB
Telephone 024 7688 8328
Fax 024 7688 8702

Programme Director
Doctorate Course in Clinical Psychology
Dr Eve Knight
BSc Clin.Psy.D. CPsychol

THE UNIVERSITY OF WARWICK

Coventry University

Coventry and Warwickshire NHS
Partnership Trust

Motherhood and the impact on the therapeutic relationship: A qualitative study of therapists in Child and Adolescent Mental Health Services

PARTICIPANT INFORMATION SHEET – VERSION 3 (May 2012)

I would like to invite you to take part in my research study. Before you decide I would like you to understand why the research is being done and what it would involve for you. I will go through the information sheet with you and answer any questions you have. I'd suggest this should take about 10 minutes. Talk to others about the study if you wish.

Part 1 tells you the purpose of this study and what will happen to you if you take part.

Part 2 gives you more detailed information about the conduct of the study.

Ask me if there is anything that is not clear.

PART 1

What is the purpose of the study?

The main aim of this study is to focus on the therapist's own experience of motherhood and its impact on the therapeutic relationship. The study will also consider how the therapist's clinical practice may have changed as a result of motherhood and how they have sought support and promoted self-care since becoming a mother. These research questions rise directly out of gaps in the current literature base, which has a focus on pregnancy, and therefore fails to acknowledge the ongoing impact of motherhood on clinical work and in particular the therapeutic relationship. It is anticipated that the study will be completed by May 2013.

Why have I been invited?

The study will involve interviewing ten clinical psychologists, psychological therapists or psychoanalysts who are also mothers and who work within Child and Adolescent Mental Health Services in Coventry and Warwickshire Partnership Trust.

Dean of Faculty of Health and Life Sciences
Dr Linda Merriman Mphil PhD DpodM CertEd Coventry University Priory Street Coventry CV1 5FB Tel 024 7679 5805

Head of Department of Psychology
Professor James Tresilian BSc PhD University of Warwick Coventry CV4 7AL Tel 024 7657 3009

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Do I have to take part?

It is up to you to decide to join the study. We will describe the study and go through this information sheet. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason. This would not affect your employment.

What will I have to do?

Taking part in this study will involve one face to face interview, lasting approximately one to one and a half hours. All interviews will be recorded and the data will be transcribed verbatim.

What are the possible disadvantages or risks of taking part?

It is possible that taking part in this study could raise potentially distressing or challenging issues for the participants. In the unlikely event of this occurring participants can contact IAPT services for staff, for additional support.

What are the possible benefits of taking part?

While there is no direct individual benefit for participants taking part in this study, it is hoped that the results will contribute to the existing body of literature on the impact of motherhood on the therapeutic relationship and clinical practice within the field of psychology.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

Will my taking part in the study be kept confidential?

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

PART 2

What will happen if I don't want to carry on with the study?

You are free to withdraw from the study until the results are submitted for publication. All information you have provided up to the point of withdrawal will be removed from the study. Withdrawal from the study will not affect your employment.

What if there's a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions (Sharla Lawrence (Chief Investigator on 07841 923721 or Jo Kucharska (Academic Supervisor) on 02476888328). If you remain unhappy and wish to complain formally, you can do this via the NHS Complaints Procedure. Details can be obtained from the Customer Service Department of Coventry & Warwickshire Partnership Trust on 0800 212445

In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against Coventry University or Coventry and Warwickshire Partnership Trust but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you.

Will my taking part in this study be kept confidential?

All data will be recorded, stored and maintained in a way that eliminates the possibility of inadvertent disclosure. All participants will be allocated an identification code and this code will be used on all documentation relating to the research. The data will be securely stored either as password protected computer files or in a locked cabinet and will be destroyed after seven years following data protection guidelines. All data will be edited for anonymity although verbatim interview abstracts will be included in published reports with identifying information removed. Participants have the right to see the information held about them and have any mistakes corrected.

What will happen to the results of the research study?

All participants will be provided with a transcript of their interview upon request. It is anticipated that the results will be disseminated locally through the Coventry and Warwickshire Partnership Trust and submitted for publication in appropriate psychological journals. Participants can obtain a copy of the final report, upon request.

Who is organising and funding the research?

This study is being undertaken as part of the academic requirements for the Doctorate in Clinical Psychology at Coventry University.

Contact point for further information

For further information or for any additional enquiries, please contact Sharla Lawrence at lawren11@uni.coventry.ac.uk or 07841 923721

This research study has been reviewed and given approval to proceed by the Research and Development department of Coventry & Warwickshire Partnership Trust.

Appendix Nine

Participant Consent Form

Priory Street, Coventry CV1 5FB
Telephone 024 7688 8328
Fax 024 7688 8702

Programme Director
Doctorate Course in Clinical Psychology
Dr Eve Knight
BSc Clin.Psy.D. CPsychol

Participant Identification Number for this study:

THE UNIVERSITY OF WARWICK

Coventry University

Coventry and Warwickshire NHS
Partnership Trust

Motherhood and the impact on the therapeutic relationship: A qualitative study of therapists in Child and Adolescent Mental Health Services (Version 1 – July 2012)

CONSENT FORM

Name of Researcher: Sharla Lawrence

	Please initial box
1) I confirm that I have read and understand the information sheet dated May 2012 (version 3) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2) I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my employment or legal rights being affected.	
3) I understand that data collected during the study will only be looked at by the Chief Investigator. Anonymised transcripts of the data collected may also be seen by the supervising team.	
4) I agree to anonymised excerpts from my interview transcript being quoted verbatim in reports and publications related to the study.	
5) I agree to take part in the above study.	

Dean of Faculty of Health and Life Sciences
Dr Linda Merriman Mphil PhD DpodM CertEd Coventry University Priory Street Coventry CV1 5FB Tel 024 7679 5805

Head of Department of Psychology
Professor James Tresilian BSc PhD University of Warwick Coventry CV4 7AL Tel 024 7657 3009

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Participant Identification Number for this study:

Name of participant: _____

Date: _____

Signature: _____

Name of person taking consent: _____

Date: _____

Signature: _____

When completed: 1 for participant; 1 for researcher site file

Appendix Ten

Interview Schedule

Motherhood and the impact on the therapeutic relationship: A qualitative study of therapists in Child and Adolescent Mental Health Services (Version 2)

INTERVIEW SCHEDULE

1) Since having children, how do you feel that the way you relate to the parents you are working with, has changed?

2) How do you feel the way you relate to the children you are working with has changed?

3) How do you feel that any other aspects of your clinical practice have changed since having children (i.e. Interface with schools or other systems, the way you work, or the clinical area that you work in)?

4) Have families ever asked you if you have children?

5) What factors affect how you answer?

6) Do you ever volunteer the information that you have children without families asking?

7) What is your understanding of the 'therapeutic relationship' within Child and Adolescent Mental Health Services?

8) How do you feel that this has changed since having children?

9) How do you manage the competing demands of work and home life priorities?

10) Have there been any times when something happening at home has impacted on your clinical practice? Can you tell me about that?

11) How do you ensure you access sufficient support and self care?

12) Is there anything else you would like to add?

Appendix Eleven

Demographic Questionnaire

Coventry and Warwickshire NHS Partnership Trust

Motherhood and the impact on the therapeutic relationship: A qualitative study of therapists in Child and Adolescent Mental Health Services (Version 2 – Feb 2012)

DEMOGRAPHIC QUESTIONNAIRE

Participant Identification Number: _____

Clinical area currently work in:

_____
_____
_____

Approximate age and gender mix of your current caseload:

_____
_____
_____

Clinical area worked in prior to having children (if different): -

_____
_____
_____

Do you work in the same geographical area that you live?

_____

Date when started training:

_____

Date when qualified:

_____

Date when had children:

_____

How many children do you have? -

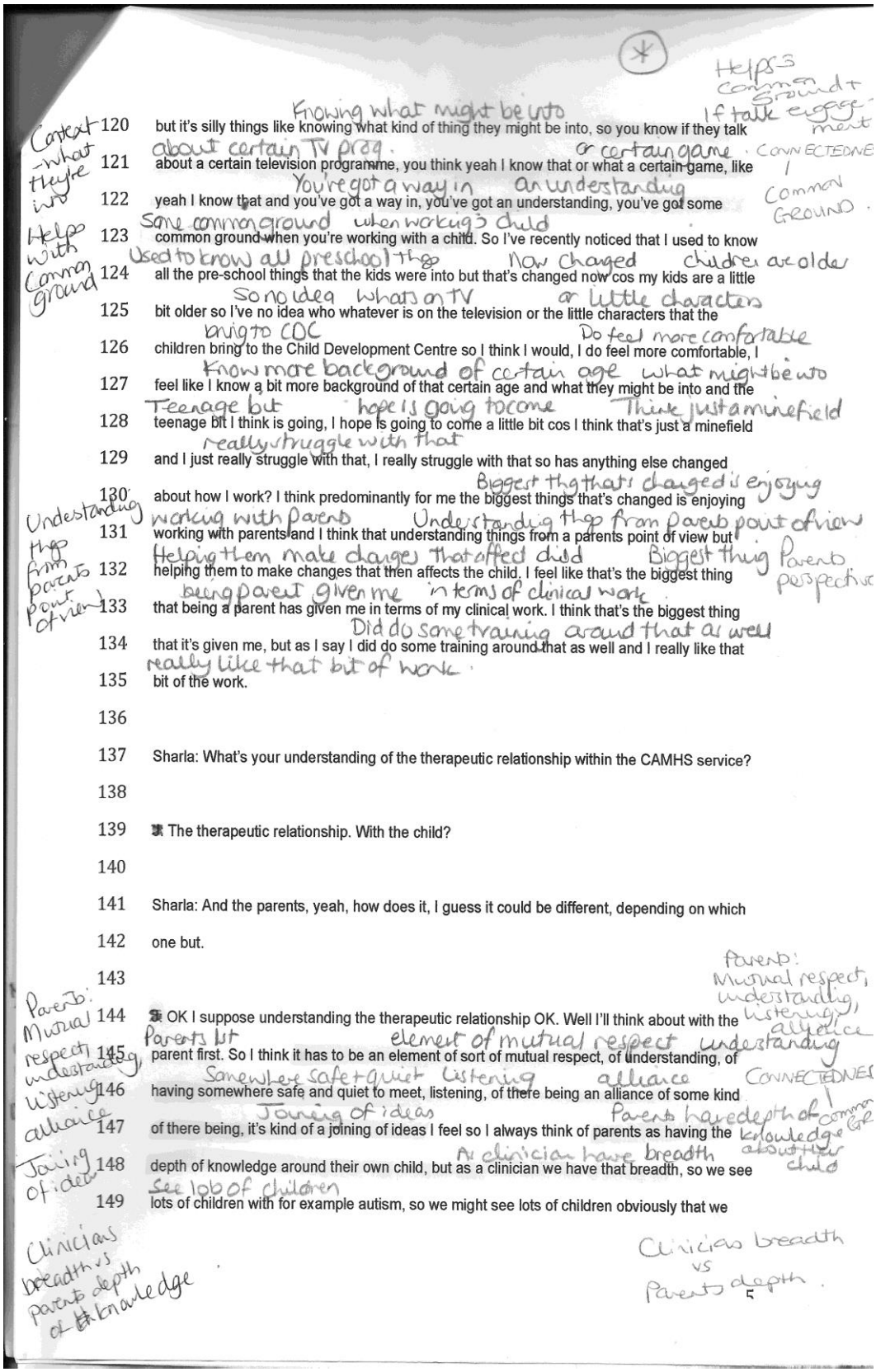
_____

How old are they? _____

Appendix Twelve

Examples of Analysis: Excerpts from four transcripts

Participant 6 – 'Common Ground'



but it's silly things like knowing what kind of thing they might be into, so you know if they talk about a certain television programme, you think yeah I know that or what a certain game, like yeah I know that and you've got a way in, you've got an understanding, you've got some common ground when you're working with a child. So I've recently noticed that I used to know all the pre-school things that the kids were into but that's changed now cos my kids are a little bit older so I've no idea who whatever is on the television or the little characters that the children bring to the Child Development Centre so I think I would, I do feel more comfortable, I feel like I know a bit more background of that certain age and what they might be into and the teenage bit I think is going, I hope is going to come a little bit cos I think that's just a minefield and I just really struggle with that, I really struggle with that so has anything else changed about how I work? I think predominantly for me the biggest things that's changed is enjoying working with parents and I think that understanding things from a parents point of view but helping them to make changes that then affects the child. I feel like that's the biggest thing that being a parent has given me in terms of my clinical work. I think that's the biggest thing that it's given me, but as I say I did do some training around that as well and I really like that bit of the work.

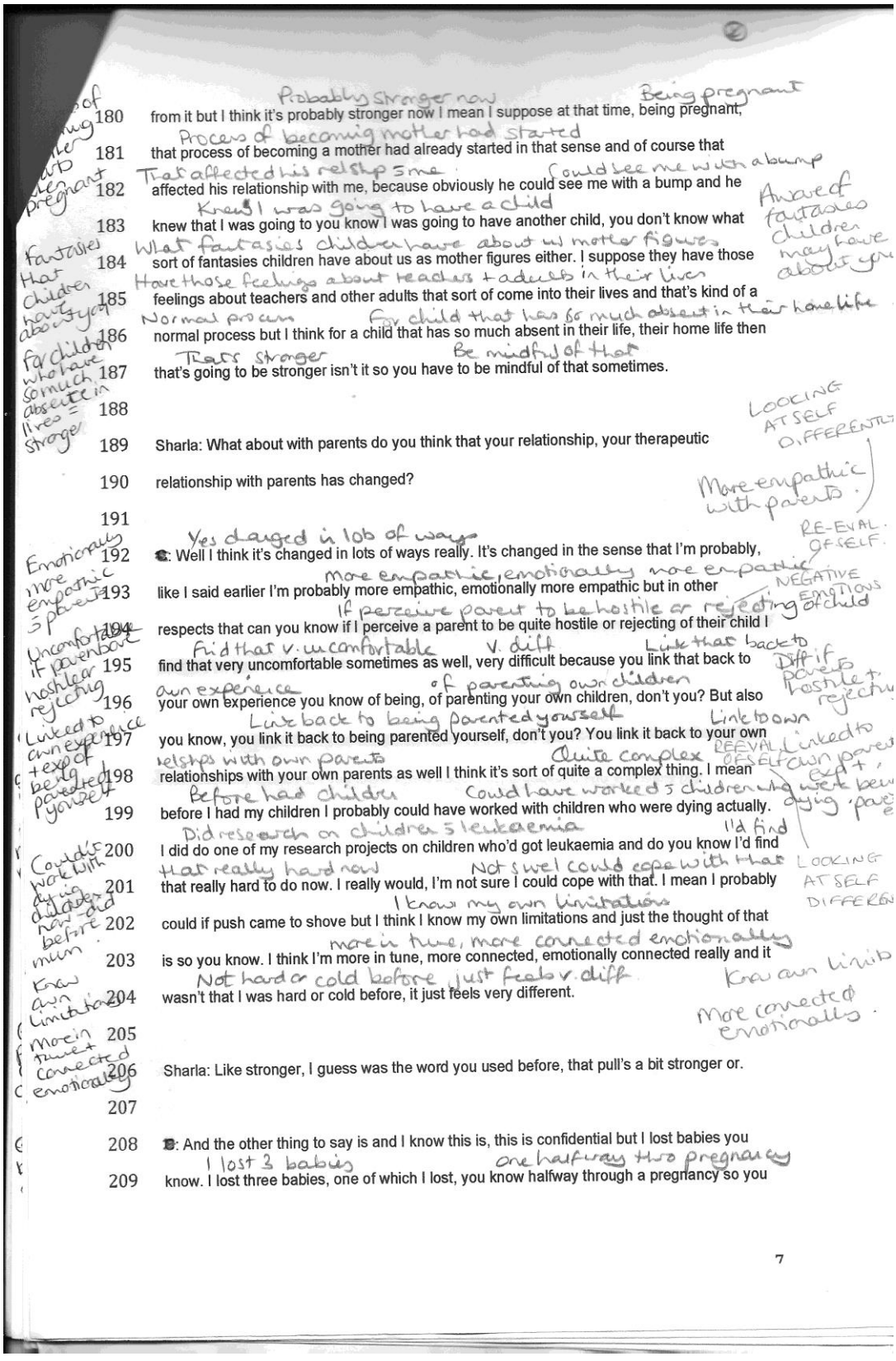
Sharla: What's your understanding of the therapeutic relationship within the CAMHS service?

The therapeutic relationship. With the child?

Sharla: And the parents, yeah, how does it, I guess it could be different, depending on which one but.

OK I suppose understanding the therapeutic relationship OK. Well I'll think about with the parent first. So I think it has to be an element of sort of mutual respect, of understanding, of having somewhere safe and quiet to meet, listening, of there being an alliance of some kind of there being, it's kind of a joining of ideas I feel so I always think of parents as having the depth of knowledge around their own child, but as a clinician we have that breadth, so we see lots of children with for example autism, so we might see lots of children obviously that we

Participant 8 – 'Looking at Myself Differently'



from it but I think it's probably stronger now I mean I suppose at that time, being pregnant,

that process of becoming a mother had already started in that sense and of course that

affected his relationship with me, because obviously he could see me with a bump and he

knew that I was going to you know I was going to have another child, you don't know what

sort of fantasies children have about us as mother figures either. I suppose they have those

feelings about teachers and other adults that sort of come into their lives and that's kind of a

normal process but I think for a child that has so much absent in their life, their home life then

that's going to be stronger isn't it so you have to be mindful of that sometimes.

Sharla: What about with parents do you think that your relationship, your therapeutic

relationship with parents has changed?

: Well I think it's changed in lots of ways really. It's changed in the sense that I'm probably,

like I said earlier I'm probably more empathic, emotionally more empathic but in other

respects that can you know if I perceive a parent to be quite hostile or rejecting of their child I

find that very uncomfortable sometimes as well, very difficult because you link that back to

your own experience you know of being, of parenting your own children, don't you? But also

you know, you link it back to being parented yourself, don't you? You link it back to your own

relationships with own parents relationships with your own parents as well I think it's sort of quite a complex thing. I mean

before I had my children I probably could have worked with children who were dying actually.

I did do one of my research projects on children who'd got leukaemia and do you know I'd find

that really hard to do now. I really would, I'm not sure I could cope with that. I mean I probably

could if push came to shove but I think I know my own limitations and just the thought of that

is so you know. I think I'm more in tune, more connected, emotionally connected really and it

wasn't that I was hard or cold before, it just feels very different.

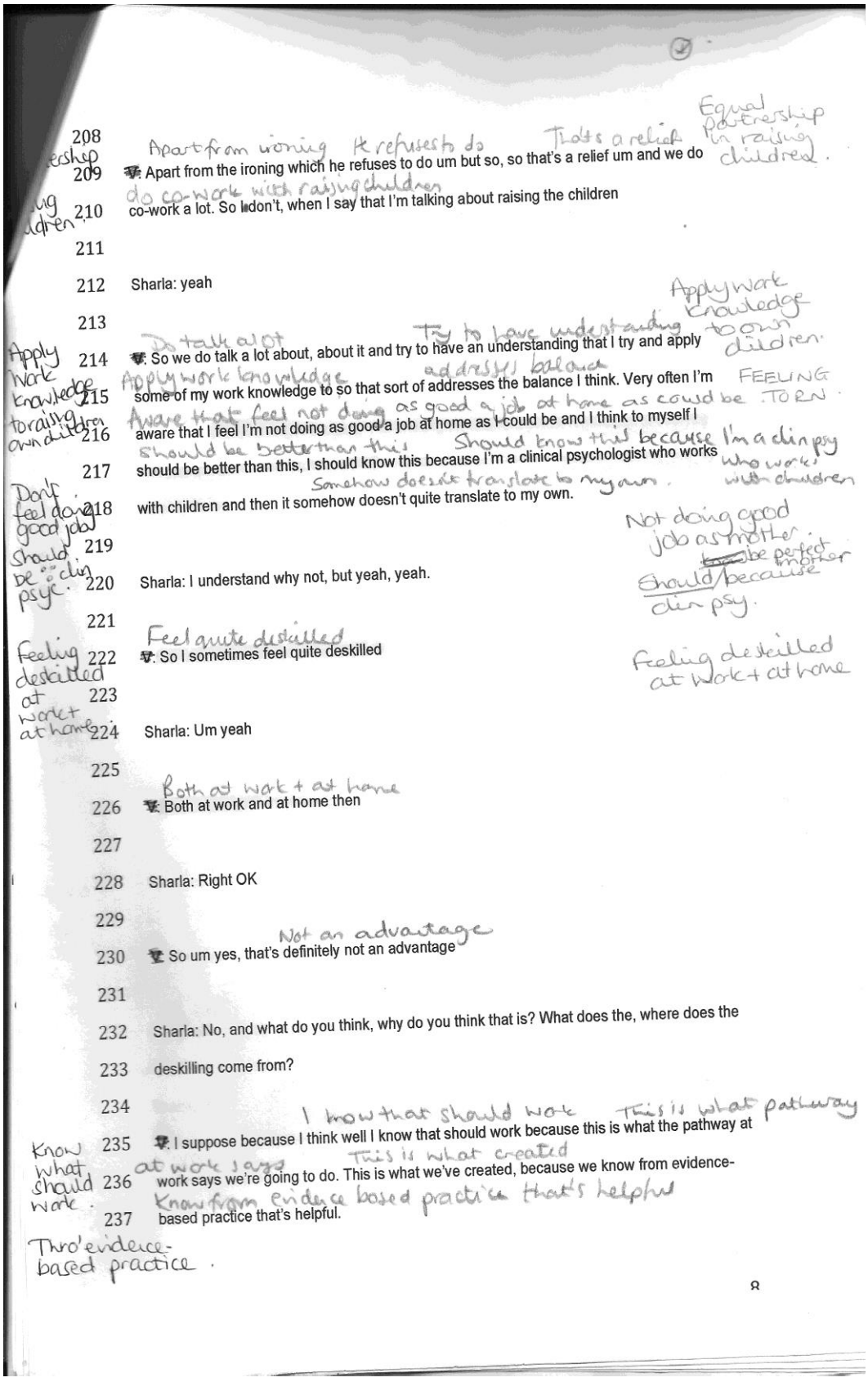
Sharla: Like stronger, I guess was the word you used before, that pull's a bit stronger or.

: And the other thing to say is and I know this is, this is confidential but I lost babies you

know. I lost three babies, one of which I lost, you know halfway through a pregnancy so you

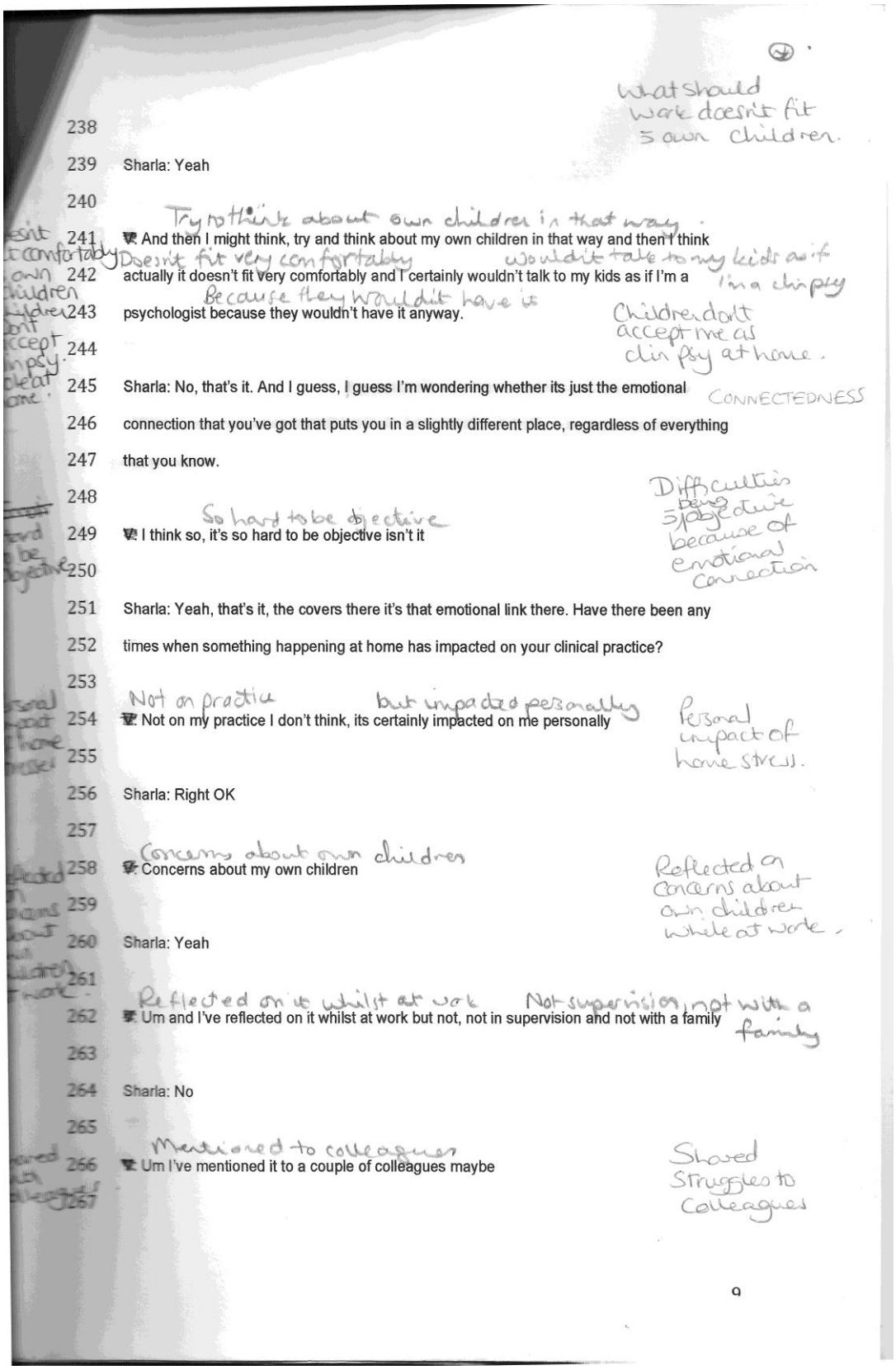
7

Participant 3 – 'Feeling Torn'



208
209 P: Apart from the ironing which he refuses to do um but so, so that's a relief um and we do
210 co-work a lot. So I don't, when I say that I'm talking about raising the children
211
212 Sharla: yeah
213
214 P: So we do talk a lot about, about it and try to have an understanding that I try and apply
215 some of my work knowledge to so that sort of addresses the balance I think. Very often I'm
216 aware that I feel I'm not doing as good a job at home as I could be and I think to myself I
217 should be better than this, I should know this because I'm a clinical psychologist who works
218 with children and then it somehow doesn't quite translate to my own.
219
220 Sharla: I understand why not, but yeah, yeah.
221
222 P: So I sometimes feel quite deskilled
223
224 Sharla: Um yeah
225
226 P: Both at work and at home then
227
228 Sharla: Right OK
229
230 P: So um yes, that's definitely not an advantage
231
232 Sharla: No, and what do you think, why do you think that is? What does the, where does the
233 deskilling come from?
234
235 P: I suppose because I think well I know that should work because this is what the pathway at
236 work says we're going to do. This is what we've created, because we know from evidence-
237 based practice that's helpful.

Participant 3 - 'Common Ground'



238
239 Sharla: Yeah
240
241 P: And then I might think, try and think about my own children in that way and then I think
242 actually it doesn't fit very comfortably and I certainly wouldn't talk to my kids as if I'm a
243 psychologist because they wouldn't have it anyway.
244
245 Sharla: No, that's it. And I guess, I guess I'm wondering whether its just the emotional
246 connection that you've got that puts you in a slightly different place, regardless of everything
247 that you know.
248
249 P: I think so, it's so hard to be objective isn't it
250
251 Sharla: Yeah, that's it, the covers there it's that emotional link there. Have there been any
252 times when something happening at home has impacted on your clinical practice?
253
254 P: Not on my practice I don't think, its certainly impacted on me personally
255
256 Sharla: Right OK
257
258 P: Concerns about my own children
259
260 Sharla: Yeah
261
262 P: Um and I've reflected on it whilst at work but not, not in supervision and not with a family
263
264 Sharla: No
265
266 P: Um I've mentioned it to a couple of colleagues maybe
267

What should work doesn't fit 5 own children.

Try to think about own children in that way.

Doesn't fit very comfortably

Wouldn't talk to my kids as if I'm a clin psy

Because they wouldn't have it

Children don't accept me as clin psy at home.

CONNECTEDNESS

Difficulties being objective because of emotional connection

So hard to be objective

Not on practice

but impacted personally

Personal impact of home stress.

Concerns about own children

Reflected on Concerns about own children while at work.

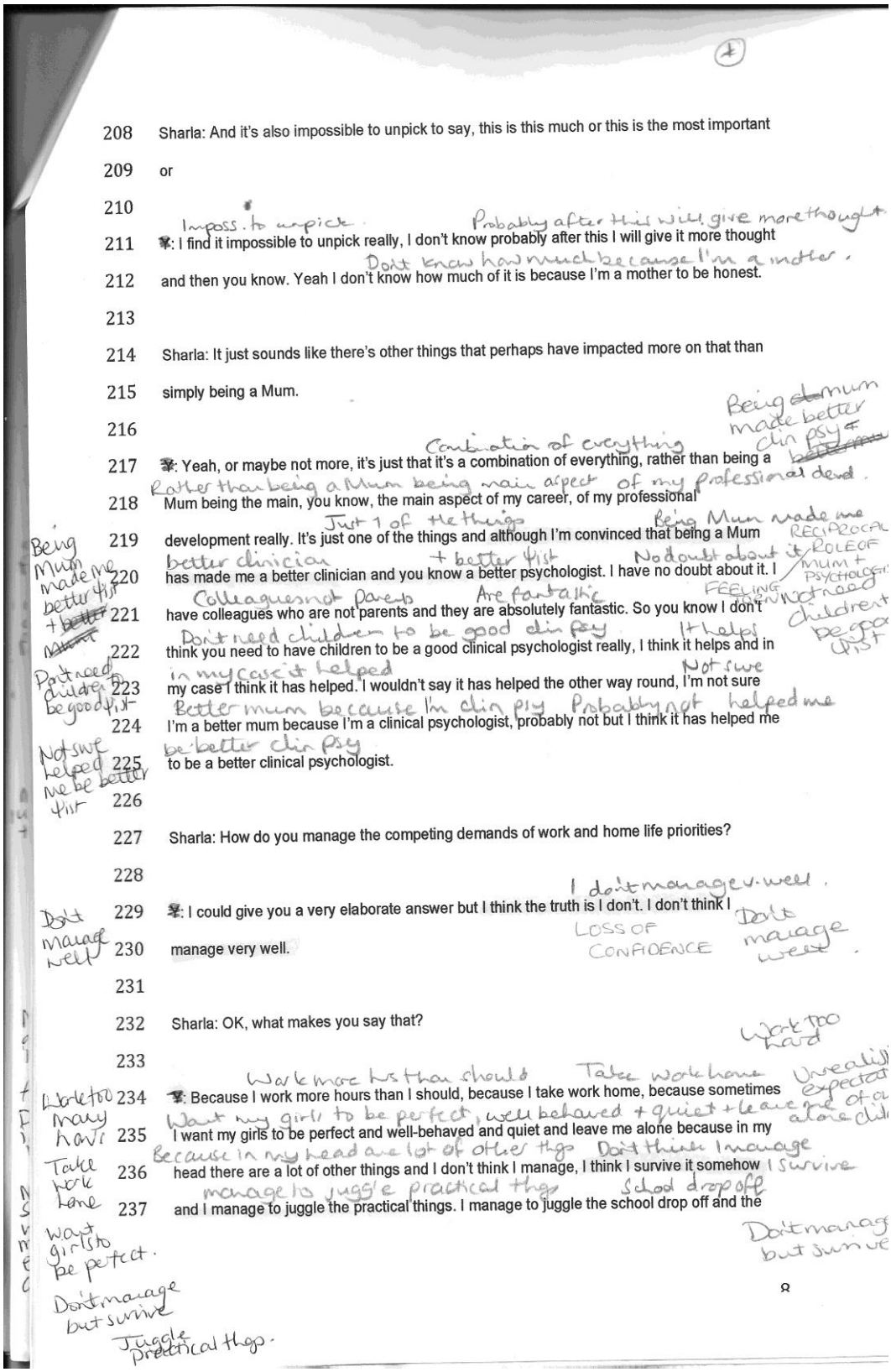
Reflected on it whilst at work

Not supervision, not with a family

Mentioned to colleagues

Shared Struggles to Colleagues

Participant 7: 'Feeling Torn'



208 Sharla: And it's also impossible to unpick to say, this is this much or this is the most important

209 or

210

211 S: I find it impossible to unpick really, I don't know probably after this I will give it more thought

212 and then you know. Yeah I don't know how much of it is because I'm a mother to be honest.

213

214 Sharla: It just sounds like there's other things that perhaps have impacted more on that than

215 simply being a Mum.

216

217 S: Yeah, or maybe not more, it's just that it's a combination of everything, rather than being a

218 Mum being the main, you know, the main aspect of my career, of my professional

219 development really. It's just one of the things and although I'm convinced that being a Mum

220 has made me a better clinician and you know a better psychologist. I have no doubt about it. I

221 have colleagues who are not parents and they are absolutely fantastic. So you know I don't

222 think you need to have children to be a good clinical psychologist really, I think it helps and in

223 my case I think it has helped. I wouldn't say it has helped the other way round, I'm not sure

224 I'm a better mum because I'm a clinical psychologist, probably not but I think it has helped me

225 to be a better clinical psychologist.

226

227 Sharla: How do you manage the competing demands of work and home life priorities?

228

229 S: I could give you a very elaborate answer but I think the truth is I don't. I don't think I

230 manage very well.

231

232 Sharla: OK, what makes you say that?

233

234 S: Because I work more hours than I should, because I take work home, because sometimes

235 I want my girls to be perfect and well-behaved and quiet and leave me alone because in my

236 head there are a lot of other things and I don't think I manage, I think I survive it somehow

237 and I manage to juggle the practical things. I manage to juggle the school drop off and the

Appendix Thirteen

Emergent Themes for all participants

Participant 1

Categories of emergent themes	Emergent themes	Line Numbers	Potential subthemes
Working with parents	Impact of parents past relationships/ experience of being parenting	241-243	Connectedness with parents
	Able to share experience with others	442-445	
	Aware of parents feelings of guilt	30	
	Being a parent = implicit understanding	152	
	Realise children are forgiving of mistakes	449	Connectedness with children
Working with families in clinical practice	Repeating patterns of intergenerational family scripts	247-263	Connectedness with parents
	Psychologists as a role model for parents	54, 230	Reciprocal roles of mother and psychologist
	Positive relationship modelling	234-237	
	Working with things that echo in own life	350-354	Assumption of shared experience
Why clients ask about parent status	Knowing parent status can get in way of therapeutic relationship	205-207	Why parents ask
	Parents asking linked to own resistance	175-176	
	Professionals should have all the answers	227-229	
	Do you understand?	180-181	
Working with children	Glimpse into childs inner world	138-139	Connectedness with children
Systemic Issues	Increased familiarity with school systems and academic expectations	89-90	Assumption of shared experience
	Understanding elements of successful family interactions	119-122	
Reciprocal nature of roles of mother and psychologist	Enriched reciprocal effect	479-480	Reciprocal roles of mother and psychologist
We as parents	"We as parents"	147-148	We as parents
Managing Demands	Luck in managing demands	285	Feeling torn
	Supportive networks	400	
Parenthood is not essential	Being a parent not an essential part of being a clinician	161-166	Connectedness
Prioritising Children	Choice to prioritise children	289-293	Choice between work and family
	Children 1st = resentment?	419	
Impact on Self	Guilt if not always available	460-462	Feeling torn
	Need to be mindful of own feelings (anger)	467-475	Negative emotions
	Activation of unprocessed issues	379-380	
	Not available for children =	305-306	Feeling torn

	Guilt (truly prioritised?)		
What is the therapeutic relationship?	Alliance – shared goals/ understanding	223-225	Therapeutic relationship in CAMHS
Better understanding of theory	Experience & theory = increased knowledge	93-94	Connectedness
	Learn from own children; more than literature	332-333	

Participant 2

Categories of emergent themes	Emergent themes	Line Numbers	Potential subthemes
Working with parents	Appreciate parental perspective once parent	37-38	Connectedness with parents
	Increasing understanding of parental demands	36-37	
Why clients ask about parent status	Unexpected question (resistant to thinking about it)	15	Why parents ask
Working with children	Being mother = focused on voice of the child	149-150	Connectedness with children
	Understand multiple demands of teenagers if parent to them	66	
Systemic Issues	Reduced sympathy for teachers	93-94	Negative emotions
Reciprocal nature of roles of mother and psychologist	Feel child had limited impact on working life	101	Reciprocal roles of mother and psychologist
Managing Demands	Lucky	229-230	Feeling torn
	Didn't manage well with competing demands	163	
	Supportive network	164-165, 230	
	Colleagues with similar struggles	232-234	Assumption of shared experience
	Sharing own struggles	236-237	
Prioritising Children	Guilt induced gifts	175-177	Feeling torn
Impact on Self	Regrets – making up for lost time	169-170	Negative emotions
	Shouldn't be hard on yourself as parent	172-173	Re-evaluation of the self
What is the therapeutic relationship?	Systemic therapeutic relationship	120	Therapeutic relationship in CAMHS
	Influence of training on understanding therapeutic relationship	144-146	
Better Understanding of Theory	Similar age children = mini control group	60-61	Connectedness with children
Experience versus being a mother	Influence of ageing	146-148	Re-evaluation of self

Participant 3

Categories of emergent themes	Emergent themes	Line Numbers	Potential subthemes
Working with parents	More depth of appreciation of parenting	13-14	Connectedness with parents
	Appreciate demands of	38-39	

	parenting once experienced it		
	Basic parental skill lacking = frustration with parents	136-137	Negative emotions
	Increased empathy with parents	41	Connectedness with parents
	Parents' role to provide what need	147	Negative emotions
Working with families in clinical practice	Changed way I practice	181-182	Reciprocal role of mother and psychologist
	Client centred therapeutic approach	116	Connectedness
	Offer alternative view of situation	105-106	Link between shared experience and re-evaluation of self
Working with children	Easily slip into other natural role as mother	77	Connectedness with children
	More comfortable and confident with children	186	
	Tighten boundaries if working with children of similar age	62-63	Link between shared experience and re-evaluation of self
Systemic Issues	Own experience of shortfall of schools = empathy	90-93	Assumption of shared experience
Reciprocal nature of roles of psychologist and mother	More you know, the less you feel you know	423-424	Reciprocal role of mother and psychologist
	Nothing prepares you, not even this job	466	
	What should work doesn't fit with own children	241-242	Feeling challenged by parenting
	Apply work knowledge to own children	214-215	Reciprocal role of mother and psychologist
	Should be perfect mother because clinical psychologist	217-218	
	Feeling deskilled at work and at home	222-226	
We as Parents	Sense it from way speak to parents	20	We as parents
Managing Demands	Supervision	305	Re-evaluation of self
	Mutually supportive relationship with husband	330-331	
	Shared struggles with colleagues	305-306, 266	
Parenthood not essential	Being parent not essential in this work	414	Connectedness
Impact on self	Too close to home	75	Assumption of shared experience
	Wouldn't be normal if didn't find it difficult at times	473	Feeling challenged by parenting

	Tightened boundaries if working with children of similar age	62-63	Assumption of shared experience
	Difficulties with being objective because of emotional connection	249	
Better understanding of theory	Being parent not changed theoretical understanding	194	Connectedness
	CAMHS not healthy reference point	344	
Experience versus being a mother	Impact of ageing	356-359	Re-evaluation of self

Participant 4

Categories of emergent themes	Emergent themes	Line Numbers	Potential subthemes
Working with parents	Comparison of self to other parents	58-59	Assumption of shared experience
	Be reflective and don't assume shared struggles	401-402	
	Being able to enter the world of parenthood	138	Connectedness with parents
	Increased empathy, understanding and tolerance of parent pressures	57-58	
Working with families in clinical practice	Maintain professional boundaries	176-178	Connectedness
Why clients ask about parent status	Credibility	22-23	Why parents ask
	Competitiveness	23	
Working with children	Help child understand my role	200-201	Connectedness with children
	Meeting children at their own level	93	
Systemic Issues	Relationships with professionals from parents' perspective	140	Connectedness
Reciprocal nature of roles of psychologist and mother	Use of theory when parenting own children	224-226	Reciprocal roles of mother and psychologist
	Learn from parenting and apply clinically	292-293	
	Better clinical psychologist now	400	
We as parents	Vague answers	24	We as parents
	Use of stories/ experiences in therapy	30	
Managing demands	Be mindful of children taking on inappropriate adult roles	360-361	Feeling challenged by parenting
	Not always aware of stress level, can leak through	274-275	Negative emotions
	Making most of professional networks	331-332	Feeling challenged by parenting
	Being part of team	339	
Parenthood not essential	Being clinical psychologist and parent helped me to relate but not essential	396-400	Connectedness
Impact on self	Influenced clinical interests	211-212	Reciprocal roles of mother and

			psychologist
	Use of humour re difficult issues	114	Negative emotions
What is the therapeutic relationship?	Containing environment	181	Therapeutic relationship in CAMHS
Better understanding of theory	Insight helps think about things differently	145	Connectedness
Experience versus being a mother	Gaining support when more experienced harder	326-327	Re-evaluation of self

Participant 5

Categories of emergent themes	Emergent themes	Line Numbers	Potential subthemes
Working with parents	Universal issues of parenting	578	Connectedness with parents
	Less tolerance to parents	64	Negative Emotions
Why clients ask about parent status	Removes separateness between parents and clinicians	523-526	Why parents ask
Working with children	Aware of context around children	124-126	Connectedness with children
	More creative with children's interventions	237-239	
Systemic Issues	Highlighted concerns about education provision	154-155	Assumption of shared experience
	Consolidated my views around education	184	
	Don't have realistic expectations	155-156	
Reciprocal nature of roles of psychologist and mother	Opportunity to experiment on own children	277	Reciprocal roles of mother and psychologist
	Through own children, their peers and relationships with other professionals	253-260	
We as parents	Implies I have children	517-521	We as parents
Managing Demands	Supportive colleagues	364-365	Feeling torn
	Accommodating employers	324-325	
	It's tough but do it anyway	76-77	Negative Emotions
	Things nothing to do with work or children	550-551	Choice between work and family
	OK if stress only in 1 sphere of life	456-457	Feeling challenged by parenting
Prioritising Children	Children come first	319-320	Choice between work and family
Impact on Self	Can all become too much	442-443	Negative Emotions Re-evaluation of self
	Do a lot of taking care of people = draining	350-351	
What is the therapeutic relationship?	Supportive, open, positive, validating	221-222	Therapeutic relationship in CAMHS
	Different skills but essence of therapeutic relationship same	232-233	

Participant 6

Categories of emergent themes	Emergent themes	Line numbers	Potential subthemes
Working with parents	I always do what's right but I don't always get it right	191-193	Connectedness with parents
	Importance of parents being heard	154	
Working with families in clinical practice	Clinicians breadth versus parents depth	147-148	Connectedness
	Have to know, don't know it all	223-224	
	Influence of training	51-53	
	More solution-focused	353-355	
Why clients ask about parent status	Influenced by model of intervention	17-20	Why parents ask
	Perceived expectations of the psychologist role	351-352	
Working with children	Helps with common ground and engagement	120-123	Connectedness with children
	Difficulties with teenage perspective	119	
Systemic Issues	Familiarity with the education system	101-103	Assumption of shared experience
Reciprocal nature of roles of psychologist and mother	2 way interaction (parent & work)	107	Reciprocal roles of mother and psychologist
	Balance different parts of self (mum & psychologist)	312-313	
We as parents	Allude to the fact am a parent	35-37	We as parents
Managing demands	Fortunate	233	Choice between work and family
	Negotiated work hours	279-281	
	Reasonable balance because of support at home	256-257	
	Supportive colleagues and organisation	238-239, 289, 277	
Prioritising Children	Work around my children	233, 272	Choice between work and family
Impact on self	Not always emotionally available to family	244-246	Feeling torn
	Felt too close to home	284	Assumption of shared experience
	Knowing own limitations	291-293	Re-evaluation of self
What is the therapeutic relationship?	Therapeutic alliance = aiming for change	167-168	Therapeutic relationship in CAMHS
	Parents: mutual respect, understanding, listening, alliance	145-147	

Participant 7

Categories of emergent themes	Emergent themes	Line numbers	Potential subthemes
Working with families in clinical practice	Learned from colleagues	184-185	Connectedness
Why clients ask about	Do you understand?	20-22	Why parents

parent status			ask
Working with children	Helps with engagement	108-109	Connectedness with children
Reciprocal roles of psychologist and mother	Being a mum made a better clinical psychologist	219-220	Reciprocal roles of mother and psychologist
	Doing neither role effectively	295-296	
	Being clinical psychologist affects me as a Mum	337-338	
Managing demands	Don't manage but survive	236-237, 229-230	Feeling torn
	Stress at home impacts personality and as clinician	259-260	Negative emotions
	Don't know if people can find balance	301-302	Feeling torn
	Good social network	322	
	Lucky	315	
	Variable in managing	291	
Parenthood not essential	Don't need to have children to be a good psychologist	221-223	Connectedness
Impact on self	Being a mother is part of complex set of influences on practice	203-206	Reciprocal roles of mother and psychologist
What is the therapeutic relationship?	Therapeutic relationship different with different age children	154-159	Therapeutic relationship in CAMHS
Better understanding of theory	Aware of limitations of theory	59-65	Connectedness
Experience versus being a mother	Became more sensitive with experience, or because of being a mother	85-86	Reciprocal roles of mother and psychologist

Participant 8

Categories of emergent themes	Emergent themes	Line numbers	Potential subthemes
Working with parents	Awareness of practical demands of parenting	75-77	Connectedness with parents
	Mindful of projecting own feelings of motherhood onto others	321-323	
	Negative impact of parent-child relationship if rejecting	65-67	
Working with families in clinical practice	Take away stigma of parenting struggles	46	Feeling challenged by parenting
	Everybody's different; no hard and fast rules	337	
Why clients ask about parent status	Barrier to therapeutic relationship	9-10	Why parents ask
Working with children	Urge to protect and mother some children	166-168	Connectedness with children
Reciprocal roles of psychologist and mother	Children aware of my preoccupations	245-247, 258-259	Reciprocal roles of mother and psychologist
Managing demands	Support should be available from organisations	276-278	Choice between work and family
	Ideal: supportive, flexible	282-286	

	management		
	Don't access formal psychological support	304-305	
	Supportive partner and family	303-304	
	Use supervision to address this	323	
Impact on self	Linked to own parenting experience and being parented	197-198	Re-evaluation of self
	Aware of fantasies children may have about you	183-184	
Better understanding of theory	Aware of broader spectrum of normal development	103-106	Connectedness

Participant 9

Categories of emergent themes	Emergent themes	Line numbers	Potential subthemes
Working with parents	Not changed advice I give	54-56	Connectedness with parents
	Parents experience more accessible	72	
Working with families in clinical practice	Tightened up boundaries	160-161	Connectedness
	Not there to be a friend	187-188	
Why clients ask about parent status	Do you understand?	17-18	Why parents ask
	Parents friendliness as defence	228-233	
	Acknowledging family as unit or want space for self or want to join you as professional	233-235	
Working with children	Can reflect on experience without being part of their peer group	213-215	Connectedness with children
	Generous and resourceful adolescent peer group	94-96	
	Vocabulary for speaking to children	77-79	
Reciprocal roles of psychologist and mother	Own children counterbalance effects of meeting young people in clinical practice	100-106	Reciprocal roles of mother and psychologist
	Make self available to others children	287-290	Choice between work and family
	Lots of children in lives by proxy	305-307	
Managing demands	Important to do things that use body	364-367	Feeling torn
	Get out of balance you're in trouble	370-371	
	External supervision – helps with process of reflecting	360-361	
Parenthood not essential	Do you have to share experience to empathise?	20-21	Connectedness
Prioritising children	Own children versus clients	300-304	Feeling torn
What is the therapeutic relationship?	Friendly unboundaried relationship less helpful	198-199	Therapeutic relationship in CAMHS
	Thoughtfulness and reflective practice	180-181	
Better understanding of theory	Intellectual thinking hasn't changed	251-252	Connectedness

	Alive rather than theoretical	70-71	
Experience versus being a mother	Mother versus maturing as a professional	45-46	Re-evaluation of self
Impact of self	Hard to do this work when chronically sleep deprived	346-348	Feeling challenged
	Mix up personal and professional persona	153-155	
	Becoming more emotionally complex	252	