Portfolio Volume 1: Major Research Project

Personal Constructions of the Mother role: Perceptions of Mothers in Health Care

Volume 1

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ABSTRACT

This study aimed to explore the personal constructs of mothers in health care, their own role, that of the doctors and how they felt the doctors they consulted construed them in their role. In addition, the study aimed to explore how these construals influenced whether a consultation was considered satisfactory or less than satisfactory. The preferred poles relating to the role of mothers identified by participants across the study included being calm, in control, nurturing, attentive, knowledgeable and confident. How participants felt perceived by doctors was reflected in a number of constructs including whether they were nurturing, calm and were able to balance the needs of the child with the demands of the consultation. Participants in the study overall experienced more satisfaction with doctors they perceived as warm, empathic, compassionate, competent and attentive. Satisfaction also correlated with feeling in control, knowledgeable, calm and being able to attend to the doctor whilst demonstrating care and nurturance to their child. Satisfactory experiences were linked in the study, to feeling validated in their role, accurately anticipating the outcome of the consultation and a greater sense of mutual understanding with the doctors. The study offers an interesting reflection on the influence of both personal agency and societal factors on how the role of mothers is viewed. It also offers recommendations regarding how doctors may consult with mothers to develop a positive and productive interaction and outcome.

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1 INTRODUCTION

"There are things known and there are things unknown, and in between are the doors of perception" – Aldous Huxley

Motherhood is one of the most revered, criticized and scrutinized roles in society. It is a role of contradictions, often hailed as one of the most important in society whilst given little tangible recognition. Mothers are subject to demands of parenting rarely expected of fathers such as basic care, nurturance, organisation, health care, education and general management. Therefore, the question arises regarding how the role of mothers is perceived. Furthermore, how has this perception been maintained and what, in particular is the experience of mothers in society when they take their child to health care appointments?

1.1 Introduction

I will commence this thesis with an introduction to the personal and theoretical significance of the subject area. I will also explain the terms used frequently throughout the thesis. These reflections are important as they form my own construction of reality, the lens through which this research was conducted.

1.2 My Personal Position

As the mother of a child who requires regular medical appointments I have an interest based in lived experience. Through my own experiences I was motivated to explore those of other mothers. I believe lived experience is an advantage in exploring this area. It has been argued that the personal resonance of research serves to increase the quality of work produced (Salmon, 1997). The advantage of conducting research from this position is that as the researcher I am a "passionate knower" of the participants' experience; affording me a level of compassion and understanding about the knowledge received through the research process (Belenky, Clinchy, Goldberger & Tarule, 1986).

1.3 My Theoretical Position

My theoretical approach to this research aligns with feminist, personal constructivist and social constructionist positions.

Feminist research recognises women's accounts as valued and important, and advocates exploring and understanding this perspective through theories and constructs that give due consideration to them (Foss & Foss, 1991). The purpose of conducting feminist research includes achieving "epistemic empowerment" (Foss & Foss, 1994) that is to promote the knowledge and research of women.

Personal constructivism holds that there is a knowable external reality but that this reality is known to the observer through their own interpretations or constructions of it (Raskin, 2002), holding that interpretations of the external world and experiences are constructed relationally through language (Chiari & Nuzzo, 1996b) based on individual internal encounters with the world.

Social constructionism emphasizes that knowledge is culturally and historically understood through language and is context dependent (Burr, 1995). From this perspective the manner in which the social surroundings (Gergen, 1991) of individuals and the language in those contexts serves to construct a culturally dependent understanding of that which is being examined is of great importance when exploring a concept of such societal significance as motherhood.

It is my belief that individuals construct meaning about themselves and the world internally and individually as well as relationally through interactions, through which they anticipate events and make predictions about future experiences. Constructions are then shaped, changed and recreated by the sharing of realities with others.

1.4 Use of Language

In line with the social constructionist philosophy that meaning is created through language it is important to consider the terms used throughout this study.

1.4.1 Terms

1.4.1.1 Mothers

The term mother has been used in this study where an individual identifies as a mother and thus has constructed an understanding of this term in relation to her own identity. An alternative understanding of being a mother may reference gestation or a biological relationship. However, for the purpose of this study, where individuals self-identified as mothers they were eligible to participate.

1.4.1.2 Doctors

The term doctor is used to reference any medical practitioner who has achieved registration with the General Medical Council as a practicing doctor. Therefore the term relates to all doctors regardless of specialty.

1.4.1.3 Disability/ Disorder/Illness

Every care has been taken, in writing this thesis, to respect the experiences of those with health care needs. Invariably language used to describe these experiences will have differing connotations for different individuals. Noting that, *"*everyone's personal images of

illness are worth exploring*"* (Viney, p. 1983), it is with this ethos in mind that the terminology used by participants will be used in the study. Where existing literature is explored, terms within this literature will be used to view the research, as closely as possible, through the lens of the researchers.

1.5 Social Constructionism

Social constructionism holds that knowledge is constructed through relationships, social interactions and language within the historical and cultural context (Burr, 2015). The understanding developed through these social interactions becomes accepted and is thus considered to be 'truth' in a world where measurable entities are considered evidence of an empirically observable reality.

One key aspect of social constructionism is the critical approach towards the accepted status quo (Gergen, 1985).

1.5.1 The Social Construction of Motherhood

It is important to explore how the popular understanding of mothering has developed, historically, culturally and through psychological theory. In this section, the construction of the mother role is considered through these lenses.

1.5.2 Motherhood Historically

The modern concept of the 'good mother' has roots as far back as the 16th century. An examination of practices in Europe at this time shows the practice of executing women accused of witchcraft. Exemption from accusation came in the form of being a good, Christian wife and mother (Thurer, 1994). The rise of capitalism led to an increased divide between the wealthy and the poor and a move towards private houses. Thus, the beginnings of the nuclear family were born. The importance of marriage was promoted by eminent Protestants such as Martin Luther and the role of women as wives, mothers and caretakers of the household developed. The order of a patriarchal society was cemented by references to God, the King and the father as leaders. (Thurer, 1994).

With the industrial revolution in the 18th century came the move towards manufacturing and growth within the cities, further consolidating the role of women as mothers who stayed in the home as fathers began the habit of daily working, serving to exaggerate gendered roles (Thurer, 1994).

The transition of attitudes around children can be noted in the 19th century when women were encouraged that caring for their infants was an essential and revered contribution to society (Rubin, 1984). This denotes a significant shift to a time when raising children became more akin to the concept we understand of parenting today. However, parenting at this stage

remained focused on moulding the nature of the child to suit the needs of the adults and society around it (Hays, 1996).

The 20th Century saw the greatest shift in parenting styles, with practices becoming more child-centred. The focus became the physical and psychological well-being of a child and how 'successful' parenting contributes to the development of a well-adjusted and happy adult (Hays, 1996). Scientific methods developed in this century were applied to child raising, which led to expert narratives around how mothers should be raising their children, which were often from male experts (Apple, 1987). The narratives around mothering and the standardised methods applied to 'good mothering' were felt to undermine and on occasions demonise mothers' abilities (Thurer, 1994). An example of this is the 'refrigerator mother' theory, which suggested that lack of maternal warmth was linked to Autistic Spectrum Disorder (Kanner, 1949; Bettleheim, 1967).

Promotion of the importance of the mother role continued in the post-war period when Bowlby's research regarding deprivation and separation of mother and child was publicised (Bowlby, 1951). This has been interpreted by some as a manipulation of this research with the aim of encouraging women, who had fulfilled essential employment roles during the war, to give way to men returning from war (Dally, 1983).

Whilst a thorough exploration of the history of mothering is beyond the scope of this project, this brief reflection on this historical narrative allows for an understanding of the cultural context which has shaped the accepted view of mothers within society.

1.5.3 Motherhood and Psychology

Historically, psychology has focused on abnormal or dysfunctional mother-child relationships or on mothers in relation the child's development rather than their own experiences (Phoenix et al, 1991).

The influence of psychological theory on the wider social construction of motherhood is important to consider as psychological theories based on research conducted in this area have been used to form the basis of successful child raising, thus accounting for what society has come to understand as 'good mothering'. Through research and publications the field of psychology has contributed to the widely accepted view that the optimum environment for raising children is in the home with the mother (Phoenix et al, 1991).

1.5.3.1 Mothering and Psychoanalysis

When considering the influence of psychology on attitudes towards child rearing practices it is important to consider the influence of the work of Freud. Freud is documented as being anti-feminist and patriarchal in his attitudes (Gay, 1988). Freud gave little recognition to the

role of the mother in influencing the development of children, instead placing emphasis on the role of the father (Thurer, 1995). Even in some of Freud's most notable work such as the oedipal complex the role of the mother is merely an object in the process of emulating the father. Whilst Freud did not directly prescribe child rearing practices, his discussion of innate drives that a baby is born with and the development of the ego and superego informed understanding of the behaviours of infants and children.

In his later work Freud acknowledged the attachment observed between child and mother with particular reference to mothers and daughters. However, he discussed this in terms of his 'penis envy' theory and identified the end of this relationship as the point in development when the child realises that she does not have a penis and consequently directs anger towards the mother, severing their close attachment and directing future attachments towards the father (Thurer, 1994). Mitchell identifies the Oedipus complex and penis envy as responsible for the feeling of castration that Freud describes women experiencing and thus causing women to believe that they are inferior. Therefore, children are socialised into gendered roles, thus perpetuating accepted constructions of these roles (Mitchell, 2000). Mitchell advocates a Marxist non-patriarchal approach to raising children which would thus remove these developmental stages and promote equality between genders.

1.5.3.2 Mothering and Attachment Theory

An example of how psychology has further shaped the wider societal concept of mothering can be seen in attachment theory (Bowlby, 1953/1988). Bowlby described the development of a secure attachment with the primary care giver offering availability and safety, thus providing reassurance, elicited in response to behaviours of the child such as crying and reaching out. Described by Ainsworth as the secure base, this is a space where parents provide reassurance, encouragement, and comfort and meet the emotional and physical needs of the child through being available in the face of perceived threat or danger (Ainsworth, 1978). It is Bowlby's assertion that in order to achieve a secure base a parent needs an intuitive understanding of their child's needs as regards their attachment (Bowlby, 1988). This theory is based on a biological drive to protect an infant and the drive from the infant to remain within close proximity to the care giver for safety (Bowlby, 1969). It is the concept of this intuitive drive that has come to hold a mystical and poorly understood element of parenting and that has been misused at times to suggest that only a mother is capable of this relationship with their child and thus in the view of some researchers has been utilised for the oppression of women through this culturally accepted expectation of motherhood (Tardy, 2000).

Building on Bowlby's theory, Ainsworth used the 'strange situation' experiments to categorise infants' attachment styles (Ainsworth, 1978), which were linked to later emotional and social development of the child.

Bowlby's assertion that raising a child successfully to be happy, healthy and self-reliant cannot be achieved by an individual alone (Bowlby, 1988) serves to demonstrate the need for both parents, wider family and indeed society itself to support the raising of a child. However, popular derivatives of attachment theory appear to have been publicised such as to place responsibility upon the mother for the successful nurturance of well-adjusted children and ultimately the next generation of contributing adults. Exploring more widely, the political and historical context of this refers back to the ideas put forward that the mystical and revered role that only a mother might fulfil in raising a child was publicised for political and economic means as previously discussed (Dally, 1983).

The emphasis that a mother in particular should fulfil this attachment role can be linked back to psychological writings such as those by Winnicott, who asserted that fathers' roles were to facilitate the attachment between mother and child by meeting other needs such as financial, to allow time for this and remove stressors that may otherwise prevent it (Winnicott, 1964).

Not only has attachment theory influenced the way we perceive the practice of mothering, it is also key in understanding the perpetuation of mothering styles. Bowlby described, that a child develops internal working models of attachment based on their own experience which later inform their adult attachments (Bowlby, 1969). This invariably plays out when women go on to mother their own children and develop attachment relationships. It is believed that when the attachment system is triggered, an individual's early attachment experiences contribute to how they construct their understanding of events (Bishop, Stedmon & Dallos, 2015). Bishop et al. explored how attachment styles influenced how mothers understood and managed the experience of their child's cancer diagnosis and treatment with exploration of different attachment styles utilized to protect the child and family in this threatening situation (Bishop et al. 2015). This study illustrates how a mother's own attachment relationships influence their relationship with their own offspring and thus how narratives around mothering practices are perpetuated through generations.

In response to the work of Bowlby and Ainsworth, Ryle and Kerr suggest that attachment theory excludes other aspects of the infant's world through focusing on the relationship with the primary care-giver. They also cite the limitations of the experiments used such as the 'strange situation', which do not allow for observation of the relationship and interactions between child and care-giver in a typical environment. In addition, they note that the relationship patterns noted are categorised, thus filtering out the complexity associated with

such relationships, which is supported by the increasing number of categories that have developed since the theory was originally devised (Ryle & Kerr, 2002). Indeed, Bowlby himself cautioned that attachment patterns should be considered tentatively, yet despite this attachment theory has been employed somewhat judgementally to evaluate the abilities of parents and in particular mothers and in the process losing the reference to 'good enough' mothering (Dallos, 2006). They also note the absence of the role of culture in attachment theory and how social values are created and proliferated in the attachment relationship (Ryle & Kerr, 2002).

This is not to say that the ideas of attachment theory are not important in the emotional development of an individual but it is prudent to note how these ideas have been widely accepted by western society to maintain the construction of motherhood as it is currently known. One consideration is that through the attachment styles, individuals' identity and the meanings that they attribute to their experiences are constructed (Dallos, 2006). Attachment theory also offers an understanding of how attachment patterns influence how we construct meaning and understanding of our worlds and events therein (Dallos, 2006).

1.5.3.3 Addressing the Contradiction

As new laws in the 20th Century gave mothers rights over their own children where previously fathers had total jurisdiction, and women were able to work and have legal rights regarding divorce and custody (Hays, 1996), the appearance of greater equality became more evident. Coupled with psychological theories that supported the importance of the role of the mother in raising children, superficially there appears to have been greater respect and deference to mothers. However, with the perceived elevation of the mother's role in raising children came increased responsibility for the children's well-being and behaviour, increased judgement, blame and ultimately guilt at being divided between roles and identities and when perceived failures in childcare occurred (Tardy, 2000). As Craig notes in her research, "… in the UK children and motherhood are valued rhetorically and not structurally" (Craig, 1999 p.361). This reflects how laws and societal attitudes towards mothers indicate support and respect whilst failing to provide practical action to reinforce this. For example, whilst women are encouraged and expected in many cases to undertake paid employment they continue to shoulder the majority of the childcare (Hays, 1996).

1.6 Personal Construct Psychology

Personal Construct Psychology also recognises the importance of considering the historical and cultural context "… man might be better understood if he were viewed in the perspective of the centuries rather than in the flicker of passing moments", (Kelly, 1963 p.3).

Personal Construct Psychology (PCP; Kelly, 1955) provides a theory of personality based on the concept of constructive alternativism, which holds that individuals construct and reconstruct their worlds, adjusting their constructs in accordance with how successfully they anticipate events (Winter, 2005). Kelly's theory was based upon the fundamental postulate that "a person's processes are psychologically channelized by the ways in which he anticipates events" (Kelly, 1963 p. 46). Kelly viewed people as scientists who were testing out hypotheses about the world (Winter & Viney, 2005). These hypotheses are either validated when experiences are 'correctly' anticipated or invalidated when they are not. Constructs are bipolar dimensions and events are construed in terms of the contrast between the two poles (Winter & Viney, 2005).

In the process of identity development, individuals discriminate between 'self' and 'other' (Kelly, 1955). This involves individuals making predictions and assumptions about themselves and also others. The development of the 'self' begins in early life and is seen as constructed (Burr, Butt & Epting, 1997). These early constructs are known as core constructs and are not easily reconstructed (Kelly, 1955/1991a. 1955/1991b). This process initially begins within the family, which may explain how constructs are perpetuated. Families provide "validational evidence" for constructs, for example, gender roles demonstrated within the family may reflect general societal power relationships between men and women (Procter, 1978). Schools also "transmit the established ideology and social structure" (Illich, 1971). This is an important factor in young people's construct development and leads to the perpetuation of cultural 'norms' such as gender roles and societal attitudes and values associated with different roles (Procter, 1978).

Thus, individuals' constructs reflect the dominant cultural ideology as the ideology limits elaborative choices offered within that society. This demonstrates how attitudes prevail throughout generations without individuals challenging them (Procter, 1978). Considering the construal of mothers in society from a PCP perspective demonstrates how the accepted societal perception of mothers has been maintained. This is supported by research that suggests societal expectations of mothers is that they produce children that continue the ways of society (Austin &Carpenter, 2008).

1.6.1 Commonality

The Individuality Corollary of Kelly's PCP outlines that each person has a unique understanding of their experiences by virtue of anticipating events through their own set of constructs (Kelly, 1963). However, the Commonality Corollary refers to the degree to which the constructions of an experience of two people are similar, suggesting that the processes through which they understand the world are likely to be similar (Kelly, 1963). It would

therefore be interesting to examine what commonality exists between a group of mothers regarding how they construe themselves, their roles and the roles of the doctors. In addition, exploring the commonality of construing this role between mothers and doctors and how this influences the experience of a consultation is of interest.

1.6.2 Sociality

Kelly's Sociality Corollary posits that *"*to the extent that one person construes the construction processes of another, he may play a role in social process involving the other person" (Kelly, 1955/1991a, p.95/p.66), meaning that in relationships, individuals anticipate the construing of another such that they may understand how and why they each understand the world and experience. Procter expands Kelly's Sociality Corollary to consider groups or families (Procter, 1981). This is relevant when considering the situation in which a doctor interacts with a child and mother, as the need arises not only to consider and make sense of the constructions of those with whom the doctor is in consultation but also to construe the relationship between the members of the group such that the doctor can participate in social processes with them.

1.6.3 PCP and Attachment

From a PCP perspective it has been suggested that the attachment relationship provides a context within which a child learns through the invalidation of their constructs. A secure attachment provides a context within which invalidations are not feared but provide an opportunity for growth. An insecure attachment, however, reflects a context within which invalidation would be intimidating and inspire fear (Sassaroli, Lorenzini & Ruggiero, 2005). This demonstrates the influence of parent construct systems upon the development of the child's construct system, highlighting the importance of early relationships. A PCP perspective on attachment considers relationships as contexts for the development of construct systems, which therefore allows for greater possibility of reconstructing events shaped by multiple attachments.

A somewhat different approach to the influence of early relationships on attachment and specifically regarding dependency was developed by Chiari et al. and focused on dependency constructs (Kelly, 1955), which develop through interactions with the caregiver and environment. This research focused on how early social interactions impact upon the process of dispersion of dependency and thus the development of personality (Chiari, Nuzzo, Alfano, Brogna, D'Andrea, Di Battist, Plata & Stiffan, (1994). It found that a dependency path initiated by aggressiveness (active elaboration of one's perceptual field) was favourable to the dispersion of dependency and was linked to child-caregiver interactions involving acceptance and high levels of sociality. Dependency paths less

favourable to this process were those initiated by threat, characterised by restriction of spontaneous activities in childhood such as withdrawal of caregiving or those initiated by guilt, characterised by hostile caregiving. These were both obstacles to the process of dispersion of dependency and thus emergence of role constructs (Chiari et al, 1994).

1.6.4 Personal Construct Psychology and Motherhood

There is limited research regarding motherhood and personal construct psychology. However, one study that explored the experiences of mothers of children with significant health difficulties, disabilities or developmental delays using a personal construct approach found that using personal construct concepts helped in understanding the experiences of mothers whose children experienced health difficulties and had implications for use by health professionals to understand these experiences (Lovenfosse & Viney, 1999). Similarly, using a PCP approach, specifically repertory grids, has helped in developing an understanding of parental adjustment to their child's diagnosis of Autistic Spectrum disorder (Sharma, Winter & McCarthy, 2013).

These studies demonstrate that exploring perceptions of motherhood by accessing mothers' constructions illuminate our understanding from this theoretical position. Similar findings have been noted in educational settings where children have special educational needs (Cunningham & Davis, 1985). This study found that parents of children with special educational needs felt the need to make sense of and have control regarding their child's needs and circumstances as well as making sense of and coping with their own feelings relating to this.

1.7 Social Constructionism and Personal Construct Psychology

Personal constructivism has been critiqued for its emphasis on the internal experience of the individual with little consideration for the contribution of social experience (Gergen, 1995b). However, Kelly's personal construct psychology includes social and relational factors as important components of developing constructs through which to understand and anticipate the world (Raskin, 2002). Whilst the emphasis in PCP is on the individual processes of construing, this does not negate the significance of the system, society or culture that represents a wider construct system through which personal construing is shaped (Procter, 2016). In addition, Kelly acknowledged the importance of relationships in the development and testing of constructs and construct systems (Chiari & Nuzzo, 2005). It is the position of the researcher that the construction of knowledge is a circular process including social interactions as well as internal processes which combine to construct, test and refine knowledge about the world.

Pavlovič (2011) addresses the differences and similarities of the two approaches and notes that by combining the qualities of both, each theory is developed and thus provides greater understanding when complemented by the other. Both theories emphasise meaning making and thus reject an essentialist view of the world and whilst PCP has been predominantly concerned with individual processes, Kelly spoke of *"*public construct systems*"* (Kelly, 1955 p. 9.) and further research has explored shared construct systems within families (Procter, 1981, 1996). Thus, a combination of approaches within this research project enables exploration of personal meaning making as well as examination of how cultural and social constructions are developed and how people become *"*enslaved*"* by personal and social constructions (Pavlovič, 2011).

1.8 Feminism

For the purpose of this research project the term feminism relates to a *"*political and social movement… and an academic perspective*"* (Schiebinger, 2003, p. 859), the purpose of which is to advocate the voices and experiences of women. Whilst feminism constitutes a variety of differing feminist theories common thread is the advocacy of women's rights with the goal of achieving equality between the genders. It is with this overarching theme of feminist action that this research project is infused.

1.8.1 Feminist Research

Feminist research can be considered that which utilises methodology considered to be feminist or that which is grounded in particular feminist theory; more loosely, some research is defined as feminist by being by women, about women or conducted for women (Gringeri, Wahab & Anderson-Nahe, 2010). It is therefore important to outline why this research project is categorised as feminist research.

1) Like motherhood, feminism is a social construct and therefore feminist research is conducted as part of the historical context that shapes current accepted knowledge and understanding (Mies, 1994). By exploring the experiences of women as mothers within the current cultural context and giving voice to this, the following research is considered feminist research.
2) In addition, this research project is concerned with critical exploration and social justice (Grinigeri, et al, 2010), in particular with challenging the accepted view and promoting the understanding of the experiences of women as mothers.
3) Finally, this research project follows the assertion that feminisms are perspectives through which the world can be observed and explored as opposed to methods through which this is done (Reinharz, 1992).

1.8.2 Feminism and Motherhood

There have historically been tensions within feminism regarding mothering, with some viewing it as a societal oppression (Thurer, 1994) and thus leading some quarters of feminism to appear anti-maternal. Others have expressed the view that it is a role that serves to bring power and agency to women in a patriarchal society (Ribbens, 1993a).

Feminist debate regarding motherhood has contributed to an understanding of the role as a social construct (Ribbens, 1994) as well as the idea of maternal instinct (Badinter, 1982; Macintyre, 1976). Further to this, feminism has contributed the understanding of the family as socially organised and thus relating to the gendered relationships reflected in the wider society (Phoenix et al, 1991).

Finally, a synthesis of the tensions regarding the role of mothering has been offered by Rich, who suggested that women do experience authority, control and power akin to men in a patriarchal society as mothers. However, this role is then turned against them through its domestification which enslaves women, resulting in the oppression (Rich, 1977).

A significant contribution to the debate regarding mothering by feminism is to listen to women themselves about the subject (Ribbens, 1994). It is with this at the forefront of the research approach that the following study is conducted.

1.9 Goffman

Goffman's dramaturgical approach (Goffman, 1959) describes people as actors on a social stage who project an image or social identity which is adjusted for the different circumstances in which they perform. This links with the social constructionist emphasis that knowledge is context dependent and that people do not possess a constant set of attributes constituting what is known as 'personality' (Burr, 1995; Gergen, 1991, 1994), but rather there are many 'selves' which are constructed by the culture and context and importantly the language within that setting (Gergen, 1991).

This context is described as front of stage and roles adopted represent an idealised self that fits the societal expectations and the individual's aims. Back stage is described as the context in which a person can be their true self due to the absence of an audience. People learn what is expected of the roles they fulfil and act accordingly to meet these expectations. Some roles are considered to be in contradiction with one another and thus one must manage contexts so that they are not required to fulfil conflicting roles. Goffman's theory of social interaction is interesting to consider regarding the role of mothers and how they manage their presentation to give the desired impression expected of them.

Goffman described how people manage impressions of themselves through concealment in order to avoid demonstrating characteristics that are socially discrediting (Goffman, 1967). This refers to the categorisation system found in society that reflects desirable and undesirable characteristics. When an individual reveals undesirable characteristics they are discredited and subject to stigma. It is interesting to consider this when reflecting on the expectations of mothers to perform this role, particularly when on a stage such as that of a medical consultation.

1.10 Fathers

It is important to acknowledge that whilst this study focuses on the experience of mothers, this does not reflect a dismissal of the role of fathers. As Bowlby noted, the role of the primary care giver does not have to be fulfilled by the mother (Bowlby, 1988). In addition Bowlby stressed that child raising is not a job that can be fulfilled by one single individual, thus indicating the importance of the father's role as well as the wider family.

Whilst it is true to say that research into parenting has generally focused on mothers to the exclusion of fathers, it is also important to recognise that until recently this research has neglected the views and experiences of mothers, focusing more on parenting abilities, mental health and child rearing practices.

2 SYSTEMATIC LITERATURE REVIEW

This section includes a systematic review of the literature pertaining to the experiences of mothers in healthcare for their children.

2.1 Literature Search Strategy

A preliminary search regarding mothers' experiences in healthcare uncovered a high proportion of research focused on the pre-natal care of mothers and their experiences specific to childbirth and immediate subsequent care. Another large proportion of the literature focused on the perception of care received by parents of children and adolescents with mental health diagnoses. These studies reflect important areas of research distinct from that of mothers' experiences of general health care for their children and, as such, research pertaining to these areas was not included in the review.

Journal articles were obtained for systematic review from the databases Scopus, PubMed and PsychArticles. Further articles were obtained from reviewing the references of articles retrieved. Through preliminary literature searches the search terms/ concepts were devised (Table 1.).

The stages of the literature search included: removal of duplicate articles, screening of titles to ascertain the relevance of those identified by the search, review of the abstracts of those remaining and finally retrieval of full texts. A flow diagram outlining the search process and number of articles depicts this strategy (Appendix I).

Table 1: Literature search terms/- concepts

Concept #1	**Concept #2**
Perceptions of mothers	**Mothers**
And	**And**
Health care	**Health care encounters**
Or	**Or**
Doctors	**Health care experiences**
Not	**Not**
Mental Health	**Mental Health**
Or	**Or**
Psychiatric	**Psychiatric**

As preliminary searches using terms including 'construct' and 'construction' were unsuccessful, these terms were omitted in the final search process.

2.2 Systematic Review of the Literature

Literature identified was reviewed with the purpose of exploring the existing research regarding how the role of the mother is construed in health care. Thirteen studies were identified to form the body of research reviewed. A table outlining the details, key findings, implications and a critique of each study can be found in Appendix II. Mays and Pope identified seven key areas used to evaluate the quality of qualitative research (Table 2; Mays and Pope, 2000). The questions posed by Mays and Pope were applied to each of the papers included in the review, and a table outlining which criteria each research paper met can be found in Appendix III.

Table 2: Criteria for Evaluating Qualitative Research (Mays & Pope, 2000).

Worth and Relevance of the Study
Clear Research Question
Appropriate Research Design
Well Described Research Context
Clear Sampling Method
Systematic Data Collection and Analysis
Reflexivity of Research Report

Three broad themes emerged from the review. These were relationships and interactions of mothers with medical staff, judgement and stigma regarding parenting and compliance within a medical environment.

2.2.1 Overview of the literature

All studies included in the review relate to mothers' (and in some studies fathers') experiences with their children within health care. All studies used qualitative research designs with a number of different analytic approaches. Most studies used semi-structured interviews, although some studies used focus groups and observation in addition to this (Cohn et al, 2009; Loudon et al, 2016). One study used mixed methods, combining semi-structured interviews with observation, group interviews and 5 point scale questionnaires which were analysed using quantitative methods (Loudon et al, 2016). Two of the studies were single case-study accounts (Cohn et al, 2009), in one instance with the author as the subject of the article (Weingarten et al, 1997). Two studies also conducted individual interviews with professionals, including group organisers who were health visitors and

inpatient ward nurses (Fenwick et al, 2001; Loudon et al, 2016). One study focused on inpatient experiences (Fenwick et al, 2001) with the remainder focusing on children who were outpatients (although some had periods of admission for treatment).

All studies were conducted within the last twenty years. Whilst no limits were placed on the geographical area of the study, all studies were conducted within westernised developed health care systems. From the literature searches it was evident that studies conducted in countries with less well developed care systems focused, understandably, on accessing health care and health care quality as opposed to perceptions within that care system.

2.2.2 Relationships/ Interactions with Health Care Professionals

A number of the studies focused on interactions and relationships between mothers and their child's medical professionals. In one study, mothers of children who were diagnosed pre- and post-symptomatically with a chronic kidney condition were interviewed (Swallow & Jacoby, 2001). This study found that mothers whose children endured a number of different or vague symptoms before diagnosis encountered scepticism regarding their child's experience, which was damaging to the relationship with the professionals and led to a loss of trust, leaving them wary of medical opinion in the future. Across both groups of mothers the need to develop trusting and respectful relationships with staff was a source of stress. Mothers felt that they needed to identify staff with whom they were comfortable, which often related to the perceived competence and credibility of the staff member. It was found that mothers who felt listened to and developed positive, trusting relationships with staff were able to attain a level of "participatory competence", thus making them a contributing member of their child's care team.

Another study that utilised semi-structured interviews with mothers, focussed on mothers who took their children to the doctor with recurrent abdominal pain (Smart & Cottrell, 2005). Participants felt that they needed to legitimise their child's symptoms to their doctor. Mothers reported feeling dismissed where the aetiology of the pain appeared to be psychological. Mothers in this study felt that if they identified their child's symptoms as medical or disease related when they were not, they were labelled as over anxious; conversely, if they neglected to recognise genuine ill health they felt labelled as neglectful, thus reflecting a double bind of the role in this context. In another study, mothers were also reluctant to seek information from GPs for fear that they would be patronising or dismissive of the mothers' concerns (Loudon, Buchanan & Ruvthen, 2016).

In a study where mothers of children with cerebral palsy were interviewed about feeding methods for their children, participants reported feeling stress when they were not in control of the care for their child and when they did not feel understood by their child's health care professionals (Sleigh, 2005). This led to feelings of frustration, anger and demoralisation. Mothers' and their families' well-being was shown to be promoted in this study when professionals were positive and acknowledged the expertise of the parents. In a single case account of her own experience, one author also recognised the importance of feeling understood by professionals when describing a comparison between her own illness, that was well understood, and that of her daughter, who had a rare genetic condition not widely known about in the medical community (Weingarten & Weingarten-Worthen, 1997).

Where health care interaction gave mothers a greater sense of control over their child's treatment, mothers reported feeling empowered (De Carvalho & Fiho, 2016). Linked to this, mothers reported difficulties in trusting paediatricians, who they felt did not understand their choices as a mother (De Carvalho et al, 2016).

Generally, a willingness to listen, honesty, trustworthiness, credibility and competence were reported across all studies as favourable characteristics of health professionals. There was a theme of mothers' voices being unheard across the research and a fear on behalf of the mothers that they would be judged unfavourably by their child's doctors. Where mutual respect and good communication developed, the relationships with health professionals were shown to be positive and collaborative (De Carvalho & Filho, 2016, Loudon et al, 2016, Swallow et al, 2001, & Sleigh, 2005).

2.2.3 Judgement and Stigma

Another theme was that of feeling judged by health care professionals. In one study, where mothers had taken their children to a general practitioner regarding abdominal pain, they experienced judgement from the doctors regarding their parenting (Smart et al, 2005). In this study mothers described feeling responsible for the health of their child and thus felt judgement in relation to their competence as mothers. Mothers in another study chose not to seek information and advice from general practitioners for fear of being judged because of parenting choices that may depart from the advice they anticipated from the medical profession (Loudon et al, 2016). Mothers in this study also expressed a feeling of pressure to present themselves to doctors as 'good mothers'.

In another study, mothers of children with a range of physical and cognitive disabilities were interviewed (Davis & Manago, 2016). This study found that mothers experienced stigma by

virtue of their association with their child. Mothers in this study experienced both felt and enacted stigma, leaving them feeling socially rejected and isolated. The study found that stigma affected mothers via two routes, through their child rearing and through their role as the gestational carrier of the child. In some situations, mothers in the study felt exonerated from the stigma created by raising the child through medical explanations of their disability. However, this led to the double bind, as the medical or genetic explanations immediately resulted in culpability through gestation. The result was that mothers felt guilt and distress due to the moral stigma they experienced.

Another study found that mothers made claims of "moral agency*",* i.e. attempting to demonstrate that they have taken the correct actions for their child and are therefore competent, good and responsible parents in instances when they disagreed with the professionals about their child's symptoms (Gunnarsson, Hemmingsson & Hyden, 2013).This study also found that for some mothers the health care professionals they encountered represented figures of blame in addition to blaming themselves for their child's symptoms. The mothers interviewed believed that within their role as mothers they should be assertive, which felt at odds with the role of a passive and compliant patron of the health system, thus creating conflict. Mothers also reported feeling rejected by health care professionals who dismissed their concerns about their child's health. Participants also reported making attempts to present their self-image as a mother in such a way that it would fit with the social and cultural constructions of good mothering. Where there was disagreement between healthcare professionals and mothers in the study, mothers' moral and self-identity had the potential to feel threatened.

Another study examining the stigma parents experienced regarding their child's disability and the impact this had on their own well-being interviewed parents of children with a range of diagnoses including physical, psychological and behavioural difficulties (Francis, 2012). In this study parents also experienced stigma due to association, known as courtesy stigma as well as stigma attached to their parenting, where they felt held responsible for the behaviours of their children. Mothers in the study were more likely than fathers to experience courtesy stigma and blame stigma for the child's health difficulties. Where children were diagnosed with conditions that were unlikely to be contested, such as cerebral palsy, parents experienced less blame than those where the condition or disorder was considered to be associated with a moral failure on the part of the parents, such as behavioural difficulties or drug abuse. Parent-blame was highest amongst those who had children diagnosed with an invisible disability such as an autistic spectrum disorder or attention deficit hyperactive disorder.

One study immersed the researcher in mother and child social groups to explore the social construction of motherhood (Tardy, 2000). This study found that conversations about health care amongst mothers served as a process through which the women in the study constructed their identities as mothers. By engaging in health care conversations about their children, mothers demonstrated evidence of being 'good mothers'. However, some topics, such as conception and returning to sexual practices following childbirth, were deemed to be inappropriate and would interfere with the enactment of motherhood as determined by cultural norms and so were either avoided or diverted from in conversation.

Another study found that mothers were reluctant to share their own stress or symptoms of depression with their child's paediatrician (Heneghan, Mercer & DeLeone, 2004). Mothers in the study reported that this was due to fear of being judged by the paediatrician or that they may be referred to child protection services should they disclose these struggles. However, some mothers in the study did report that they may feel more comfortable discussing their own well-being with a paediatrician that they knew well. Some participants identified discussing parenting stress and depressive symptoms as admitting to failure.

2.2.4 Compliance with Medical Staff

In one study, mothers of infants being cared for by nursing staff in neonatal nurseries were interviewed, as were nursing staff (Fenwick, Barclay & Schmied, 2001). Nursing staff perceived "good" parental behaviour as presenting as friendly and sensible whilst demonstrating interest in the care of their child. In addition, 'good' parents visited their infant regularly but did not stay too long. Those who did not meet these criteria were often considered by staff to be difficult. In this study, mothers found nursing staff who practiced a style of nursing focussed on protecting the infant, directing or teaching the mother to be inhibitive. This was a barrier to mothers in the study collaborating in the care of their child. Where nursing staff prevented physical closeness between the mothers and infants in order to protect the child, mothers experienced anger and frustration and those who felt directed by staff in an authoritarian manner were found to experience anxiety and depression. In addition, mothers in the study demonstrated a tendency to blame themselves when they were dissatisfied with aspects of the nursing. Those who were able to voice their concerns often felt distressed and like an outsider or disaffected mother. These mothers described earning a negative reputation for not being compliant.

In a single case study, a mother's self-identified "protective" behaviour was regarded by the medical professionals caring for her asthmatic children to be non-adherence and the mother

was labelled as problematic (Cohn, Cortes, Hook, Yinusa-Nyahkoon, Solomon & Bokhour, 2005). The mother in this study framed her refusal to follow medical instructions as 'good mothering' as she felt she was meeting the needs of her children by increasing their comfort, as often the medical interventions resulted in discomfort.

In the study regarding feeding children with cerebral palsy, families experienced stress when they felt that they were not in control of their child's care, and when the professionals they interacted with did not appear to understand them (Sleigh, 2005). When professionals were positive and acknowledged the expertise of the families, their well-being was promoted. Carers preferred it, when professionals assumed an 'expert' position when required rather than remaining in this stance throughout all interactions. It was particularly important for parents to maintain 'normal' duties of care such as feeding as it was part of their role and contributed to the development of their relationship with their child.

2.2.5 Synthesis

The perception of the health care professionals explored in the studies found that when doctors were viewed as trustworthy, honest, credible, sympathetic and competent and understood the parenting choices of the mother a more collaborative relationship formed with parents (Swallow et al, 2001; Henneghan et al, 2004; Sleigh, 2005; De Carvalho, 2016). When health professionals were sceptical or dismissive about the accounts of mothers, this was damaging to the relationship between the professional and the parent (Swallow et al, 2001; Smart et al, 2005). Doctors were more likely to be seen as dismissive or unsympathetic when symptoms represented contested, invisible or psychological illnesses (Smart et al, 2005; Francis; 2012).

Frequently, mothers across the studies felt that health professionals were making judgements about their parenting and parenting choices and that by being unable to manage their child's health needs they were inadequate (Smart et al, 2005; Loudon et al, 2016). Mothers therefore frequently felt the need to present themselves as 'good mothers' (Fenwick et al, 2001; Gunnarsson et al, 2013; Loudon et, 2016) in order to be viewed favourably by health professionals. Mothers experienced stigma associated with their children's health needs and disabilities (Francis, 2012; Davis et al, 2016).

The role of the mother was viewed by health care professionals and mothers across the studies as being responsible for the health needs of their child and competence in this role included recognising and managing health difficulties (Smart et al, 2005; Francis; 2012). Where mothers were consulted and felt in control of decisions regarding their child's health

they felt more empowered, when they felt that they were not in control they experienced stress (Sleigh, 2010; De Carvalho et al, 2016). Where control or protection was not in alliance with the views of the participant they were labelled as difficult or problematic (Fenwick et al, 2001; Cohn et al, 2009).

2.2.6 Evaluation

A number of the studies focused on specific conditions (Weingarten et al, 1997; Swallow et al, 2001; Sleigh, 2005; Cohn et al, 2009; Gunnarsson et al, 2013) and as such reflected the experiences of mothers of children with that condition. In addition, eight of the studies related to ongoing or chronic health needs (Weingarten et al, 1997; Swallow et al, 2001; Smart et al, 2005; Sleigh, 2005; Davis et al, 2006; Cohn et al, 2009; Francis, 2012 & Gunnarsson et al, 2013), giving an understanding within this context but providing less insight regarding the more everyday medical interactions mothers and their children encounter.

There was a mixture of sample sizes within the literature, the largest study recruiting 200 participants (De Carvalho et al, 2016). However, this was an online questionnaire and therefore there were no measures in place to know who was responding. Of the remaining studies, 10 had between 7-44 participants, one was an in-depth case study of a participant from a previous study (Cohn et al, 2009) and one was an account by the authors, a mother and daughter who had different health conditions (Weingarten et al, 1997).
Most of the studies were conducted within or recruited in medical facilities such as hospitals, outpatient clinics or groups for children with health needs (Fenwick et al, 2001; Swallow et al, 2001; Henneghan et al, 2004; Sleigh, 2005; Smart et al, 2005; Davis et al, 2016), again reflecting a specific population that does not represent the average mother attending a medical appointment for their child.

Five studies did not reflect on the relationship between the researcher and the study (Tardy, 2001; Fenwick et al, 2001; Sleigh, 2005; Francis, 2012 & De Carvalho et al, 2016). In some studies the researcher was part of the team or group in which the research was taking place (Swallow et al. 2001), which may have had an impact on what the participants reported.
In some studies demographic information was missing (Swallow et al, 2001; Loudon et al, 2016).

None of the studies involved asking participants directly about the perceptions of the role of mothers and doctors although how mothers felt they were perceived was often described. Whilst the interview format used by most of the studies was an appropriate method to explore and understand the experiences of the mothers, none of the studies utilised specific

methods to elicit exploration of construals of the roles or how these perceptions have developed.

Aims and Rationale of the Study

The aim of the study is to explore constructions of the role of mother within health care, specifically how mothers perceive their role and believe they are perceived by the doctors they take their children to for consultation. This will be achieved through using personal construct methods and interviewing mothers about their experiences of taking their children to see medics. Research has previously neglected these aspects of motherhood (Birns & Hay, 1988). Viewing constructs as “shared relational entities” (Procter, 2002), the researcher aims to consider how the construal of the mother role influences relationships between doctors and mothers of patients. This can then be more widely considered within the historical and cultural context.

Research Questions

1. How do mothers perceive their role when taking their children for consultation with a doctor?
2. How do mothers believe doctors perceive them and their role as mothers during a consultation?
3. How do mothers perceive the role of doctors in consultations for their child/ren?
4. How do mothers construe a satisfactory and less than satisfactory consultation for their child?

3 METHODOLOGY

"You cannot create experience. You must undergo it." - Albert Camus

This chapter outlines the methodology used in the study and the rationale for the approach and methods. Following this an outline is given regarding the procedure, recruitment, data collection and ethical considerations of the study.

3.1 Design

There is limited research giving voice to mothers' experience of interactions with medical professionals. The approach of this research project was therefore committed to promoting an understanding of these experiences and associated meanings. In line with the belief that "feminist psychology is about understanding the person within a social world" (Wilkinson, 1998, p. 111) this research was conducted to facilitate an understanding of the meaning-making of the mothers within their cultural context. Therefore, a qualitative, interview-based approach was considered most appropriate.

As a key aim of the study was to understand the meanings attributed to the roles of mothers, a methodology that enabled this exploration was fundamental in developing this research. In addition, recognition that meaning is socially dependent and co-constructed through interaction (Hare-Mustin & Marecek, 1990) was important as the meanings explored in this study are thus a collaborative construction of participant and researcher.

As much previous research regarding mothers in healthcare settings has served to blame or pathologize mothers, particularly those of children with disabilities or ongoing health concerns (Mckeever & Miller, 2004; Singh, 2002), one of the concerns of this project was to redress this imbalance of power and give voice to the experience of mothers in healthcare.

3.1.1 A Qualitative Approach

A qualitative approach was considered appropriate as it is underpinned by the ethos that there are many ways of understanding the world and that the purpose of research is to explore the experiences of participants with the aim of understanding their views (Jones, 1995). This approach is in keeping with the epistemological position of the research project. Therefore, a methodology emphasising an understanding of meaning-making was employed. In contrast, the positivist nature of quantitative methods would not allow for the exploration of such rich and subjective data and as such these were not considered in keeping with the aims of the study.

3.1.2 Choosing Thematic Analysis

A thematic analysis was chosen for the study due to the flexibility of the approach, as it is independent from a specific epistemology or theoretical background (Braun & Clarke, 2006). This means it can be applied to research that is realist as well as research from a constructionist/ constructivist perspective. In addition, it is a method that enables data to be interpreted from a social as well as psychological perspective (Braun & Clarke, 2006).

Whilst the study aims to understand the meaning-making of mothers, the researcher acknowledges that research in itself as a form of social action involves collaboration between the researcher and the participants. Therefore, the meanings explored in this study are a co-construction of this collaboration.

3.1.3 Consideration of other Qualitative Methods

Interpretative phenomenological analysis (IPA; Smith & Osborne, 2003) was considered for this study, as it has been used in studies with PCP backgrounds alongside qualitative grids (Denner-Stewart, 2010). However, IPA is primarily concerned with understanding the lived experiences of participants (Reid, Flowers & Larkin, 2005) and it was felt the approach was more appropriate when exploring major life events. With this link to phenomenological epistemology, it was also felt that TA had greater flexibility given its independence from a specific theoretical approach.

Grounded theory (Glaser, 1992) was also considered, however, the aim of this approach is to develop theory which is driven by the data (McLeod, 2001). As this study is concerned with the participants' meaning-making and not with theory development, this approach was discounted.

3.2 Recruitment

3.2.1 Recruitment Locations

It was important that recruitment was conducted in naturally occurring social contexts for parents, therefore, locations that may elicit an emotional or trauma-related response such as health settings were avoided. In an attempt to recruit participants from diverse backgrounds, recruitment locations included fee-paying and non-fee paying services. Locations included public libraries where children's groups were held and church buildings which hosted secular mother and child groups. Posters and leaflets (Appendix IV) were also displayed at local dance schools and day nurseries.

Whilst locations were carefully selected to recruit mothers from diverse backgrounds, the historical challenges of engaging mothers who experience more difficult financial,

employment and housing circumstances persisted in this study. Social, economic and cultural factors have been recognised as barriers to research participation (Knobf, Juarez, Lee, Sun, Sun & Hoazous, 2007). These factors can relate to difficulty accessing transportation and childcare and challenges regarding the disruption of work and family life that participation would involve.

3.2.2 Sample

In total, 6 participants responded. Whilst this reflects a small sample size, it enabled the researcher to engage in the exploration and interpretation of in-depth and rich data (Crouch & McKenzie, 2006). Three participants responded directly to advertisements, two from a fee-paying children's club and one from a day nursery. A further three participants were recruited via snowballing, through word of mouth regarding the study.

3.2.3 Inclusion and Exclusion Criteria

Participants who identified as a mother to the children in their care were eligible to participate. The rationale for this was that where an individual identifies with a personal or social construction relating to their understanding of mothering this is relevant to developing our understanding of what it means to be a mother taking a child to a medical consultation and contributes to the ongoing development of the social and cultural understanding of this role.

An age range of 0-5 years for the children of participants in the study was defined, the purpose of this being to enable some comparison between the experiences of the participants.

Further eligibility criteria included being English speaking. Given the importance of language in qualitative research, fluent English was an essential requirement. In order to understand the meanings described by participants it was necessary for them to be able verbally to express themselves to the researcher. Participants also had to have taken their child to the doctor within the past 12 months in order to ensure recall of the experience. Participants also had to be aged 18 years or over to meet the ethical requirements of the study.

3.2.4 Recruitment Procedure

Participants all contacted the researcher directly after seeing or receiving a copy of the recruitment advertisement. Participants were then provided with the participant information sheet (Appendix V) and a copy of the consent form (Appendix VI). Participants were then given time to read the information and the opportunity to ask questions via email. Following this, an informal meeting was arranged with each of the participants to answer any further

questions and make arrangements for the interviews. Participants were given the option of being interviewed at home on in a local public building such as a library or village hall. All participants opted to be interviewed at home.

3.3 Data Collection

3.3.1 Demographic Data

Demographic data was collected prior to each interview including: age, occupation, level of education, number of, ages and gender of children, ethnicity and marital status. This can be found in Table 3 in the Findings section. Reflective accounts of meeting with the participants can be found in Appendix VII.

3.3.2 Qualitative Grids

Qualitative grids are flexible tools designed to elicit and display the construing, assumptions and perspectives of individuals with little interference from the orientation of the researcher or therapist and as such can be used in conjunction with any theoretical approach (Procter, 2014).

Qualitative grids were chosen as an engaging method to discover and represent the views, meanings and experiences of the participants. It was felt that this methodology offered a unique way of accessing the experiences and internal processes of the participants, through which a detailed understanding could be developed.

3.3.2.1 Perceiver Element Grids

Perceiver element grids (PEGs; Procter, 2002) are one type of qualitative grid used to elicit and explore an individual's interpersonal construing. They are used frequently in clinical work but more scarcely in research (Procter, 2014). Studies utilising this method include the exploration of a father and son's construing of ADHD (Denner-Stewart, 2010) and foster carer and looked after children's constructs of family (Cooper, 2011).

Participants in the study completed two PEGs, one related to a consultation they had taken their child to that they considered was satisfactory. They also completed a PEG for a consultation they had taken their child to that they considered was less than satisfactory. In keeping with the PCP underpinnings of the study, this enabled a comparison of opposing poles and allowed for exploration of what constitutes a satisfactory consultation, thus providing useful information to those working with families. An example of a PEG used can be found in Figure 1.

Figure 1: Example PEG

Context: Satisfactory/ Less than Satisfactory Consultation

Element Perceiver	Self	Mother	Doctor
Self	How I see myself	How I see myself as a mother	How I viewed the doctor in the consultation
Mother	How I as a mother see myself as an individual	How I as a mother see myself as a mother	How I as a mother viewed the doctor in the consultation
Doctor	How I believe the doctor viewed me	How I believe the doctor viewed me as a mother	How I believe the doctor viewed themselves

Each box within the grid was completed on a separate piece of paper. The pieces of paper were then placed together to form the entire grid to facilitate discussion and complete the interview by comparing both satisfactory consultation and less than satisfactory consultation grids.

PEG completion was initiated by asking the participant to consider within the context of the consultation, how they saw themselves. This was introduced with the following statement:

In this consultation, how did you see yourself as an individual? Regardless of other jobs or roles you have, how would you describe yourself in that moment? What were your characteristics? Can you tell me how you would best describe yourself during that experience?

Each box was then completed in order for both grids, allowing for breaks at regular intervals. A full list of questions can be found in the Standardised Instructions (Appendix VIII).

The 'self' element/perceiver was included to obtain a baseline understanding of how the participants construe their own personality/ characteristics irrespective of their role as a mother. This would then allow a comparison facilitating clarity in understanding specific aspects of the mother role. It also allowed exploration of how closely connected the role of mother is to an individual's self-identification.

Following the completion of both PEGs, the grids were displayed alongside one another and formed the basis of the semi-structured interview, the prompts and questions for which can be found in Appendix VIII.

3.4 Interview Procedure

3.4.1 Pilot Study

A pilot study was conducted prior to the main study. Pilot studies are considered a "crucial element of a good study design" (van Teijlingen & Hundley, 2002 p.33) as they provide information about the suitability of the proposed method of inquiry to be used. In the pilot study the PEG completion and interview were completed separately. Exploration of participants' responses to the PEGs was documented and then addressed at the end of the PEG completion. A reflection from the participant identified this as an obstacle to elaborating on the PEG completion as it was a challenge to revisit these topics once other subjects had been introduced. Therefore, in the main study, questions and prompts were asked following each PEG box completion. In order to prevent confusion between the constructs of the researcher and those of the participant, these prompts and questions were asked once the participant had indicated that they had nothing further to add to that element of the PEG.

In addition, the participant was asked to draw and/or write their own answers in the pilot study. This was also identified as an obstacle to interview rapport. Therefore in the main study the researcher documented the participants' answers then offered them the opportunity to add anything themselves to the grids after each answer. Much consideration was given to this adaption as it was important not to further exaggerate the power balance already naturally skewed towards the researcher in this dynamic. However, feedback from the pilot study suggested that this would be beneficial to participants, enabling them to focus on their thoughts and verbalising their experiences.

3.4.2 Main Study

3.4.2.1 Interview Locations

It was important for the researcher to consider how the interview location itself can hold meaning which can "…construct the power and positionality of participants in relation to the people, places and interactions discussed in the interview" (Elwood & Martin, 2000 p.649), in particular considering the power and position of the participant in relation to the researcher. It was hoped that allowing participants to choose the interview location would alleviate some of the power imbalance of the researcher as an expert, help facilitate open dialogue and offer a pragmatic solution to where to host the interviews (Elwood & Martin, 2000).

3.4.2.2 PEG Completion and Interviews

Prior to interviews, the participant information sheet (Appendix V) was reviewed and participants were given the opportunity to ask questions. After consent was received, demographic information was collected. The participants were then read the standardised instructions (Appendix VIII), which included the request for them to recollect two consultations that they had taken their child or children to in the past 12 months. Participants were asked to recall one consultation that they considered to be satisfactory and one consultation that they considered to be less than satisfactory.

The PEGs and interviews were completed concurrently and were audio recorded. Recording was paused to allow breaks throughout. The purpose of the PEG completion and interview was to explore the constructions of motherhood and the role of the doctor that the participants held. In addition, it was hoped that exploring how they felt they were perceived by the doctors would add further depth of understanding of their personal constructions of motherhood. With these research aims in mind an interview schedule with prompts was developed (Appendix VIII). This was modelled on previous research projects with similar methodologies and epistemological underpinnings (Cooper, 2011; Denner-Stewart, 2010).

4.4.2.3 PEG and Interview Process

PEG completion was facilitated prior to the interview. The rationale for this approach was that by eliciting the constructs first the researcher was receiving a candid, unbiased or influenced understanding of participant's constructions. The interview was then conducted in order to further explore and enrich the researcher's understanding of the participants' experiences and constructions.

Following collection of the details of the two consultations that the participants had described, PEG completion was explained. Participants were informed that they would be expected to think from different perspectives throughout the process. Each grid of the PEGs (Figure 1) was completed on a separate piece of paper, when participants indicated they had answered each question they were asked if they wanted to add anything. Following this, the researcher asked more in depth questions prompted by the participants' responses in order to gain a richer, more in-depth understanding and allow expansion of the answers whilst they remained current in the participants' minds. Once all grids for both PEGs had been completed, and following a short break, the PEGs were laid out next to each other and participants were given time to read and consider the PEGs together. They were then asked about their thoughts and reflections on reading the PEGs. This formed the basis of the transition from PEG completion to interview. The interview began with discussion and comparison of PEGs and became more broadly focused on the experiences of mothering.

This enabled a detailed discussion about their specific experiences whilst allowing the themes of the study to include information from the participants' wider perspectives and allow for an understanding of the influences of these ideas, constructions and beliefs.

3.5 Ethical Considerations

Ethical approval for the study was given by the Health Sciences, Engineering and Technology Ethical Committee and Delegated Authority (ECDA) at the University of Hertfordshire (Appendix IX). Furthermore ethical practice in this study was guided by the British Psychological Society's Code of Human Research Ethics (BPS, 2010).

3.5.1 Informed Consent

In accordance with the BPS Code of Human Research Ethics (BPS, 2010) consent was obtained freely on the basis of adequate information. Participants were given the right to withdraw from the study or modify their consent at any time. They were informed they could request that any data provided be destroyed. In addition, participants gave explicit consent for audio recording and the use of transcription services (Transcription service confidentiality agreement Appendix X). In developing the study care was taken to provide detailed information to participants regarding the rationale and aims of the study, as well as clear information detailing what participation involved including interviews, storage of data and the eventual report. This information was provided in the participant information sheet (Appendix V), consent was obtained using the participant consent form (Appendix VI).

3.5.2 Confidentiality

Every effort was made to ensure confidentiality of the participants. Demographic details and details of the participants' children were recorded and kept separately from transcripts. Recordings, transcripts and participant details were kept securely.

Participants were made aware that anonymity was not guaranteed particularly given the small research sample. However, names of participants were changed along with identifiable information to protect the anonymity of participants.

3.5.3 Managing Distress and Complaints

The possibility of psychological distress was minimal due to the nature of this research project. To further minimise potential distress, the aims and processes of the project were clearly explained to participants prior to interview. Participants were also informed that they could refuse to answer any questions they did not want to answer and could withdraw from the study at any time.

In addition, following the interview, participants were debriefed (Appendix XI). This included signposting to support services as well as the complaints process and supervisory team for the study.

3.6 Data Analysis

All six interviews were audio recorded and transcribed. The full interviews were analysed using a thematic analysis, the procedure for which is outlined below. The PEGs were analysed separately by applying a content analysis of personal constructs (Feixas, Geldschlager, & Neimeyer, 2002). In addition, consideration was given to the content of the PEGs through the wider PCP principles (Cooper, 2011).

3.6.1 Content Analysis of PEGs

3.6.1.1 Classification System for Personal Constructs (CSPC; Feixas, Geldschlager & Neimeyer, 2002)

The Classification System for Personal Constructs (Feixas et al, 2002) is a tool devised to analyse personal constructs that have been uncovered through constructivist assessment methods (Neimeyer, 2002). An alternative classification system that could have been used for this is that of Landfield (1971). However, the CSPC was chosen as it offers 45 categories from which to classify constructs and is considered more exhaustive than the 32 categories offered by Landfield's method.

The CSPC consists of 45 categories of constructs divided into six areas. These areas are ordered in a hierarchy with constructs being coded in only one area, at the highest level that it fits. The six areas, in hierarchical order, are 1) moral, 2) emotional, 3) relational, 4) personal, 5) intellectual/operational and 6) values and interests. The CSPC focuses on the content of value constructs as opposed to superficial or relational constructs (Feixas et al, 2002). Value constructs are described as "the meanings people give to their own and others' psychological traits or characteristics" (Feixas et al, 2002 p.3). It was therefore considered a useful tool to explore the meanings that the participants attributed to their own characteristics as individuals and as mothers. In addition, it was used to explore the meanings that the participants gave to the characteristics of the medics they sought consultation with. Constructs and opposing poles were identified through discussion of the PEG grids during the interview and PEG completion.

The focus on value constructs enabled the researcher to decipher which constructs discussed to focus on. Constructs focused on for detailed analysis were also selected based on the significance attributed to them in the interview. Constructs that were the focus of conversation, were returned to repeatedly or were identified as core constructs, formed the

basis of the analysis using the CSPC. This method of identifying which constructs to focus on was employed due to the scope of the project which unfortunately prohibited detailed exploration of all constructs identified.

The CSPC has been used in a number of areas including bulimia nervosa (Dada, Izu, Monteburno, Grau & Feixas, 2017), depression (Montesano, Feixas & Varlotta, 2009) and fibromyalgia (Compan, Feixas, Varlotta, Torres, Agular & Dada, 2011) and has been used with the repertory grid technique but can be used with constructs derived from other constructivist assessment procedures (Dada et al, 2017) and as such was considered an appropriate tool to utilise in this study.

3.6.1.2 Analysis of Constructs

The researcher categorised each construct derived from the participants' PEGs under the overarching themes of self, mother and doctor. These constructs were mapped to the corresponding area and category of the CSPC with opposing poles identified from discussion with participants. This process was repeated for the satisfactory and less than satisfactory grids to allow for comparison between identified constructs in each of the contexts. Whilst the CPSC has been found to be a reliable tool in categorising constructs (Feixas, et al, 2002), the focus of this study was to explore individual meaning in depth rather than generalise findings. However, observing patterns between participants was of interest, therefore, credibility checking was undertaken by the supervisory team to consider differing perspectives of the content of constructs explored. This was undertaken by reviewing the identified constructs and corresponding area of CPSC allowing for discussion regarding areas of agreement and disagreement.

3.6.2 PCP Principles

Alongside the content analysis of the grids, wider PCP principles were held in mind during the analysis process. This enabled reflection on the emerging constructs through a personal construct lens. The advantage of this approach was that in addition to categorising the constructs, a comparison between the contexts of a satisfactory and less than satisfactory consultation was facilitated.

In particular the concepts of validation and invalidation were held in mind. Validation refers to the application of a construct followed by a predicted outcome. Invalidation refers to experiences whereby the outcome of a situation differs to that predicted by the construct applied.

3.6.3 Thematic Analysis

The interviews were analysed using thematic analysis guided by the steps set out by Braun and Clarke (2006). These offer sufficient guidance for a robust analysis whilst allowing the flexibility required to develop themes from the data that are of interest regarding the research questions. The phases for thematic analysis include: reading and re-reading the data whilst recording notes and reflections, generating initial codes, clustering codes into themes, reviewing themes with reference to the codes generated and transcripts.

The thematic analysis process and themes were discussed with a research tutor to ensure that the method was robust and to facilitate reflection and discussion regarding the coding and the themes generated. In addition, the project supervisors reviewed a sample of the data to credibility check the coding and themes generated. The purpose of this was to promote consideration and discussion of the themes to ensure that the interpretation had been considered from different perspectives and represented the voices of the participants.

4 FINDINGS

"Words mean more than what is set down on paper. It takes the human voice to infuse them with shades of deeper meaning" – Maya Angelou

This chapter presents the findings from each interview and PEG completion. In total six interviews were conducted with six mothers completing a total of 12 PEGs (6 regarding satisfactory consultations and 6 regarding less than satisfactory consultations). Each interview was comprised of PEG completion with simultaneous discussion, followed by an interview to explore the PEGs and the experiences of the participants in more detail.

To commence the chapter, the participants will be introduced. Following this, the constructs elicited will be described and explored. This will be followed by a discussion of the PEGs using a PCP lens as used by Denner-Stewart (2010) and Cooper (2011). Finally, a thematic analysis of the interviews will be presented, identifying themes that emerged throughout the interview process.

4.1 Participants

Table 3 outlines the demographic information of the study participants. This is followed by a brief introduction to each participant.

Table 3: Demographic Information

Name	Age	Ethnicity	Marital Status	Occupation	Level of educational attainment	Number of children
Gemma	36	White British	Married	Civil engineer (P/T)	Degree	2
Sian	34	White British	Single (Cohabiting)	Researcher/ Lecturer	PhD	2
Kate	40	White South African/ British	Married	Stay at home mother	Degree	2
Jane	37	Portuguese/Indian	Single (Cohabiting)	Psychologist	Doctorate	2
Jo	36	White British	Divorced	Social Worker	Masters	1
Louise	37	White British	Married	Full-time mother	Degree	3

Gemma

Gemma had two children aged 2 and 5 years, one boy and one girl. She was married and lived in a village location. Gemma responded to an advertisement for the study placed in a children's group location. She spoke about a satisfactory consultation with an emergency department doctor that she had taken her 5 year old daughter to due to dislocation of the radius bone. The less than satisfactory consultation that Gemma discussed was an

emergency ‘out of hours’ consultation that she had taken her 2 year old son to due to high temperature and red, painful eyes. She had previously taken her children to this doctor on two occasions. Neither child had any ongoing medical needs although her daughter experienced a ‘pulled elbow’ on several occasions.

Sian

Sian had two children aged 2 and 4 years, both girls. She lived with her partner and children in a village location. Sian responded to an advert for the study placed in a childcare facility. Sian spoke about a satisfactory consultation with her youngest daughter. This was an emergency appointment with a GP due to her child developing red spots on her skin. Sian had taken her child to see this doctor on 3-4 previous occasions. Sian discussed a less than satisfactory consultation that she took her eldest daughter to when she was 4 years old. This was an emergency, out of hours appointment due to vomiting, general ill health and food refusal. This was the first time she had met this doctor. Sian’s children had no ongoing medical needs.

Kate

Kate had two children, a boy and a girl aged 6 and 5 years. She lived in a town location with her husband and children. Her family were not located locally. Kate responded to an advertisement for the study placed in a children’s group location. Kate spoke about a satisfactory consultation with a GP that she took her daughter to. This was an emergency appointment due to a high heart rate and shallow breathing. The appointment was with her family GP. The less than satisfactory consultation that Kate discussed was with her 6 year old child, and was a routine appointment with an ear, nose and throat (ENT) specialist in a hospital setting. This was the first time Kate had seen this doctor. Kate’s son had ongoing medical needs due to glue ear causing impaired hearing.

Jane

Jane had two sons, aged 3 years and 8 months respectively. She lived in a village with her partner and children. Jane was recruited via snowballing having heard about the study by word of mouth. Jane spoke about a satisfactory consultation with a GP for her youngest son for a rash he had on his face. This was a routine appointment. She had seen this doctor on approximately 3 occasions in the past year. The less than satisfactory consultation that Jane discussed was with her eldest son aged 3. This was a routine appointment with a GP whom they had not met before for an infection he had in a cut on his finger. Neither of Jane’s children had any ongoing medical needs.

Jo

Jo had one son and lived in a village, with extended family located locally. Jo was recruited via snowballing having heard about the study by word of mouth. Jo spoke about a satisfactory consultation with a GP. The consultation was a routine appointment with a doctor they had seen approximately 4 times in the previous year. The appointment was for chronic sinusitis. The less than satisfactory consultation that Jo discussed was an emergency appointment with a GP that they had not met before. The consultation was for croup. Jo's son had a diagnosis of childhood asthma.

Louise

Louise had three children aged 2 ½, 5 and 8 including two boys and a girl. She lived in a village with her husband and children, with family living locally. Louise was recruited via snowballing having heard about the study by word of mouth. Louise spoke about a satisfactory consultation with her 5 year old daughter. This was a routine appointment with a GP for localised skin irritation. Louise had seen this GP on two previous occasions in the past year. The less than satisfactory consultation that Louise discussed was an emergency appointment with a GP with her 2 year old son. This was for a rash, tummy ache and general ill health. Louise had seen this GP on 2 occasions in the past year. None of Louise's children have any on-going medical needs.

4.2 Summary of Consultations

In total 12 consultations were described, 7 of which were emergency appointments and 5 routine appointments. 10 appointments were with GPs, 1 with an accident and emergency doctor and one was with an ear, nose and throat specialist. Half of the appointments were with doctors that the mothers had met before and half were with doctors they had not previously encountered.

Interestingly, of the consultations that were described as satisfactory, all but one were with a GP that the participant had met on more than one occasion previously, with the other consultation being with an emergency doctor that they had not met before. Half of the satisfactory appointments were emergency appointments and half were routine.

Of the consultations that were described as less than satisfactory, all but one were with a GP, and only one of the participants had met the GP before, with all other less than satisfactory consultations being with a doctor that the participant had not met previously. Two thirds of the less than satisfactory appointments were emergency appointments, with the remaining third being routine appointments. Table 4 depicts the types of consultations with corresponding percentages.

It is interesting to reflect that the majority of satisfactory consultations were with doctors that the participants had met previously. It is possible that having had a previous consultation meant that the participants had an existing construal of the consultation which may have previously been applied and either validated or invalidated and re-construed to increase the likelihood that subsequent consultations would validate the participants' constructions.

Table 4: Frequencies of Consultation Type

	Satisfactory		**Less than satisfactory**		**Both***
Details of consultation	No. of appointments	Percentage of sample (Satisfactory)		Percentage of sample (Less than satisfactory)	Percentage of total sample
Emergency	3	50%	4	66.7%	58.3%
Routine	3	50%	2	33.3%	41.7%
1st consultation with Doctor	1	16.7%	5	83.3%	50%
Doctor previously seen	5	83.3%	1	16.7%	50%
Speciality GP	5	83.3%	5	16.7%	83.3%
Speciality Other	1 (A&E)	16.7%	1(ENT)	83.3%	16.7%
Nature of child's condition					
Significant risk to health	1	16.7%	0	0%	8.3%
Risk to health unknown	1	16.7%	4	66.7%	41.7%
Minor risk too health	4	66.7%	2	33.3%	50%

*Percentage of total (satisfactory + less than satisfactory)

4.3 Participant Anxiety

Table 4 indicates the severity of the conditions participants' children were presenting with at their consultations. Whilst none of the children were subsequently diagnosed with critical or life threatening conditions or conditions requiring hospital admissions, some symptoms were more ambiguous and resulted in a greater level of anxiety for the mothers. Within the satisfactory consultations 1 mother presented with a child who had significant health risks, this was Kate who took her child for a consultation due to a high heart rate and shallow breathing. One of the satisfactory consultations was for symptoms, the severity of which,

was not known, this was Sian who took her daughter to a consultation due to red spots on her skin. The remaining four consultations were for conditions that were mild. Within the less than satisfactory consultations, there were none for significant health risks, four were for health complaints where severity of the health complaint was unknown. These included Sian who took her daughter for a consultation due to vomiting and food refusal, Jo who took her son for croup and had previously had an A&E admission for this, Gemma whose son had a fever and painful eyes and Louise whose son was experiencing a high temperature and stomach pain. The remaining two consultations in the less than satisfactory group were for minor health complaints.

Where consultations involved symptoms that were either of high or unknown risk to health, mother's in the study experienced a greater sense of anxiety than when presenting with mild health conditions. It is therefore important to reflect on the impact of anxiety on the experience of their consultations. This links with the existing constructions participants held for consultations, the development of which is linked to the previously discussed internal working models of attachment (Bowlby, 1969). Where anxiety or threat is experienced i.e. when a child presents with a serious or ambiguous health condition the attachment system is activated. Therefore the experience of medical consultations will naturally be influenced by the level of anxiety experienced by each participant.

In addition participants described experiencing anxiety unrelated to their child's wellbeing. For example Kate described feeling anxious ahead of her son's routine appointment with the audiology department as she had not previously taken her son to these appointments and was concerned that her views of his condition and treatment may be challenged. Feeling unprepared for the experience as well as holding concern that she may be challenged in her role led to an increased feeling of anxiety. Similarly, Sian described feeling unsure prior to her satisfactory consultation as she had previously experienced inconsistent and therefore unpredictable interactions with the doctor. In addition to this she described considerable work stress. Therefore throughout analysis it was important to reflect on the varied and complex experience of anxiety experienced in consultations.

4.4 PEG Data

The data collected from the participants' PEGs are presented below in brief form (a full version can be found in Appendix XII). Each participant's constructions of their role as a mother, themselves as an individual and the doctor's role are considered and discussed. Constructs for each of these are given having been identified during the interview and mapped to the Classification system for Personal Constructs (Feixas et al, 2002). Opposing poles were clarified through PEG content and discussions in interviews. Following this, there

is an exploration of the differences and similarities between the PEGs for the satisfactory and less than satisfactory consultations using a PCP perspective. A summary is then given to explore commonalities amongst the constructs of the participants.

4.4.1 Gemma

Table 5: Gemma's PEG: Satisfactory Consultation

Perceiver/ Element	Self	Mother	Doctor
Self	Calm Not panic Organised	Reassuring Caring Flustered Managing Showing confidence Empathy	Competent Engaging Considerate Calm
Mother	Critical Caring Regimented Cold	Keeping my daughter calm Control Good mother Organised Nurturing	Helping child Caused daughter distress He did his job Smiley, chatty
Doctor	Made right decision Calm and not worried Not stressed	In control Calm Had confidence in me Caring.	Getting the job done Reassuring Managing feelings Friendly

Table 6: Gemma's PEG: Less than Satisfactory Consultation

Perceiver/ Element	Self	Mother	Doctor
Self	I gave facts Helpful	Comforting Calm Explaining	Medically, very professional Not reassuring
Mother	I did well to go with my gut- he needed to see a doctor Difficult to separate self and mother	Reassuring son but following doctor's instructions Having to do what doctor asked but wasn't making him happy- felt guilty	Doctor didn't interact with him at all Not reassuring Medically doing what had to do but not caring
Doctor	Nuisance Worrier Time waster	I'm a worrier I would hope he would say not a time waster Caring Compliant	Professional/ competent Providing information Fixing the person

4.4.1.1 Gemma's Constructs

To begin the analysis of Gemma's constructs, emerging poles were recorded following an in-depth reading of the PEGs. These were then mapped to the value constructs as outlined by Feixas and colleagues (Feixas, 1988, Feixas et al, 2002). (P) denotes the preferred pole as indicated by Gemma.

Self:

The following constructs relate to Gemma's understanding of herself as an individual.

Calm (p) ——————————— Panic

This construct relates to the Emotional area of the classification system for personal constructs (Feixas et al, 2002), in particular the category Balanced-Unbalanced. Gemma described herself as a calm individual in the consultations. However, when she was discussing herself as a mother she explained that it was important to present as calm even though she experienced feeling 'flustered' at times. Gemma placed herself at the preferred pole of calm in both consultations that she described.

Helpful (p) ——————————— Nuisance

Gemma identified herself as helpful by making correct decisions and providing information. In her less than satisfactory consultation, whilst she identifies herself in this way, this perception was invalidated as she perceived that the doctor viewed her as a nuisance and time waster, which is not how she anticipated his perception. This construct can be mapped to the Relational area and specifically the Conformist-Rebel category of the CSPC (Feixas et al, 2002).

Mother:

The following constructs relate to Gemma's understanding of herself as a mother:

Confident (p) ——————————— Flustered

This construct relates to the Intellectual/Operational area, in particular the Capable-Incapable category, as Gemma describes the difference between feeling confident and in control and feeling flustered and out of control. She identifies confident as the preferred pole. In order to feel confident Gemma talked about needing to be organised and in control, but this then creates the potential for her to move into being regimented and cold, the contrast pole to caring. This may reflect an area where Gemma experiences some conflict in her role as a mother.

Caring (p) ——————————— Regimented/Cold

This construct relates to the Emotional area outlined by Feixas et al. (2002). Gemma's preferred pole is caring and is in contrast to being regimented and cold, reflecting the Warm-Cold construct as outlined in the classification system for personal constructs (CSPC).

Caring ——— Attentive

In this construct Gemma describes a conflict between being caring and nurturing towards her child, which she connects with being a good mother, and being attentive to the doctor by listening and complying with requests. Gemma describes difficulties aligning herself with a particular pole, instead moving between the two poles of this construct. In PCP terms this is described as 'slot rattling' (Winter & Procter, 2013). This may reflect a difficulty in balancing characteristics of the self vs. mother constructs as Gemma presented as a conscientious individual keen to be approved of whilst being dedicated to her role as a mother, which she recognises as one that predominantly requires her to be caring towards her child. This construct again reflects Warm-Cold in the Emotional area in the CSPC as being attentive to the doctor involves being distant and insensitive to the needs of her child.

Compliant (p) ——— Dismissive

Gemma's construct regarding how the doctor views her relates to the Relational area and in particular the Conformist/Rebel category. Gemma is keen that the doctor views her as attentive to him, both as a mother and an individual, and compliant with his requests. However, this again can result in some conflict, as the context of the consultation demands that the child is undressed for examination or that investigations are carried out, therefore requiring Gemma to be compliant whilst sacrificing her preferred pole in previously mentioned constructs as caring. Gemma described experiencing guilt in this situation, which in PCP terms is the experience of dislodgement from one's core role (Winter & Procter, 2013).

Good mother (p) ——— Bad mother

This construct relates to the Moral area outlined by Feixas et al (2002). Gemma aligns with being a good mother by demonstrating calm and in control characteristics as well as nurturing her children. A bad mother is considered to be one that is too regimented and not connected with their child. When further considering some of the conflicts that Gemma describes in her role it can be seen that fulfilling her criteria of a good mother at times involves utilising aspects she relates to being a bad mother. When she is required to attend to the doctor in order to ask questions or share information she experiences a sense of conflict as this can make her feel that she is neglecting the emotional needs of her child in these moments.

Doctor:

Calm (p) ——————————— Panic

Interestingly the constructs Gemma described relating to herself and her role as a mother are mirrored somewhat in those that relate to the role of the doctor. An example of this is the construct of calm/panic, which relates to the Emotional area of the CSPC and the Balanced/ Unbalanced category. It was important for Gemma that the doctor she saw in consultations was calm and reassuring.

Attentive/ engaged (p) ——————————— Professional

This construct again relates to the Warm/Cold category within the emotional area and reflects Gemma's preference for a doctor not to be too medically focused or clinically professional, but to demonstrate warmth and sensitivity towards her and her children.

4.4.1.2. Comparison of Gemma's PEGs:

In the consultation that Gemma identified as satisfactory her experience reflects a validation of her constructions as they endorse her preferred poles as calm, nurturing and confident, characteristics she anticipated in the consultation. These aspects are subsumed by her overall construction of a good mother. The preferred poles of the constructs associated with the doctor role include being calm, attentive and engaged rather than just medically professional or panicked. These too were endorsed in her satisfactory consultation.

In the consultation that Gemma described as less than satisfactory Gemma also identifies herself as calm and caring, suggesting that these reflect core constructs she holds about herself as a mother. However, in this consultation she was concerned that the doctor may perceive her as a worrier and nuisance and that the conflict she felt between complying with the doctor's requests and attending to her son may have led him to perceive her as non-compliant and wasting his time. These elements are at odds with how she views herself and may reflect an experience of invalidation. She also viewed the doctor in this consultation as more clinical and less reassuring and engaging, which invalidated her prediction of how a doctor will conduct themselves in a consultation.

4.4.1.3 Summary of Gemma's Constructs:

Gemma described a conflict that by being too calm and in control she may be regimented and cold, which she identifies as the contrast pole to her preference of being caring. In the context of the emergency department consultation, Gemma appears to align more with the control pole as a necessary aspect of negotiating the situation. In accordance with the

Fragmentation Corollary[1] of Kelly's (1955) theory one can hold differing constructions that may appear incompatible. Therefore whilst being caring and being in control and regimented may be incompatible, Gemma employs these constructs as relevant to the context. In relation to this Gemma also reflected the self and mother could not easily be separated.

This is an interesting reflection about how the role of mother may contribute significantly to an individual's identity. In conversation with Gemma it became apparent that being organised was a characteristic she attributed to herself but was at odds with some of the important aspects of mothering which she described as nurturing and caring. This may be an example of where Kelly's Organisation Corollary[2] (Kelly, 1955) is relevant as the ordinal organisation of constructs enables the resolution of conflicts between the application of differing constructs.

4.4.2 Sian

Table 7: Sian's PEG: Satisfactory Consultation

Perceiver/ Element	Self	Mother	Doctor
Self	Concerned Grateful Interested Absorbing advice	Reassuring and caring Not different to Self Concerned Keen for medical expert opinion Wanted to know how to care for her Wanted a good experience for my child	Experienced Calm Distant Reassuring Getting expected response Reliable knowledge
Mother	Seeking information Primary role- nurturing, supporting and caring Responsibility	Responsible Look after child Questioning Decision making	Initially disappointment as previously had poor experience with this doctor He made me feel empowered Good doctor Taking us seriously
Doctor	Responsible Give good care Capable and competent at communicating Respectful and kind A bit worried Interested	Capable Not responsible for child's health. I was demonstrating less concern than I felt due to daughter's presence. Responsible, caring, ready to take advice.	He embodied what he believed a doctor should be. Gentle, calm, respectful, helpful. Open communication Experienced.

[1] Fragmentation corollary (Kelly, 1955 p.77) refers to the employment of a variety constructions subsystems which are incompatible.

[2] Organisational corollary (Kelly, 1955 p.56) refers to the personal construction systems individuals hold which reflects ordinal relationships between constructs. Superordinal constructs subsume subordinal constructs. The organisational corollary enables individuals to resolve conflicts regarding when to use constructs.

Table 8: Sian's PEG: Less than Satisfactory Consultation

Perceiver/ Element	Self	Mother	Doctor
Self	A bit tense. This was a moment to get some advice. Pressured	I didn't want to put my daughter in an awkward position but wanted to help the GP. Saw role as someone who had been monitoring her. Illness was beyond competency of parent/ mother could manage- need help/ advice.	Didn't embody role of a good GP. Didn't inspire confidence. Role as sign posting to other medical professionals. Questioned competency. Not calming or reassuring with advice.
Mother	Confusing. Conflict in role.	Slightly unsuccessful. Key intermediary between my child and the doctor. Not managing it well. Wanted child to feel happy, confident going to the doctor- ok to trust doctor.	He didn't want to take responsibility. Not helpful Not engaged with child Not satisfactory answer.
Doctor	Unassertive with my child as negotiated more, can't force child to do things. Children unruly, not doing what supposed to do. Little bit scatty Stressed. Distracted- paying attention to both girls and answer doctors questions.	Hard to separate two roles in my mind (self and mother). Not making children follow instructions. Not taking charge of situation. I wish she was able to get her daughter to follow instructions- would be helpful.	Not engaging. Checking for signs of immediate danger. In absence of danger, sign posting for help. Not meaningful interaction. No strong ethos of what it means to be a GP. Busy Performing basics of role.

4.4.2.1 Sian's Constructs

<u>Self:</u>

Concern (p) ——————— Indifference

One of Sian's value constructs related to her level of concern. She demonstrated this by describing not only concern regarding her own child but a wider sense of concern for other children whose health may be at risk due to contact with her child. She related concern as a characteristic of herself as an individual. This construct can be mapped to the Altruist/ Egoist category within the Moral area of the CSPC as it relates to Sian's kindness and generosity (Feixas et al, 2002).

Calm (p) ——————— Stressed

Sian also identified the value construct of calm/ stressed, with calm her preferred pole, and this can be mapped to the Balance/Unbalanced category of the Emotional area of the CSPC

(Feixas et al, 2002). Being perceived as stressed in her less than satisfactory consultation may have contributed to this experience.

Responsibility (p) ——————— Disregard

Sian relates a number of different situations to this construct, in line with Kelly's Range Corollary[3], which suggests that there is a finite range of events for which a construct is convenient (Kelly, 1955). In completing her PEGs Sian spoke about being responsible in relation to her decision making and information seeking, suggesting a link between these construct poles in understanding herself as an individual. This construct relates to the Responsible/ Irresponsible category within the Moral area of the CSPC (Feixas et al, 2002).

<u>Mother:</u>

Capable (p) ——————— Not managing

This construct relates to the Capable/ Incapable category of the Intellectual/Operational area of the CSPC (Feixas et al, 2002). This is in reference to Sian's understanding of the role of a mother including being in control, competent and capable. She believed that the doctor perceived her as capable and competent in her satisfactory consultation as opposed to the less than satisfactory consultation when she felt that the doctor perceived her as scatty, unassertive and lacking control. It is therefore possible that her understanding of herself and her ability to fulfil the role of a mother is invalidated in the latter consultation.

Caring (p) ——————— Distracted

This construct maps to the Warm/ Cold category of the Emotional area of the CSPC (Feixas et al, 2002). This again relates to how Sian felt she was perceived in her consultations. She describes feeling conflict between caring for her child by being attentive and nurturing and being distracted by needing to attend to the doctor and comply with their requests. She also felt compromised as she recognised protecting her child from distress as an aspect of caring and was unable to fulfil this during times she tried to persuade and encourage her child to cooperate with examinations.

<u>Doctor:</u>

Calm/ gentle (p) ——————— Rushed

This construct can be mapped to the Balanced/ Unbalanced category of the Emotional area of the CSPC (Feixas et al, 2002). Important characteristics of a doctor to Sian included being calm, gentle and respectful. These characteristics were recognised in the doctor in Sian's

[3] Range Corollary (Kelly, 1955 p.76) refers to the range of events that a construct can be employed to anticipate.

satisfactory consultation in contrast to the doctor in the less than satisfactory consultation, who was described as busy, rushed and not calming or reassuring.

Good doctor (p) ——————————— Bad Doctor

Sian's understanding of a good doctor who listens, engages, is calm and gentle fits with the good pole of the Good/Bad category in the Moral area of the CSPC (Feixas et al, 2002). She describes the doctor she saw for the less than satisfactory consultation as not embodying what a good doctor should be.

4.4.2.2 Comparison of Sian's PEGs

In Sian's satisfactory consultation she identified herself as concerned but not too stressed. In her less than satisfactory consultation she describes experiencing conflict between her role as a mother and being compliant with the doctor's requests. Interestingly, Sian believed that the doctor perceived her as stressed in the less than satisfactory consultation, and it is possible that being viewed at the opposing pole to her preference may have contributed to her experience of the consultation as less than satisfactory.

In Sian's satisfactory consultation she saw a doctor that she had previously had a poor experience with. She describes an initial sense of disappointment and anticipated another less than satisfactory consultation. However, her predictions in this instance were invalidated as she described the consultation as empowering and the doctor as calm, gentle and experienced, which she recognises as the characteristics of a good doctor. This suggests that Sian does not hold her construing in this context too tightly as she is able to loosen her construing to allow for more variation in her predictions.

4.4.2.3 Summary of Sian's Constructs

Sian's construal of her role as a mother is to be capable and caring, which was validated in her satisfactory consultation. Her construal of how a doctor should be is engaged, gentle and calm. It was important for Sian to present as calm and responsible, attributes she acknowledges as part of how she identifies as an individual. She explained that she found it difficult to separate her characteristics as an individual and as a mother. This once again demonstrates how the role of being a mother may be a key element of a person's identity.

4.4.3 Kate

Table 9: Kate's PEG: Satisfactory Consultation

Perceiver/ Element	Self	Mother	Doctor
Self	Respectful Came across as having it together.	In control Understand child's needs Advocate for my child	Warm Professional Takes me serious. Honest, relates. Concerned but not alarmed.
Mother	Child behaving nicely. Looked together- in hand. (Control)	Child's best advocate. Mind reading. Handling. Fall short of mothering instinct- unrealistic. Ideals from things you read, see and what women say, NCT. It's a fallacy but can't help but absorb it.	Partnership. Expertise. Rapport. Respect.
Doctor	Might have over-estimated my ability to advocate. Grateful May have thought I had it more together than I did.	I understood seriousness- responsive mother. Warm mother Child focused mother, she was snuggled into me. Mummyish.	Professional. Professionally alarmist, sounding out (severity) but not creating panic.

Table 10: Kate's PEG: Less than Satisfactory Consultation

Perceiver/ Element	Self	Mother	Doctor
Self	Nervous Unsure	Supportive. Prepared. Advocate for son.	Going about job in a perfunctory way. Routine for her but not for us.
Mother	Unsure of myself because of my nervousness and history of not knowing what to expect. Worried.	I'm looking after my little boy. Had all the information.	She was just doing her job. I didn't relate to her. Not very empathetic. Not clear about next step- perhaps a locum?
Doctor	Just seen me as a typical middle class mummy.	Typical middle class mummy. Well turned out child- first world problem. A little bit breast feedish, a little bit blueberry- natural, softly, non-interventionist.	It's her job to analyse data and relay that in lay terms. Not experienced helping with decisions.

4.4.3.1 Kate's Constructs

Self:

Prepared (p) ——————— Nervous/ unsure

This construct relates to the Strong/ Weak category of the Personal area of the CSPC (Feixas et al, 2002). Kate's preferred pole is prepared as she described feeling more in control and powerful when she feels prepared. This is how she describes herself in the satisfactory consultation. In contrast she experiences feeling nervous in her less than satisfactory consultation when she describes feeling vulnerable and unsure. In PCP terms this feeling of worry or anxiety can be explained as difficulty construing the world or experience through existing constructs (Winter & Procter, 2013).

Respectful (p) ——————————— Disrespectful

This construct can be mapped to the Respectful/Judgemental category of the Moral area of the CSPC (Feixas et al, 2002). Kate described feeling a sense of respect and gratitude at the provision of care she has access to. This may relate to Kate's cultural and social understanding of herself as she made frequent references to culture of origin making her aware others in less privileged positions may not be afforded this care. This is in line with our understanding that the cultural belief systems and discourses a person grows up with shape the development of their construct system (Procter & Parry, 1978).

Mother:

Control (p) ——————————— Reactive

This construct relates to the Capable/Incapable category of the Intellectual/Operational area of the CSPC (Feixas et al, 2002). Kate described the importance of being in control of the situation including the behaviour of her child as a representation of her abilities as a mother. The preparation and understanding she had in her satisfactory experience led her to feel in control and empowered. She described feeling together and believing that the doctor in this situation perceived her as competent. In the less than satisfactory consultation Kate described feeling worried that she may struggle to make decisions on her own and may be influenced by the doctor to act in a way that was contrary to her beliefs about the appropriate medical intervention.

Warm (p) ——————————— Cold

Kate describes being warm as an important aspect of being a mother. This maps to the Warm/Cold category of the Emotional area of the CSPC (Feixas et al, 2002). In her satisfactory consultation she believed that the doctor perceived her in this way, thus providing a validating experience as she anticipated being perceived in this way. Throughout

both PEG completions she referenced the importance of being supportive and caring as important characteristic of mothering.

Instinct

Kate talks about her understanding of instinct associated with being a mother. Kate relates this to intuitively knowing what the needs of her child are without having to ask. Kate describes this ability as unrealistic and a fallacy but is conflicted as she talks about not being able to help but absorb this message.

Doctor:

Concern (p) ——————————— Panic

This construct relates to the Balanced/ Unbalanced category of the Emotional area of the CSPC (Feixas et al, 2002). Kate's preferred pole is concern and she distinguishes this from panic as an appropriate level of concern in relation to the medical condition.

Warm (p) ——————————— Cold

Interestingly, Kate described the Warm/Cold category of the Emotional area of the CSPC (Feixas et al, 2002) as important characteristics of a doctor and a mother. In her satisfactory consultation she describes the doctor as warm, friendly, nice, engaged and empathetic in contrast to the less than satisfactory consultation, in which she experienced the doctor as cold and routine. In her satisfactory consultation she experienced being perceived as warm as well as experiencing the doctor as warm. This experience therefore validated her prediction of the characteristics of both a mother's role and a doctor's role.

Accepting (p) ——————————— Judgemental

This construct maps to the Respectful/ Judgemental category of the Moral area of the CSPC (Feixas et al, 2002). Kate references stereotypes of mothers throughout the PEGs but in particular when describing how she believed the doctor perceived her as a mother. In her less than satisfactory consultation she recounts stereotypes of mothering including a dedication to organic produce, being focused on natural interventions and being perceived as anti-medicine in this way. Of interest, Kate debunks this stereotype and is keen not to be perceived in this way whilst at the same time recognising aspects of her own conduct that adhere to it.

4.4.3.2 Comparison of Kate's PEGs

In Kate's satisfactory consultation her constructs relating to how she understands herself and the elements of being a mother were validated. In particular, she experienced feeling prepared and in control. She believed that the doctor perceived her in this way and was accepting of her. In both the satisfactory and less than satisfactory consultations she

believed that she was perceived as warm. However, in her less than satisfactory consultation she believed that she was perceived as lacking control and she felt nervous. She also perceived the doctor as cold and lacking in empathy and rapport as well as judging her as a mother. Kate also spoke about feeling that she knew what to expect in her satisfactory consultation whereas she anticipated the less than satisfactory consultation as more unpredictable, resulting in her feelings of anxiety or nervousness.

4.4.3.3 Summary of Kate's Constructs

Kate's constructs regarding being a mother relate to the Emotional area of the CSPC (Feixas et al, 2002). As a mother she aligns herself with the poles of warmth and control. Her position regarding the construct of instinct is less clear as she appears to be conflicted between her internal feelings regarding the ability to intuit her children's needs, which she appears to believe is both desirable and impossible. The experience in her less than satisfactory consultation appears to echo this somewhat as she demonstrates concern that she is perceived as a caricature of a mother in her circumstances whilst acknowledging that she embodies some of these characteristics.

4.4.4 Jane

Table 11: Jane's PEG: Satisfactory Consultation

Perceiver/ Element	Self	Mother	Doctor
Self	To the point, what I thought I needed to say Aware of what I wanted as a treatment	Worried. Disappointed that needed to go to the doctor. Disappointed that cream not working on that area. Aware he needed additional treatment.	Very nice. A bit strange Good listener Aware of previous consultations. Caring
Mother	Confident Aware.	Adequately concerned about the rash. At ease to explain train of thought.	Less engaged with my son than usual. I like him Variable in communication, sometimes chatty, others not- unpredictable.
Doctor	Happy to agree with me- knows what I'm talking about. Reassuring. Fairly reliable.	Caring. Aware of his needs. Conscious of what has/ hasn't worked before.	Safe. Explaining thoroughly- pros and cons. Listened to concerns. Aware of what tried before.

Table 12: Jane's PEG: Less than Satisfactory Consultation

Perceiver/ Element	Self	Mother	Doctor
Self	Not too worried Concerned about the infection Unsure what should be done Doubt Comfortable	Uncertain Worried Eager to fix the problem Concerned about outcome- antibiotics as didn't want this.	Friendly. Professional. Good listener. A bit concerned about what meant to be doing- antibiotics or topical treatment. Not confident in decisions.
Mother	Concerned with making sure solved. Not keen on going to doctors. Dismissive of clinicians' role/ of guideline following. Confident in saying what felt necessary, questioning doctor.	Comfortable. Confident. Listened to. Aware of needs. Going to doctor- warranted. Distracted.	Very sweet with son. Engaged him in conversation. Warmth and attentiveness.
Doctor	Somebody they could approach with thoughts and questions re: choices of medication/ treatment. Easy going Polite. Not too complicated within a consultation.	Caring and concerned. Balanced in my concerns. Didn't think I was being seen as someone too concerned.	Caring. Listened. Safe in explaining why medication. Clear why prescribing antibiotics. Clear in information.

4.4.4.1 Jane's Constructs

Self:

Control/aware (p) ——————————— Unsure/ unaware

This construct relates to the Capable/ Incapable category of the Intellectual/Operational area of the CSPC (Feixas et al, 2002). Jane described feeling in control in her satisfactory consultation and feeling confident to ask for the treatment she believed to be appropriate. This was validated when the doctor agreed with her and prescribed as requested. Jane described having an understanding of what she needed to convey and what she wanted to happen and therefore felt a sense of empowerment.

Mother:

Relaxed (p) ——————————— Worried

This construct relates to the Balance/ Unbalanced category of the Emotional area of the CSPC (Feixas et al, 2002). In both of consultations she identifies as being worried in relation to her role as a mother. In her less than satisfactory consultation she described herself as not too worried despite being worried as a mother. This is an interesting contradiction within the same context. It is possible that Jane's overall level of anxiety as an individual was not considered high but that this increased when specifically relating it to her role as a mother.

Caring (p) ——————————— Cold

This construct relates to the Warm/ Cold category of the Emotional area of the CSPC (Feixas et al, 2002). This relates to one of Jane's guiding values as a mother, which is being caring and warm towards her children. In both consultations Jane aligned with the caring pole of the construct and believed that she was perceived in this way by the doctor she saw. It is therefore likely Jane's understanding of herself as a caring and warm mother was validated in each experience.

Doctor:

Engaged/ Friendly/ Warm (p) ——————— Disinterested/ uncaring

This construct can be mapped to the Pleasant/ Unpleasant category of the Relational area of the CSPC (Feixas et al, 2002). Jane used words such as warm and friendly to describe the doctor she saw in the less than satisfactory consultation. She labelled the doctor in the satisfactory consultation as nice and a good listener although felt that he was less engaged than she would have liked. Although she used words such as warm, the construct maps to this category as her descriptions are more relevant to the relationships with the doctors rather than their emotional attitude.

Safe/ competent (p) ——————————— Incompetent/ inexperienced

This construct relates to the Capable/Incapable category of the Intellectual/Operational area of the CSPC (Feixas et al, 2002). In both consultations, Jane described the doctors as safe. However, in her less than satisfactory consultation she questioned the competency of the doctor more. This may have been because in prescribing a medication that was not anticipated he invalidated Jane's prediction of the outcome of the consultation.

4.4.4.2 Comparison of Jane's PEGs

Whilst Jane recognises that the characteristics that she favours in a doctor include being engaging, listening and friendly, the presence or absence of these did not determine whether the consultation was satisfactory or less than satisfactory. Indeed, the attributes of the doctor in her less than satisfactory consultation aligned with the preferred poles of the constructs associated with doctors, whereas those identified in her satisfactory consultation included being less engaged and having little rapport with her son. Importantly, Jane reported knowing the doctor in the satisfactory consultation and being aware of what she described as his "variable communication". Therefore, Jane had a construct that she could apply to this scenario based on her previous experience, which meant that her prediction was validated.

This relates to the Modulation Corollary[4] of Kelly's theory, which describes the evolution of construct systems (Kelly, 1963). Jane's constructs regarding the role of the doctor may be more permeable, thus allowing for greater variation in the range of convenience of this construct.

The main factor influencing whether the consultation was satisfactory or less than satisfactory was whether Jane's predicted outcome was validated. In her satisfactory consultation, Jane describes knowing clearly what the predicted outcome should be, i.e. what medical intervention was appropriate. When this was confirmed, the constructs relating to the consultation as well as those relating to how she understands herself (competent/ intelligent and in control) were also validated.

4.4.4.3 Summary of Jane's Constructs

Jane used fewer value constructs than other participants in the study and spoke about more context and relational constructs that appeared more subordinate as they were less associated with her core constructs. It was less clear in Jane's examples which constructs were essential to satisfactory consultations. Overall, there was a sense of flexibility in her reflections, with allowances for variation in interpersonal styles of the doctors she saw. Anticipated outcomes that validated her specific predictions about practical aspects of the consultation such as treatment appeared the most relevant.

4.4.5 Jo

Table 13: Jo's PEG: Satisfactory Consultation

Perceiver/ Element	Self	Mother	Doctor
Self	Caring Informed Asking appropriate questions Reasonable	Caring Managing son's behaviour In control Loving	Attentive Listened Reassuring
Mother	Wanting the best outcome for my son Asking appropriate questions Giving information	Trying to get the best outcome Really stressed	Reassuring Alleviated my concerns Knows me as a mother He is an attuned GP Gently spoken- smiles, nods, good eye contact
Doctor	Reasonable Calm	Caring Wanting the best for my child Able to manage him Loving I interacted with my son and encouraged him to interact with the doctor	Reassuring He gave a good outcome for my son

[4] Modulation Corollary (Kelly, 1963 p.77) refers to the variation in an individual's construct system which is limited by the permeability of the constructs within the range of convenience.

Table 14: Jo's PEG: Less than Satisfactory Consultation

Perceiver/ Element	Self	Mother	Doctor
Self	Anxious Concerned Seeking reassurance	Seeking answers Anxious. Keen for an outcome- medication Concerned	Dismissive of my anxieties Made me feel like I was wasting time
Mother	Anxious Description of what had happened and what was happening Distressing for my son	Advocate for child Doctor understand salient points Correct course of action	Really dismissive of concerns Wasting her time Not alleviating concerns Not regular doctor
Doctor	Anxious Pushy More forceful Ask can he have steroids- see me as wanting to medicate him	Asking appropriate questions Having his best interest at heart Appropriate following visit to A&E Caring	She asked appropriate questions Alleviate concerns by not over dramatizing Not needing to medicate- might be appropriate Least interventionist approach She might have thought she'd reassured me.

4.4.5.1 Jo's Constructs

Self:

Informed (p) ——————— Unaware

This construct relates to the Responsible/ Irresponsible category in the Moral area of the CSPC (Feixas et al, 2002). Jo described being informed of the needs and symptoms of her child and asking appropriate questions as an important aspect of her own personality and in relation to being a mother. In both her consultations she described being informed and giving the doctor relevant information. However, in her satisfactory consultation the doctor validated this aspect of her personality by listening and responding to the information she provided. In contrast to this, in her less than satisfactory consultation she experienced the response from the doctor as invalidating.

Reasonable (p) ——————— Pushy

This construct can be mapped to the Visceral/ Rational category of the CSPC (Feixas et al, 2002). Jo aligns herself with the reasonable or rational pole of this category. However, when she experienced the dismissive encounter in her less than satisfactory consultation she describes concern that the doctor experienced her as pushy and forceful. Jo had requested a specific medication for her son in this consultation following a recent emergency admission. Her understanding of herself as a reasonable individual was therefore invalidated in this scenario.

Calm (p)——————————— Anxious

This construct relates to the Balanced/ Unbalanced category in the Emotional area of the CSPC (Feixas et al, 2002). Jo described feeling comfortable and calm in her satisfactory consultation which was routine, whereas she was highly anxious in her emergency appointment, which she labelled as less than satisfactory. As previously noted, the experience of anxiety in PCP terms occurs when an individual is unable to construe their experience (Winter & Procter, 2013). This fits with the scenario Jo describes as she struggled to anticipate the less than satisfactory consultation as previous constructs of interacting with a doctor were invalidated.

Mother:

Caring (p) ——————————— Neglectful

This construct can be mapped to the Warm/ Cold category of the Emotional area of the CSPC (Feixas et al, 2002). Jo felt that this construct was validated in both consultations as she aligns herself with the caring pole and felt that this was recognised by both doctors.

Control (p)——————————— Reactive

This relates to the Capable/Incapable category of the Intellectual area of the CSPC (Feixas et al, 2002). Jo described an experience of being in control during her satisfactory consultation as she was able to manage the behaviour of her young son, who was not behaving as she would have wanted. She demonstrated control by getting her son to listen to her and follow her instructions. In contrast, Jo did not experience herself as in control in her less than satisfactory consultation due to being unable to alleviate the distress of her son and being unable to obtain the course of treatment she felt was appropriate.

Doctor:

Attuned/ Reassuring (p) ——————————— Dismissive

This relates to the Sympathetic/ Unsympathetic category of the Relational area of the CSPC (Feixas et al, 2002). Jo aligns the role of the doctor with being attuned, listening attentively and demonstrating empathy. In her satisfactory consultation she described in detail experiencing these characteristics from a doctor she had known for a number of years. Jo was very clear that this was absent in her less than satisfactory consultation and this invalidation of her anticipation of the characteristics a doctor should embody was a key factor in how she experienced the consultation.

4.4.5.2 Comparison of Jo's PEGs

Jo experienced the interpersonal style of the doctor in her satisfactory consultation as engaging and validating of how she perceived herself and her role as a mother. In addition, the doctor validated some of the struggles associated with being a mother, which she found reassuring. Jo described an existing relationship with the doctor in her satisfactory consultation, which suggests that she had a previously validated construction regarding his nature and could accurately predict the outcome of a consultation. Therefore, her experience of the consultation validated her anticipated outcome.

In contrast, in her less than satisfactory consultation the interpersonal style of the doctor was perceived as dismissive and invalidating as her anxiety and concerns were discredited. In addition, the doctor disagreed with Jo's perception of an appropriate medical path for her child, which again invalidated Jo's predicted outcome. Jo also expressed concern that she may have been perceived as pushy or forceful in this consultation. This is the opposing pole to Jo's preference, which may explain her discomfort at being aligned with these characteristics.

4.4.5.3 Summary of Jo's Constructs

In Jo's interview she was one of the clearest participants in distinguishing construct poles that defined a satisfactory versus a less than satisfactory consultation. The constructs that she described reflect her defined value constructs that represent her guiding principles informing her understanding of herself and her role as a mother as well as how a doctor should be in a consultation. She was confident and committed to these convictions, suggesting that she has tight construals of these roles.

4.4.6 Louise

Table 15: Louise's PEG: Satisfactory Consultation

Perceiver/ Element	Self	Mother	Doctor
Self	Knowledgeable Confident In control Relaxed	Calm Prepared Predict child's behaviour In control Experienced Good understanding of my child Confident- how my child was responding to the situation Nurturing Caring Proactive	Attentive Empathetic Thorough Displayed knowledge of difficulties Personable Careful Respectful
Mother	Caring Nurturing Sympathetic Confident Able to communicate Thorough understanding Assertive	Care for my child Clearly communicated history and relevant information Solve problem	Friendliness On same level as my daughter and talked to her. Made me feel I'd done everything I could do. Gave me confidence Thorough Listened Did what I expected
Doctor	Confident Able to communicate Reasonably intelligent Common sense Concerned	Had a handle on things My daughter was very good In control Reassuring Nurturing and caring Calm parent	Diagnose the problem Provide medical assessment Listening Empathetic and sympathetic Holistic Respectful because of examination

Table 16: Louise's PEG: Less than Satisfactory Consultation

Perceiver/ Element	Self	Mother	Doctor
Self	Concerned - my child was poorly and upset Communicative Confident Slightly flustered Really proactive Attentive	Experienced parent Looked in control but didn't feel it Stressed and worried Nurturing and caring Sympathetic side Practical	Calm Attentive Listened Respectful to a degree Nice manner with my son Thorough Insensitive
Mother	Nurturing and caring Sympathetic Calm Practical- chocolate buttons Communicative Confident Assertive	To present poorly child to the doctor quickly and get treatment Keep situation as calm as possible for doctor Child respond how needs to respond Caring and inventive side Needing to have control I hadn't done my job as a mother by giving chocolate buttons	Listened Relaxed and calm Competent Clear Lacked empathy with my situation- really affected how I felt about consultation
Doctor	Fairly confident Slightly distracted- trying to calm child down. Experienced Assertive	Experienced Distracted but degree of control Awareness of what doctor needed. Practical- too practical (chocolate buttons). Judgemental of mothering Relatively calm if distracted Intelligent parent Sensible	To diagnose problem and treat it Listen carefully to parent Give sensible and practical advice Holistic approach (not care/ empathy) Practical approach More empathetic once challenged.

4.4.6.1 Louise's Constructs

<u>Self:</u>

Knowledgeable (p) ———— Uninformed

This construct can be mapped to the Intelligent/ Dull category of the Intellectual/Operational area of the CSPC (Feixas et al, 2002). Louise describes herself as informed about details of the medical condition and about interventions already attempted as well as having a good understanding of her children and how they would behave in this context. Louise attributed this to herself as an individual as she felt it concerned the person she is regardless of her role.

Confident/Control (p)———— Uncontrolled

Linked to her knowledge is the sense of being in control of the situation, herself and her children. Louise again attributes this construct to herself as an individual as well as her role as a mother. This can be mapped to the Capable/ Incapable category of the Intellectual/

Operational area of the CSPC (Feixas et al, 2002). Louise gives examples of this by being assertive, asking questions and giving information.

Mother:

Experienced (p) ——————— Naïve

This construct maps to the Capable/Incapable category in the Intellectual/Operational area of the CSPC (Feixas et al, 2002). Louise describes being an experienced mother and relating this to being competent at parenting. Overall this construct was validated in both consultations. However, in her less than satisfactory consultation one of her parenting practices was criticised by the doctor. Louise described this as the major factor in defining the consultation as less than satisfactory. It is likely this action invalidated an important construct in understanding herself as a mother.

Calm (p) ——————————— Flustered/ Stressed

This construct relates to the Balanced/ Unbalanced category in the Emotional area of the CSPC (Feixas et al, 2002). Louise describes feeling stressed and flustered in her less than satisfactory consultation as she was concerned for the health of her child and was unable to manage his distress and behaviour. This resulted in the invalidation of her construal of herself as a mother. This construct is closely linked to her construal of control as she became stressed when she felt she was unable to manage the situation.

Confident/Control (p) ———— Uncontrolled

This construct applies to both Louise's construal of herself as an individual and her role as a mother. This is another indication of how closely linked the role of mothering was to the participants' identity. This construct relates to the Capable/ Incapable category of the Intellectual/ Operational area of the CSPC (Feixas et al, 2002). Louise's preferred pole is confident/ controlled and she was validated in both of her consultations in relation to her own conduct and knowledge. The exception to this was in her less than satisfactory consultation in relation to the behaviour of her son, who was distressed and would not cooperate with examination. This may have resulted in Louise experiencing this as invalidating and thus contributed to her experience of the consultation as less than satisfactory.

Nurturing/ caring (p) ——————— Uncaring

This construct can be mapped to the Warm/ Cold category of the Emotional area of the CSPC (Feixas et al, 2002). Louise placed a great deal of importance on this construct, in particular in reference to appeasing any distress her children were experiencing. In order to manage this she demonstrated care and affection. In both situations she believed that the doctor perceived her in this way, thus validating this construction.

Attentive (p)——————————Distracted

This construct relates to the Responsible/ Irresponsible category of the Moral area of the CSPC (Feixas et al, 2002). This refers to Louise's description of being attentive to the needs of her children and focused on attaining a necessary outcome for them. It is also relevant in her relationship with the doctor as she describes needing to attend to the consultations whilst being distracted by the distress her child was experiencing. Louise's preferred role is attentive, but in her less than satisfactory consultation she describes believing that the GP may have experienced her as distracted and thus would have perceived her as at the opposing pole to her preference.

Doctor:

Attentive/ Empathic (p)——————Insensitive

This construct relates to the Warm/Cold category of the Emotional area of the CSPC (Feixas et al, 2002). Louise described this as an important construct relating to the role of the doctor. Overall both consultations reflected a validation of this construct. However, in Louise's less than satisfactory consultation the doctor behaved in a way that invalidated this construction by criticising her.

Competent/ thorough (p)——————Incompetent

This construct maps to the Capable/Incapable category in the Intellectual/Operational area of the CSPC (Feixas et al, 2002). In both consultations the doctors conformed to Louise's predictions regarding their professional conduct.

Respectful (p)——————————— Judgemental

This construct maps to the Respectful/ Judgemental category of the Moral area of the CSPC (Feixas et al, 2002). Louise aligns the role of the doctor with the respectful pole of this construct and this was validated generally in both consultations. However, in her less than satisfactory consultation Louise describes feeling judged by the doctor.

4.4.6.2 Comparison of Louise's PEGs

In Louise's experience there was a specific event that resulted in one consultation being labelled as less than satisfactory. This event involved the doctor invalidating the value constructs associated with Louise fulfilling the role of a mother including being calm, experienced and in control. In addition, this event discredited Louise's prediction of how the doctor would conduct himself in this consultation. However, Louise was able to reflect on a number of positive aspects associated with her less than satisfactory consultation, perhaps because she had an existing relationship with the doctor which was positive. This may reflect

the Experience Corollary[5] (Kelly, 1963), as Louise may be able to vary her construction system having experienced replications of this event.

Louise also described feeling flustered, judged and not in control in her less than satisfactory consultation whereas her satisfactory consultation involved her being in control and her predictions of the outcome of this were validated.

4.4.6.3 Summary of Louise's Constructs

Louise describes feeling confident, proactive, assertive and knowledgeable in both consultations. These constructions were consistent across both consultations suggesting that they are guiding principles to which she adheres. This may indicate that these constructs are superordinate in her construct system.

4.4.7 Summary of PEG Findings

Core constructs associated with the role of being a mother common amongst participants included being caring, nurturing and calm. Being responsible and organised were also frequently identified as important constructs associated with being a mother. Most of the participants recognised some conflict between constructs. This was often due to the context of the consultation requiring them to move away from nurturing or protecting their child in order to comply with requests of the doctor such as attending to what they were saying or facilitating examinations. At times, in order to manage stress they also had to move away from preferred poles such as being attentive or caring to their child in order to be organised or manage their child's behaviour. In PCP terms this reflects the choice corollary[6] (Kelly, 1963), which refers to the ability of an individual to choose alternative poles of constructs in order to enable greater extension of their system of constructs.

Commonly preferred constructs participants identified for the role of the doctor included being empathic, attentive and sensitive. Overwhelmingly, where anticipated outcomes were invalidated, participants experienced the consultation as less than satisfactory.

In addition, participants held in mind the impact of being tired or busy on how the doctors presented. This demonstrates a level of flexibility regarding the perceptions participants held

[5] Experience Corollary (Kelly, 1963) refers to variation in the construction system occurring when an individual construes replications of events.

[6] Choice Corollary (Kelly, 1963) refers to choosing alternative (opposing poles) of a construct in order to enhance subsequent predictions. An individual therefore chooses between the certainty already established by the preferred pole of their constructs and broadening their understanding by choosing an alternative pole.

and in PCP terms a sociality[7] (Kelly, 1963), which is the process of construing another person's construction processes.

A common struggle for participants was to distinguish between constructs relating to themselves as individuals irrespective of their role as mothers and those related specifically to fulfilling the role of a mother. This suggests that the constructs related to being a mother may constitute core constructs that are central to an individual's identity (Kelly, 1955). In turn this indicates that being a mother is a core element of the participants' identity.

4.5 Themes

The following section describes and explores the major themes generated through the thematic analysis of the six interviews that were conducted. The overarching themes were organised in relation to the original research questions. They were then divided into superordinate and subordinate themes; these are presented in Table 15. The final themes were developed using the method outlined by Braun and Clarke (2006) and are depicted below in thematic maps and described using verbatim extracts from the interviews to illustrate them. The final thematic maps were developed from broader maps of themes and codes (Appendix XIII). The process of coding and generating themes can be traced through the audit trail (Appendix XIV) along with a full anonymised transcript with notes and initial coding (Appendix XV). It is important to recognise that the generation of themes is an interpretive and collaborative process between the researcher and the participants, with final themes reflecting the researcher's interpretation of the data collected at interview (Braun and Clarke, 2006).

Table 17: Final Themes from Interview Data

Overarching theme	Superordinate Themes	Subordinate Themes
How mothers perceive their role	Responsibility and Role	Expectations and Demands
		Conflict
	Control	Predicting and Managing
		Knowledge and Preparation
How mothers believe Doctors perceive them	Expectations of the role	Nurture
		Knowledge
	Judgement	Balancing needs
		Validation/ approval
How mothers perceive the Doctor they take their children to consultations with	Holistic care	Medical competency
		Managing feelings
	Validation	Predicted outcome
		Engagement

Themes are presented as independent entities. However, there are interactions and overlap between themes as they are invariably interconnected. These links will be discussed

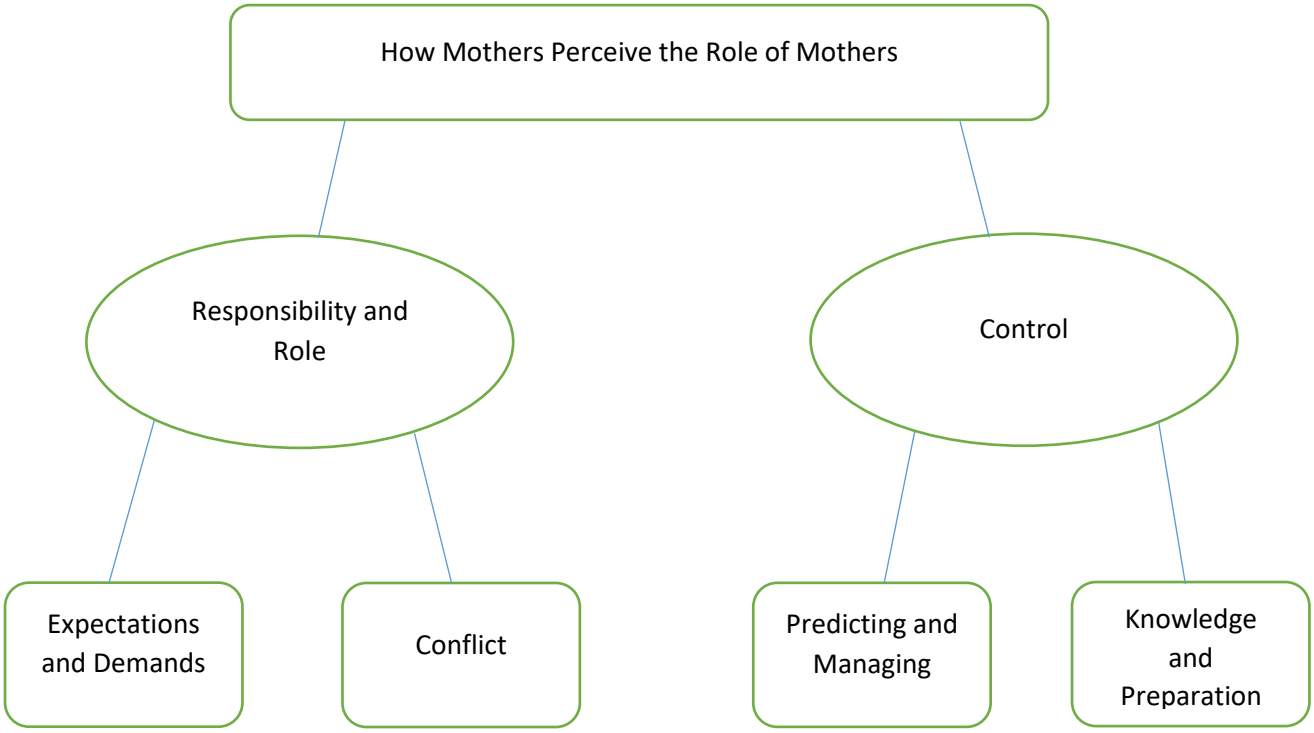
[7] Sociality Corollary (Kelly, 1963) refers to the extent to which an individual construes the construction process of another thus enabling them to participate in social processes with them.

alongside the explanations of each theme. Themes identified closely reflected the constructs described in detail in the above section. Therefore, a summary of themes is described in this section with reference to quotes listed in Appendix XVI.

4.6 How Mothers Perceive the Role of Mothers

Two superordinate themes regarding how mothers perceived their role emerged from the data. These included the responsibility and demands of the role associated with being a mother in a medical consultation for their child and the concept of control.

Figure 2: How Mothers Perceive the Role of Mothers



4.6.1. Responsibility and Role

This superordinate theme reflects the responsibilities and associated demands participants perceived as inherent in their role as a mother. The subordinate themes that emerged within this included the expectations and demands they perceive as well as the conflicts they experience within their role.

4.6.1.1 Expectations and Demands

A number of areas were grouped to form the collection of expectations and demands that the participants described. These included advocating for their child, reassuring and calming their child, protecting, offering competent care at home and managing their child's behaviour. The latter was frequently linked to how they felt they might be perceived, as their child's behaviour was considered a reflection of their competence as a mother. Participants

described concern that they may be negatively evaluated based on the behaviour of their child as Jo[1] describes.

Managing the behaviours of their children was a common theme participants' reflected on as part of the mother role. This was linked to the other expectations of the role including being caring and nurturing, as Jo[2] further illustrated.

The importance of being caring and nurturing was an expectation highlighted by most participants and was described by Jane[3].

Louise linked the nurturing and caring characteristics to remaining calm during consultations in order to best fulfil the role of a mother:

"… the sort of nurturing and caring characteristics would come to the fore, and this sympathetic side as I tried to… I think I remained pretty calm…"

This was further supported by Gemma[4.]

A further demand of the role identified by the majority of participants was advocating for their child. This reflected the deep sense of responsibility involving promoting the needs of their children, Kate reflected on this as follows:

"…you're supposed to be your child's best advocate"

In addition, some of the participants identified advocating for their child, as an opportunity to model seeking care and expressed that a further expectation of the role being to prepare their children for these situations, explained by Gemma[5].

Another significant demand of the role was identified as protecting one's child, as illustrated by Louise:

"… I feel one of my main roles as a mother is to keep them safe…"

Although the elements of this theme can be seen as broad-ranging, they are connected by the common thread that they collectively represent the expectations and demands that participants in the study referenced as key aspects of their roles as mothers. This can be particularly challenging and anxiety-provoking within this context. Sian encompasses the key elements of this theme in commenting on the role of a mother:

"…just responsible and caring, and ready to take advice…"

4.6.1.2 Conflict

The concept of conflict was present for the majority of the participants interviewed and appeared to be an inherent aspect of the role of a mother identified in the study. When the

need arose for a distressed child to be examined, participants frequently experienced guilt at sacrificing the emotional wellbeing of their child in order to meet their health needs. This was described by Gemma[6].

This sense of conflict was also evident when participants felt they had to choose between being organised and practical over being nurturing or caring. Although both aspects were identified as important elements of the role, the context often meant that participants had to choose which they could fulfil. The participants overwhelmingly identified being caring and nurturing as very important and thus often experienced conflict when they felt they had to choose more practical strategies during consultations. This is illustrated by Louise[7].

A further common area of conflict was that between attending to the doctor and attending to the needs of the child. A number of participants experienced stress when trying to meet the needs of their child whilst ensuring that the doctor they saw perceived them as attentive and conforming to requests. This links how mothers felt they were perceived by the doctor. Gemma explained this[8].

Finally, conflict was identified regarding the concept of intuition or mothering instinct. This was interesting as it is a concept that most participants reflected on as very personal and innate whilst describing the externally constructed pressures as described by Kate:

"…I sometimes think I fall short of having that mothering instinct…I just feel like it's this fallacy that's just, it's put on you, which you can't help but absorb it."

Kate acknowledged the impact of social pressures regarding mothering such as information from pre-natal groups and from the media. Despite a resistance to these constructions she recognised how difficult it was to avoid their impact. In relation to this, participants reflected that as a mother they should be able to meet the needs of their child and care for them at home. Consequently they were often conflicted about taking them to the doctor as this signalled that they were unable to fulfil this part of their role as illustrated by Jane[9].

It emerged that often participants felt that requiring medical intervention was invalidating to their mothering abilities as it indicated that they had not been able to meet the needs of their child.

4.6.2 Control

Another feature of how the participants viewed their role as a mother was having control within the context. In PCP terms this can be considered in relation to the circumspection-pre-emption-control cycle (Winter & Procter, 2013). This cycle involves the consideration and selection preceding the application of a particular construct pole. As previously discussed

anxiety occurs when an individual struggles to construe the world (Winter & Procter, 2013), and therefore control is an important aspect of reducing anxiety by selecting the most appropriate construct pole. This is demonstrated by Louise[10].

Participants in the study identified feeling in control as an important aspect of the consultations, enacting this through predicting the outcomes and their children's behaviour and managing the context as well as being prepared and knowledgeable.

4.6.2.1 Predicting and Managing

As previously discussed, participants in the study felt that managing or controlling the behaviour of their child was an important part of their role as this reflected their ability as a mother. In the context of the consultation this included predicting how their child would respond to the situation and anticipating their needs accordingly as Louise[11] explained.

A further aspect of experiencing the reassuring sense of control was successfully predicting the course of the consultation and the ultimate outcome as demonstrated by Jane[12].

4.6.2.2 Knowledge and Preparation

Participants in the study identified that they experienced a sense of control in consultations when they felt knowledgeable and when they were prepared for the questions they would be asked or for the behaviours they anticipated in their child. Jane expressed feeling in control and listened to due to her professional background and Louise experienced this sense due to knowing her child's condition and feeling like she knew how her child would react[13].

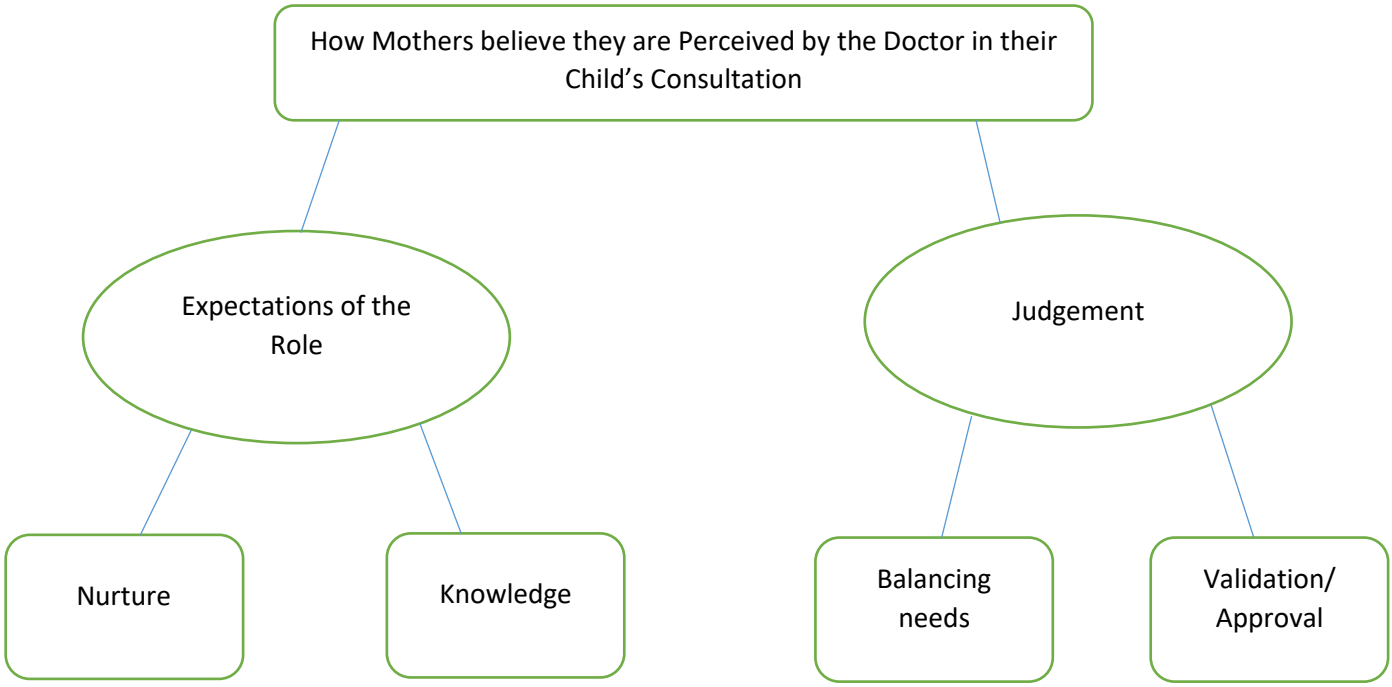
Louise and Gemma both reflected on how being prepared for their consultations made them feel confident and in control[14].

In PCP terms, knowing their children well and being able to anticipate their reactions as well as having previously validated constructs for the context of medical consultations for their children contributed to the knowledge base that enabled them to apply construct poles appropriately and their experience of a sense of control.

4.7 How Mothers believe they are Perceived by the Doctor in their Child's Consultation

Two superordinate themes regarding how participants in the study believed they were perceived by the doctors in their child's consultations emerged from the interviews. These included what they believed the doctor's expectations of them in the role were and how they believed the doctor was judging them as a mother.

Figure 3: How Mothers believe they are Perceived by the Doctor in their Child's Consultation



4.7.1 Expectations of the Role

Participants in the study identified that doctors appeared to hold expectations regarding the role of a mother. Subordinate themes relating to these expectations included being nurturing and having knowledge about their child and their role. These closely link to the themes participants recognised themselves.

4.7.1.1 Nurture

Interestingly when discussing their own perception of the role of a mother, participants spoke about many different expectations and demands. However, when discussing what they felt the doctors' expectations of them as a mother were, they focused on the role of nurturing and caring, as Jo commented in her interview[15].

It is interesting to consider where this difference originates from. It is logical that the personal understanding of their role may be more complex as it would follow that they have a richer understanding of the facets of their own identity. However, construal of the perception of another individual is less detailed as it may be more difficult to confirm or discredit this perception as observed interactions can be open to many different interpretations. It is also possible that predicting the construals of another may be informed by social constructions or

broader cultural norms of the role. As discussed in the introduction this often relates to the caring and nurturing aspects of mothering.

4.7.1.2 Knowledge

A second subordinate theme was that of knowledge. Knowledge identified as an important element of mothering, included being aware of their child's symptoms and presentation, knowing their child well and being a credible source of information for the doctor. This was highlighted by Jane[16].

However, where doctors recognised the participants as an important source of knowledge, some participants described pressure associated with being responsible for providing this, as Kate described[17].

4.7.2 Judgement

The theme of judgement relates how participants felt they were evaluated by the doctors. This superordinate theme was further divided into the subordinate themes of balancing needs and validation and approval.

4.7.2.1 Balancing Needs

Balancing needs refers to the judgement participants described relating to how they balanced attending to the needs of their child and attending to, or complying with the doctor. Gemma described in detail how she felt that the doctor she visited may not like her or take her seriously if she did not listen careful and comply with requests[18].

Louise further reflected on the challenge of managing her child's behaviour whilst facilitating a productive consultation[19].

4.7.2.2 Validation and Approval

Linked to the above section was how the participants were validated or approved of, or conversely invalidated when they believed the doctor disapproved of their actions. Sian explained how the validation of efforts she had made to care for her child made her feel empowered and confident in her abilities, thus contributing to her experience of the consultation as satisfactory:

"…[he said] 'Go home and look after her', makes you feel empowered, in a way, and the best thing you can do is look after your child…That you've got the capacity to cope with that…"

Louise described the invalidation she felt when criticised for her attempts to calm her distressed child during a consultation[20].

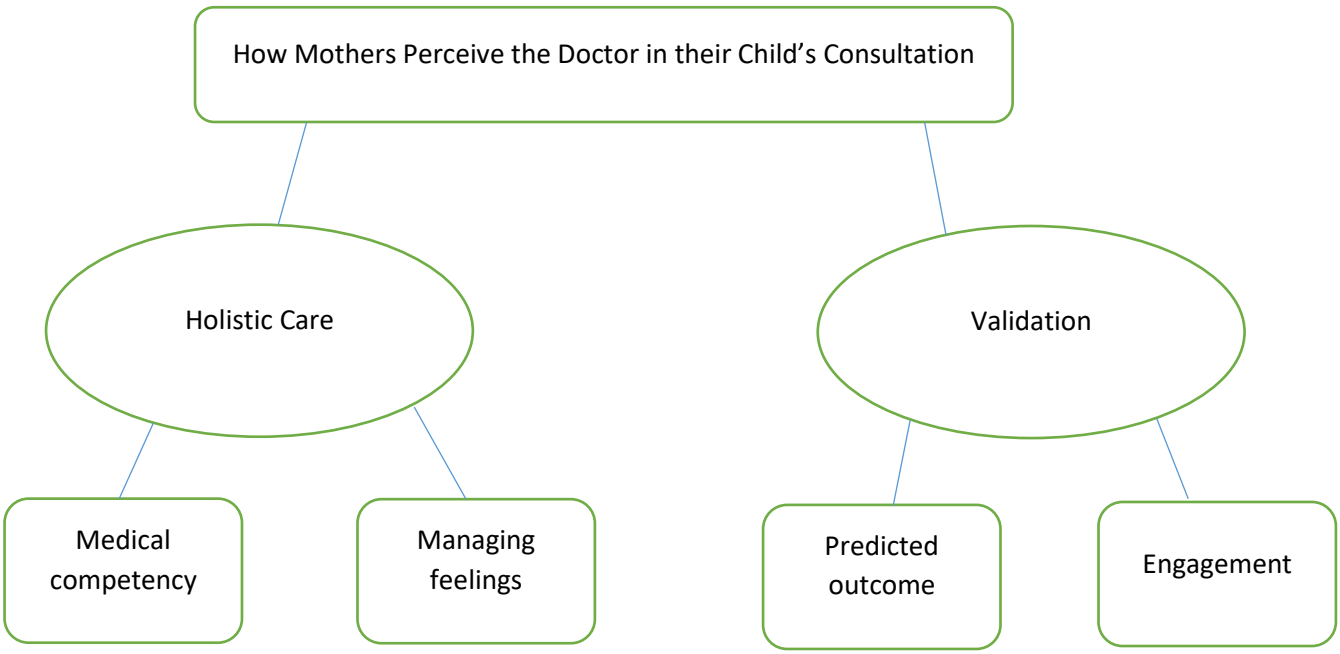
Participants in the study also described feeling judged regarding their decision to seek medical advice, feeling validated when the doctor confirmed that they had made the 'right' decision to seek help or when the actions of the doctor confirmed that had made the correct decision, as Gemma explained[21].

When participants felt that the doctor disagreed with their decision to seek medical help or that they had made an appointment unnecessarily or were wasting the doctor's time, they experienced this as invalidating.

4.8 How Mothers Perceive the Doctor in their Child's Consultation

Two superordinate themes were identified within the overarching theme. Themes that emerged included Holistic Care and Validation.

Figure 4: How Mothers Perceive the Doctor in their Child's Consultation



4.8.1 Holistic Care

The theme of Holistic Care encompasses clinical/medical care and psychological/emotional care. This theme constitutes two subordinate themes including medical competency and managing feelings. Where the doctor was perceived to be too focused on the medical aspects of patient care they were labelled as impersonal or detached. This was more commonly the case in emergency consultations with doctors that the participants had not encountered previously. Louise described the importance of a holistic approach[22].

However, demonstrating professional competency was also important for participants as discussed below.

4.8.1.1 Medical Competency

Medical competency was described in terms of the doctor's experience, professionalism and knowledge. Where participants questioned the course of action taken by a doctor they often related this to concerns regarding their competency or level of experience, as Jane described[23].

Questioning competence or suitability to the role, often occurred when participants' predicted outcome was invalidated, for example where prescriptions were given when participants did not agree or when participants anticipated receiving a treatment that the doctor did not provide as illustrated by Jo[24].

4.8.1.2 Managing Feelings

A fundamental component of holistic care was attention to the emotional well-being of the child and in some cases that of the mother. This links with the theme of engagement as it involved the doctor attending to and understanding the needs and experiences of the patient. Gemma described in her interview that the doctor she consulted recognised the anxiety the situation may evoke and responding in an attentive and reassuring way[25].

Jo described how her doctor was attuned to the pressures involved in the role of the mother and how this helped manage her anxiety and made her feel understood. This further reflects the sociality corollary (Kelly, 1955) outlined earlier in the chapter[26].

4.8.2 Validation

Validation refers to the confirmation of predictions participants made regarding the consultations they attended for their children. Validation is linked in the study to satisfaction with the consultation. How the participants viewed the doctor was intrinsically linked to whether their predictions regarding the consultation and interaction were correctly anticipated.

4.8.2.1 Predicted Outcome

This subordinate theme is linked to medical competency and relates to the predictions participants held regarding their children's consultations. For example, when Jane's son required antibiotics for a localised infection, Jane described feeling disappointed as her prediction of the consultation was invalidated[27].

In contrast, where the outcome confirmed the participants' anticipated result a positive experience was reported, as illustrated by Jo[28].

4.8.2.2. Engagement

Engagement relates to how the doctors were viewed regarding their attention and interaction with the participants and their children in consultations. Frequently, participants referred to expectations that doctors, as part of their role, should be engaging and interact with them and their children. Where this occurred, the anticipated interaction was validated and again was linked to an overall sense of satisfaction with the consultation as described by Kate[29].

However, whilst being engaged and attentive was considered an important aspect of the doctor's role, where this was absent but the predicted outcome of the role was met, this took precedence and could then result in a consultation where engagement was considered poor being deemed satisfactory, as Jane illustrated[30].

This demonstrates that the role of the doctor in consultations was to engage, validate, understand and deliver medical assistance. However, ultimately mothers felt that their role involved validating them, their role and the anticipated outcome of the consultation.

4.9 How Mothers Perceive a Satisfactory and Less than Satisfactory Consultation

The following section provides a summary of the themes discussed and addresses how the themes relate to whether a consultation was considered satisfactory or less than satisfactory. Figure 5 depicts the final thematic map which was developed from the themes previously outlined in detail.

One superordinate theme is that of validation/ judgement, which is further divided into parenting practices and the anticipated outcome. Where participants perceived that their parenting practices were criticised or invalidated, this contributed to the consultation being evaluated as less than satisfactory. Many of the participants reported difficulty distinguishing between constructs relating to themselves as individuals and those concerning their role as a mother. This indicates that the role of being a mother is an integral part of their identity. Thus, when this is invalidated the impact on the individual is understandably significant.

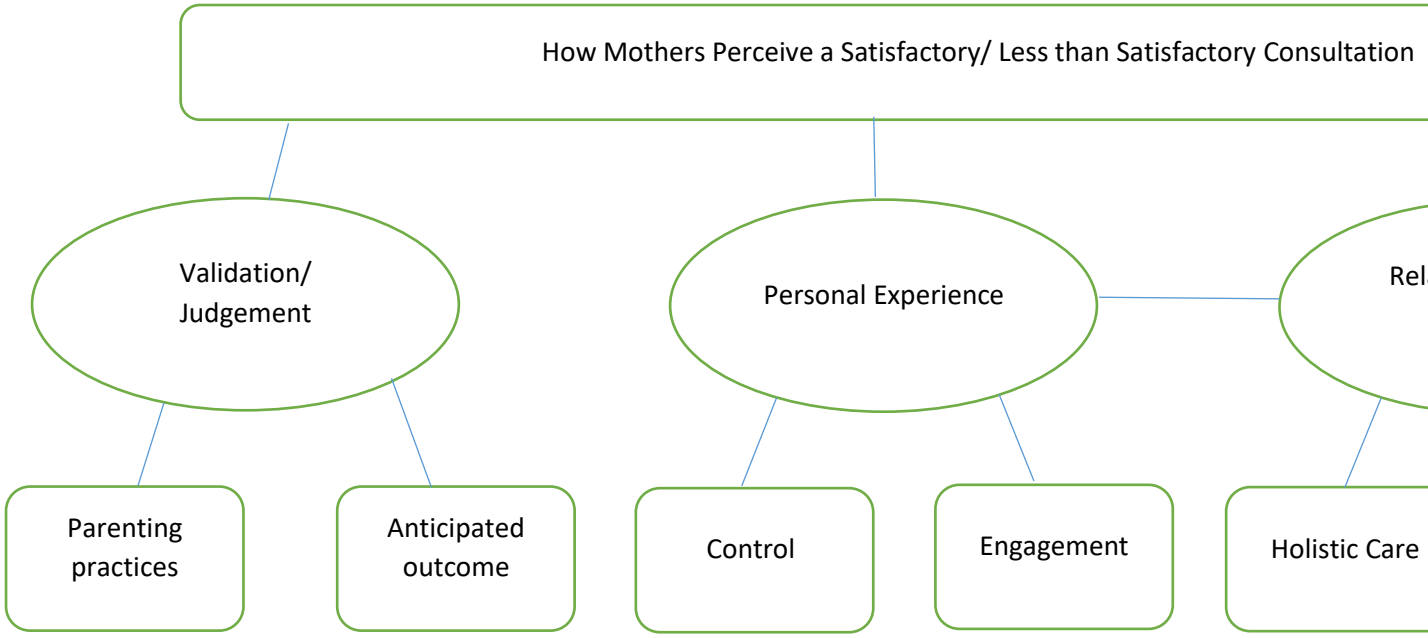
A common factor regarding whether a consultation was satisfactory was whether the outcome was as anticipated. This related to whether the treatment delivered was as expected or the consultation was conducted by the doctor in a way that validated the previously held constructions. It is therefore particularly relevant that the majority of satisfactory consultations were with doctors known to the participants, suggesting they may have held previously validated constructions regarding the situation. Further to this, the one satisfactory consultation that was not with a doctor previously known was Gemma's experience in A&E which was a familiar situation to Gemma and her daughter as they had

previously attended A&E for the same condition and therefore this was a predictable consultation.

A further superordinate theme was that of the personal experience of the participants with two subordinate themes of control and engagement. Participants in the study typically viewed the consultations as more satisfactory where they felt a sense of control or where they believed that the doctor perceived them to be in control of the situation. This included holding and communicating knowledge about their child, their condition and well-being and being able to manage the behaviour of the child. This was in particular relation to managing their behaviour and presentation when they were distressed or misbehaving. When a child was distressed or non-compliant this often resulted in increased anxiety for the participant and therefore resulted in an experience that was less than satisfactory. This was also linked to engagement with the doctor in the consultation as, when the doctor responded to the participants' anxiety in a reassuring and empathic manner, this generally correlated with a more positive experience. Where participants experienced the doctor as dismissive they reported less satisfaction. Therefore, when participants were experiencing anxiety or distress regarding their child's health, their negative experience was compounded by a lack of compassion from the doctor in their consultation. Most participants described how important nurturing and caring for the child was, with many reflecting the desire to be able to care for them at home and struggling to make the decision to attend a medical appointment. Some participants reflected that they felt disappointed at having to seek medical advice. When they were perceived as wasting the doctor's time this was a further invalidation of their ability to fulfil their role. Where doctors demonstrated that they understood the pressures and anxiety related to the role of the mother, they were experienced as attentive and attuned and this correlated with a satisfactory experience.

The final superordinate theme regarded the relationship that participants had with the doctor, which was closely linked to that of personal experience. This theme constituted two subordinate themes including holistic care and knowledge. The participants reflected the need for these themes to be carefully balanced. Participants valued it when the doctors demonstrated knowledge and competency regarding medical understanding and also knowing their child well. However, they often described dissatisfaction when doctors demonstrated clinical and medical knowledge without attending to the emotional needs of the child and in some situations the mother. A number of participants specifically referenced how important a holistic approach to the child.

Figure 5: How Mothers Perceive a Satisfactory and Less than Satisfactory Consultation



5 DISCUSSION

"The universe is made of stories, not atoms" – Muriel Rukeyser

In this section the research questions are revisited and considered in relation to the study findings, literature and epistemology outlined earlier in the project. The stories of Kate and Louise have been chosen to synthesize these ideas, as it is my belief that the best way to engage with research is to connect with stories of those who created it. The clinical implications of the study along with the strengths and weaknesses are then discussed.

5.1 How Mothers Perceive their Role when taking their Child for Consultation with a Doctor

The preferred poles relating to the role of mothers identified by participants across the study included being calm, in control, nurturing, attentive, knowledgeable and confident. These characteristics were linked to form a complex understanding of the role which is explored below through the stories of Louise and Kate.

Louise was a thoughtful and reflective interviewee who had a clear understanding of what the role of mothering meant to her. Like many of the participants, Louise struggled to separate constructs relating to her role as a mother from her individual sense of identity, thus highlighting the link between these concepts.

One construct regarding the role of a mother that both Louise and other participants identified was control, with the opposing pole as being uncontrolled. Control was further linked to confidence and knowledge in the role. One of the most important aspects of the development of the self-concept or an individual's understanding of their identity is that of autonomy, which is the ability to choose or direct one's own actions (Gecas & Schwalbe, 1983). As Louise reflected, she believed that managing or being in control were important aspects of mothering. This supports the findings in the literature review that when mothers felt in control of decisions regarding their child's health they felt empowered (Sleigh, 2010; De Carvalho et al, 2016). In PCP terms control can be considered in regard to the circumspection-pre-emption-control cycle (Winter & Procter, 2013) in selecting the appropriate construct pole. Thus control or autonomy represent important aspects of the role as Louise described: *"I always feel - I feel better if I'm in control of the situation".*

One way in which Louise and others in the study felt more in control of their consultations was by being prepared and feeling knowledgeable. This can be considered in terms of sociality (Kelly, 1955) as by preparing for what the doctor might need to know, she was predicting what they would ask and was therefore behaving in accordance with the perception she anticipated (Kelly, 1963); *"by making sure that I clearly communicated the*

problem and the history, and all the kind of relevant pieces of information that I needed to pass on; and to ask questions of the doctor once she had begun to engage with me about it, so to be questioning and thorough".

Collett (2005) claims that women assume the mother identity by playing this role as defined by society. From a social constructionist perspective the mothering identity is shaped by the historical and cultural narrative. Where the role of mothering is intrinsic to an individual's sense of self it follows that deviating from this understanding would be experienced as threatening, which is when an individual anticipates an imminent change in their core constructs (Kelly, 1955). This gives further understanding as to why socially accepted role constructs are perpetuated. Linking the PCP and social constructionist perspectives, it can be viewed that the process of control or selecting the appropriate construct pole governs the presentation of the role that the individual is playing. This connects to the work of Goffman (1959) regarding the presentation of selves in accordance with the context. Louise presented herself in accordance with the values she associated with being a good mother when presenting herself to the doctors she met in consultation for her children.

In PCP terms a role is referred to as "a psychological process based upon the role player's construction of aspects of the construction systems of those with whom he attempts to join in a social enterprise" (Kelly, 1963 p.96). This reflects how mothers identify with the socially constructed roles and enact the poles of their personal constructs in accordance with others within the social group. It is an example of how personal construct theory recognises the personal agency of individuals in relation to the context of social constructions (Butt, 2001).

Louise also referred to nurturing her children as key to her role as a mother, in bringing them up in a loving and caring way both to meet their needs for security as described in attachment theory (Bowlby, 1953) and to demonstrate to them how to behave, thus shaping their development as independent adults. Where identity is so closely linked to the maternal role, the achievements of children provide evidence of being a 'good mother' and thus mothers are often judged as individuals by the successes of their children. Therefore, worth as an individual is linked to maternal ability (Tardy, 2000). In PCP terms, where constructs regarding good mothering are validated by meeting societal expectations, maternal identity is validated as is an individual's understanding of their own character and attributes. In demonstrating her maternal abilities, Louise was engaging in impression management by promoting characteristics considered optimum to the role and concealing those that are not, (Goffman, 1959). This has been linked to an individual's self-concept (Gecas, 1982). Impression management is how individuals present how they see themselves and the role they are enacting (Goffman, 1959). In addition to demonstrating their competence to others,

it is a process through which they demonstrate competence in the role to themselves (Collett, 2005) and can thus be linked to self-esteem (Brown, Collins & Schmidt, 1988).

When asked about other influences regarding the role of the mother, most participants referenced their own experiences of being mothered. Louise referenced her attachment with her own mother as informing her abilities, such as organising and managing. However, she attributed her nurturing and caring skills to her own personality. This further promotes the concept of maternal instinct or intuition, which is viewed by mothers in the study as an intrinsic element of their personality.

Kate was an articulate, dynamic and animated interviewee. One aspect of the mother role highlighted by most participants was conflict, which often resulted in the experience of guilt, which is when an individual feels dislodged from their core role constructs (Kelly, 1963).

Kate was particularly articulate regarding the conflict created by the concept of maternal instinct and intuition. Bowlby described maternal instinct as a biological drive in children to seek proximity to their caregiver for protection in threatening situations (Bowlby, 1969). Infants subsequently develop attachments to their caregiver through their responses, which facilitate a sense of security from which they can stray and return, leading to adaptive emotional development. This drive evolved due to the increased survival of a child when they remain proximal to the caregiver (Holmes, 1993). Through this proximity an affectionate reciprocal bond develops (Prior & Glaser, 2006). It is interesting to reflect then that the instinct described is actually attributed to the child, with the resulting bond being what the caregiver experiences. The maternal aspect of this instinct therefore relates not to the biological drive but more to the ability of the caregiver to decipher and construe the needs of the child. It is through their appropriate responses to these cues that secure attachment is created. This may therefore more accurately refer to intuition rather than a biological instinct. It is this that Kate reflected on as a source of stress, particularly in relation to the expectations that mothers are placed under to have and demonstrate their intuitive abilities: *" the idea of a mother, there's this concept of somebody who is very… is almost hallowed in some kind of way. Your children and you do the right thing, and you're always responsible…" "So I do feel as if everyone expects that you're going to know everything about your children".* Kate reflected on the pressures and expectations related to the role and specifically being able to intuit the needs of the child accurately and ultimately the outcome of raising that child. This links to the culturally accepted view that mothers are responsible for the development of children and their characteristics as adults (Phoenix & Woollett, 1991).

Linked to this is the pervasive cultural belief that good mothering is an intensive process which requires complete devotion (Douglas & Michaels, 2004). This is referred to as the "mommy myth" and is regarded as a source of oppression to women perpetuated through media and parenting books (Douglas & Michaels, 2004). Examination of media representations of motherhood found that women's choices remain subject to considerable scrutiny and criticism, with mothering practices outside of traditional or socially accepted constructs of mothering represented as a crisis for the institution of the family (Hadfield, Rudoe & Sanderson-Mann, 2007). As previously discussed, the family is the first source through which individuals begin to develop their identity and is also where gender roles are demonstrated, thus perpetuating the norms and roles of wider society (Procter, 1978). Kate, in addition to other participants, referenced the media and child birthing groups in perpetuating the ideal of mothering, with Kate describing a stereotype that she viewed as undesirable on the surface but the influence of which was unavoidable: *"…when I start describing all these things and I'm thinking, oh no, I tick all these boxes. Maybe I am this person, this is petrifying."* Thus, a further sense of conflict for Kate was created.

The perpetuation of this idealized role of intensive mothering, it is argued, strengthens the centrality of the role of mothering in society and the identity of mothers as it is currently understood (Hays, 1996). Boulton (1983) argues that by following these practices women may lose their personalised identities and derive their sense of meaning from motherhood. This view demonstrates how the perpetuated view of ideal mothering practices can serve to oppress mothers.

As with other participants, in Kate's interview we discussed her own experience of being mothered. Kate spoke about the grief she felt at having lost her mother when she was in her twenties. For Kate this meant the absence of advice and influence on her own mothering. Kate was the only participant who had lost her mother before becoming a mother herself. She spoke about feeling as though she may be departing from some of the hopes her own parents had for her regarding her education and career by choosing to stay at home and care for her children and was deeply affected by not being able to turn to her mother for advice and guidance; *"I feel a pressure for it,… maybe it's because my own mum is not around, and it's just an uncertainty I've created for myself".* This highlights some of the conflict that women may feel when they choose to diverge from societal or family expectations. In addition, it demonstrates how constructions regarding mothering are perpetuated through a continuous process of relating back to the mother even in adulthood, thus demonstrating the power of these cultural constructions. Whilst it is agreed that labelling people with attachment styles is not straightforward or even helpful at times (Vetere & Dallos, 2008), Kate's ability to communicate openly about her experiences, name her

feelings and consider the perspectives of others suggests she experienced a secure attachment, and indeed this was reflected by all participants in the study.

Kate also reflected on the impact of moving between cultures on mothering, noting that being a mother in a new culture serves to further exaggerate an identity dominated by being a mother. Given Kate's existing conflict about the stereotype of mothering, this contributed further to a sense of conflict regarding her own identity:

"… only being one version of yourself. Whereas I think if you grow up somewhere, or you lose some of the narrative…But we moved here, and it's like my life started in this version of me".

5.2 How Mothers believe Doctors Perceive them and their Role as Mothers during a Consultation

How participants felt perceived by doctors was reflected in a number of constructions including whether they were nurturing, calm and were able to balance the needs of the child with the demands of the consultation. Central to these constructs were the expectations of the role of a mother and how the doctor evaluated the participants in respect to these. This reflects the interaction of the personal agency recognised in personal construct theory regarding the poles of constructs that participants aligned with, whilst considering the influence of the social world and wider societal constructs that shape the decisions individuals make (Butt, 2001).

Participants in the study identified being nurturing as a construction of the mothering role that doctors would be concerned with. This also reflects how mothers viewed the role of mothering themselves. Furthermore it suggests that doctors are familiar with the importance of attachment on development and therefore may, from a professional perspective, be vigilant to signs of a secure attachment and the corresponding wellbeing of a child. Louise spoke about being nurturing towards her children as a method of helping them cope in the situation. By offering reassurance through nurturing and affection, Louise explained that she was calming her children such that they felt comfortable in the consultation and thus would comply with the doctor, in particular with reference to being examined: *"I felt like a heightened sense of caring and nurturing… I was keen to make the experience as positive a one as we could for her…I felt, I suppose, in control of myself…I was as prepared as I could be…I felt confident in her, because I knew her and the way she tends to behave in these situations…" "She [daughter] was very good, so I think I had, I suppose I would have come across as being in control of that situation, both of her and her illness"*

As mothers' parenting ability is frequently evaluated by the achievements of their children, when a child is uncooperative or demonstrates undesirable behaviour this can be experienced by mothers as a reflection of their mothering and thus of themselves as individuals. Concern about how their child would respond or behave in consultations was a common theme throughout the interviews and reflected the concern of the participants that they would be judged by the doctor they went to see. This links to how parents in a previously discussed study felt when seeking medical advice regarding their child's abdominal pain (Smart et al, 2005). Managing the behaviour of their children therefore reflected presenting themselves in the idealized role of a mother in this 'front of stage' situation (Goffman, 1959). Where individuals were unable to manage this impression they risked being negatively evaluated and thus experiencing the judgement and stigma recognised in previous studies (Davis & Manago, 2016; Francis, 2012). Louise reflected on this in her less than satisfactory consultation: *"I ended up taking offence, because I felt that he was being quite judgemental about that, which I didn't like".* This represented an invalidation of Louise's constructs as she believed she was presenting herself in accordance with these by being assertive, experienced, confident and nurturing. As previously outlined, where being perceived as a good mother is central to an individual's identity, such invalidation can be threatening. This further links to the research which found that mothers felt pressure to present as good mothers in medical consultations (Loudon et al, 2016; Gunnarsson et al, 2013).

Louise describes what some feminist theorists reflect on as the power and agency women experience in motherhood (Ribbens, 1993a); she talks about being in control, assertive and experienced in her role and that the doctors she saw perceived her in this way. However, by criticising her parenting practices the doctor invalidated constructs core to her understanding of herself and thus made her feel judged and offended. Thus, the power of fulfilling this role can be lost and judgement regarding this role can be experienced as oppressive. McMahon (1995) suggests that the moral value that was once attributed to the mothering role has been superseded by the social worth of children and therefore a mother's worth is intrinsically linked to their children, so that when children present in a way that negatively reflects the parenting they have received this has an impact on the perceived value of the mother.

5.3 How Mothers Perceive the Role of Doctors in Consultation for their Children

Across all interviews, being warm, attentive, compassionate, accepting, competent and holistic were preferred poles regarding the role of doctors. Kate's experiences of consultations demonstrated a very clear distinction between the poles of constructs attributed to the role of doctors. Kate experienced a doctor in her satisfactory consultation

who embodied these characteristics: *"… she's really nice, she's sort of warm… She's very professional… you feel like you can talk to her about stuff".*

Where doctors were perceived as cold, dismissive or there were concerns regarding their competency, participants construed the consultation less favourably. Kate experienced a doctor who did not appear interested in understanding the experience from Kate and her son's perspectives, therefore lacking the warmth and compassion anticipated of the role: *"she seemed to be going about her job and in a fairly perfunctory way…I suppose for her it's probably a really routine thing but for us it's quite a big thing".* This reflects Kelly's Sociality Corollary, which states that one needs to have acceptance of another and how they view things in order to have a constructive role in a relationship with that person (Kelly, 1963).

In contrast to this Kate described how the doctor in her satisfactory consultation demonstrated an understanding of how Kate viewed things: *"I think she gets us, and because we've developed a relationship with her over the years, I think she understands, she kind of gets me and she gets the concern that I have."* This indicates that the doctor's construct system subsumes, in part, Kate's construct system thus enabling her to understand how Kate construes her role and the consultation.

Whilst it is not necessary for two people to construe things in the same way to understand and accept another person's construing, it follows that where this commonality (i.e. where constructions of an experience are similar) exists, it makes it more likely that one person's construction system will subsume part of another (Kelly, 1963, p.97). This is relevant because a number of the participants, including Kate commented that where a doctor they saw was also a mother they felt more understood: *"…talking about her own experience as a mother. So I think she does relate"*. It is possible that this reflects commonality between the participant and doctor regarding the role of a mother, which may have in turn led to greater sociality.

5.4 How Mothers construe a Satisfactory and Less than Satisfactory Consultation for their Child

It is clear from the discussion above that participants in the study overall experienced more satisfaction with doctors they perceived as warm, empathic, compassionate, competent and attentive. Satisfaction also correlated with feeling in control, knowledgeable, calm and being able to attend to the doctor whilst demonstrating care and nurturance to their child. Themes that encompass a number of these elements include validation and judgment, and holistic care.

It was important to participants that the doctors in their consultations balanced the medical needs of the child whilst also being considerate of the emotional well-being of the child and in some cases of the mother herself. Louise spoke about this as a central component of the role of a doctor, making the appointment a satisfactory consultation: *"…to provide a medical assessment of the problem, and propose treatments for it. To listen to the history, as given by the parent in that situation, to listen to the child in terms of describing their symptoms. To ask - to be empathetic and sympathetic, to ask relevant questions….To be quite holistic in the approach".* It is possible that this reflects a desire for mothers in consultations for themselves and their children to be recognised and validated as individuals encompassing a rich and developed personality rather than a list of medical symptoms, and as such they experienced satisfaction when they experienced this.

Central to a satisfactory consultation was the concept of validation. In PCP terms this refers to the correct anticipation of an experience, i.e. construct poles applied accurately, thus increasing the likelihood it will be applied again in a similar situation (Kelly, 1955). Validation of constructs came in a number of forms in the study, most notably concerning the mother role as previously discussed. Validation regarding these constructs is important as they represent core constructs and are thus fundamental aspects of the individual's personality. These constructs are therefore not easily reconstructed, which is why when invalidated, threat is experienced. In addition to this, other areas relating to validation included anticipated outcomes, such as prescriptions, treatment, advice and the characteristics of the doctor.

Where a consultation was considered less than satisfactory it invariably correlated with invalidation in one or more of these areas, and for most participants this was identified as the causal factor. This links with judgement, which is when participants felt negatively evaluated regarding their parenting or in PCP terms felt their constructs regarding mothering were invalidated and they were not perceived in accordance with their idealised role or their preferred poles. The concept of judgement has been explored regarding how the participants felt they were perceived by doctors and how they perceived themselves. For example, where they identified with the poles *calm* or *in control* and were unable to demonstrate this in their consultation due to concern over their child's welfare or feeling flustered when their child was distressed or misbehaving, their anticipated outcome was invalidated as was their role identity. This further links to impression management (Goffman, 1959) as it reflects an inability to manage the perception of the role they are trying to fulfil in the particular social arena.

5.5 Clinical Implications

Although the small sample utilized in this study warrants caution in generalising the findings, the study reflects the findings of literature explored previously whilst bringing an additional dimension in highlighting the personal constructs of mothers in healthcare. Previous findings outlined the impact of interactions between health care professionals and mothers, and in particular on compliance, concordance and collaboration in healthcare settings. Where participants in these studies experienced positive interactions, they experienced themselves as participating in the health care of their child, thus feeling empowered and increasing the sense of a collaborative approach (Fenwick et al, 2001; Swallow et al, 2001; Henneghan et al, 2004; De Carvalho, 2016). Similarly, the current study found that where participants felt understood and validated they had a more satisfactory experience in health care. The primary concern of doctors in these situations may reasonably be considered to be to assess and treat the child. However, in doing so they require information and compliance. In order to establish this, the interaction with a child's caregiver is therefore important. This study therefore highlights the importance of relational factors in health care. The study described by Cohn and colleagues (2005) demonstrates that where professionals and the mother have differing perceptions of the child's health care needs, this can have a detrimental effect on the child receiving appropriate care. A link can therefore be made between the engagement of the doctor and mother and the level of collaboration and compliance with medical interventions. It therefore follows that where there is better communication and agreement between mothers and doctors regarding medical interventions, a child is more likely to receive adequate treatment and thus the risk of a deterioration of their health is reduced. This is echoed in research that found when patients were in agreement with their doctor regarding treatment, it was associated with recovery (Stewart, Brown, Donner, McWhinney, Oates, Weston & Jordan 2000). Furthermore, research suggests that where there is good communication between doctors and patients, this is linked to increased satisfaction, information sharing, accurate diagnosis, following advice and adherence to treatment (Fong Ha & Longnecker, 2010), further highlighting the importance of the perceptions, interactions and relationships within healthcare. It also follows that when conditions are appropriately treated through a combination of parental compliance, provision of information and the doctor's accurate assessment and treatment a child is less likely to need to return for further appointments. In instances when further medical assistance is required, a satisfactory previous consultation increases the likelihood that mothers will feel comfortable returning for further advice; this was found in both this study and in previous literature (Loudon et al, 2016).

One way to promote the positive interactions described by participants in the study could be to encourage a credulous approach (Kelly, 1955; p. 322) in healthcare. This refers to the PCP approach of taking the accounts of patients or their carers at face value (Winter, 2007). By being open minded and willing to hear the experiences and perceptions of mothers bringing their children to consultations, it is likely that they will experience a sense of being listened to and understood, which in turn may lead to a greater sense of collaboration and empowerment. Feeling empowered relates to the sense of control that many participants recognised as an important aspect of mothering and their consultations with doctors.

The study also highlights the importance of reflexivity in health care. Incorporating this practice may help doctors recognise their own values and judgements when consulting with mothers of children in consultations in addition to considering their practice and outcomes. Research suggests that reflective practice in medicine is linked to the acquisition of expertise and therefore doctors who reflect on their practice and conduct, may better serve their patients (Mamede & Schmidt, 2004). However, time cultivating reflectivity and reflexivity involves coping with uncertainty and ambiguity, which are concepts not generally linked to medical practice and therefore may be challenging to promote, particularly in the context of an overwhelmed NHS where time and resources are already pressured.

One way to take this into consideration would be to link these skills to training for medical students. Existing guidance recommends that doctors acknowledge parents and elicit their understanding of the child's health needs, listen carefully, keep an open mind and avoid judgemental comments or blame (GMC, Good Medical Practice, 2013). However, this appears to focus more on situations where doctors are concerned about the welfare and care of a child and may need to implement safeguarding measures. Therefore training recommendations could offer guidance regarding more commonplace interactions. More specifically, the approach used in the study could be incorporated into medical training, specialist training and personal and professional development within health care settings. The experiential nature of the PEG completion would be a powerful method through which to help medics and practicing psychologists in health care alike to place themselves in the position of their patients and patient's family as well as reflect on themselves within their role and wider profession.

The study recognises the centrality of the mother role in participants' identities. It may be helpful for doctors in clinical practice to be mindful of this when reflecting on parenting practices which relate to the patient's well-being. It may also be helpful for doctors to have time to reflect on the function of the presentations of mothers and alternative construals. For example, where in previous studies protective behaviours have been construed as

problematic (Cohn, et al, 2005), it may be helpful for clinicians to attempt to construe behaviour from the perspective of the patient and their parent. This reflects an important role of psychology in paediatric medical teams in facilitating this reflection and reflexivity when consulting on psycho-social aspects of patient care.

More specifically, it may be helpful for doctors to establish the mother's anticipated outcomes early in consultations. Therefore, if their professional opinion differs to this it would enable them to facilitate a sensitive discussion in order to assist the mother in reconstruing the health needs of the child. Noting that mothers' construing is complex and individual may also be helpful to avoid assumptions about the experiences of mothers in consultations. Thus, building a rapport and establishing the expectations of mothers may help facilitate a satisfactory consultation. Awareness of this may help in avoiding the feeling experienced by some mothers in the study that their consultation was routine and perfunctory.

5.6 Strengths and Limitations of the Study

5.6.1 Strengths

The main strength of the study was its exploratory nature in eliciting, listening to and understanding the experiences and interpersonal construing of mothers attending medical appointments for their children. This elicited a rich and in-depth account of their experiences allowing for a thorough analysis utilising both content and thematic analysis. The study facilitated the expression of the participants' experiences, thus developing the co-constructed understanding of the roles discussed as presented in the study. It is believed that this approach offers an engaging and enlightening process through which participants can feel empowered. In addition, where much previous research has focused on a critical approach to mothers or examined the impact of their practices on their children, this research has focused on the perceptions and views of mothers, thus highlighting the importance of considering their experience for its own merits and as such providing a form of social action.

A further strength of the study was the novel approach in using the CSPC (Feixas, et al, 2002) to analyse the qualitative data of the Perceiver Element Grids. Not only did this add to the understanding of participants' core constructs by mapping them to the corresponding areas and categories within the CSPC, it also lays the foundation for use of this system alongside PEGs in future research. This is further supported by the agreement regarding mapping constructs between the researcher and research supervisor. In addition to this, the successful combination of thematic analysis and the CSPC, which has not previously been done, is a strength of the study. Using a combination of these approaches enabled exploration of richer information, thus adding to the complexity of analysis.

Furthermore, the combination of PCP, social constructionist and feminist positions in the study enabled a consideration of the role of mothers and their experience in health care facilitated by exploration of the individual and social world. This allowed for consideration of the influence of societal factors whilst appreciating the personal agency of the women collaborating. This was essential in furthering the pursuit of feminist research by challenging the accepted view and factors which have led to oppression without placing mothers in the role of victim, therefore empowering mothers to challenge the status quo and allowing the freedom to challenge accepted constructions.

5.6.2 Limitations

One limitation of the study was the small sample size. Whilst this allowed for an in-depth exploration of the experiences of mothers in the study, it also limits the ability to generalise the data. A larger sample would have generated a level of data that would have allowed for more comparison between accounts, but this was not possible within the scope of this research project. In addition, in keeping with the approach that construing is individual in nature, further accounts would have generated more constructs which could then have been considered in relation to the historical and cultural context.

Whilst there was a degree of diversity regarding cultural and ethnic background amongst the participants the sample pool was relatively homogenous regarding socioeconomic background and education. This may be due to the geographical area in which recruitment was conducted. It would therefore have been of interest to explore constructs of mothers presenting to medics from more diverse backgrounds to develop an understanding of the impact of these circumstances on the perceptions of mothers in healthcare.

A further limitation to the study was the challenge of representing the data due to the volume and detail of information collected. Decisions regarding how to present, organise and focus the information collected in the project proved difficult and ensuring that the voices of those who collaborated was respectfully and fully considered, analysed and presented was a recurrent challenge throughout.

Further to this, whilst it was strongly felt that maintaining the epistemological positions of feminism, social constructionism and personal constructivism was an important aspect of the study, it was an ambitious aim of the study to reflect on and combine these approaches in contemplating the data collected.

5.7 Suggestions for Further Research

Future research could give consideration to how the role of mothering relates to identity in comparison to that of the father. It would be interesting to explore this using dyads of parents to consider their identities and construals of the roles of each parent.

In addition, it would be interesting to conduct this research with doctors who regularly consult with mothers and their children to develop an understanding of how they construe mothers and their own role in comparison to the PEGs presented here. Initially, the researcher had hoped to include this perspective in the study, however, this was not possible within the scope and limitations of the research project.

Further exploration of the centrality of the mother role to identity could be considered in women before and after having children in a longitudinal study. Alternatively a similar study to this project could be developed adding the completion of a self-characterisation prior to PEG completion. Self-characterisations are a method used in personal construct therapy whereby an individual writes a passage about themself, and it is used to understand how they see themself and structure their understanding of their world (Crittenden & Ashkar, 2011). This method may be a helpful strategy to consider further the relationship between individual identity and role identity associated with mothering.

It would also be interesting to explore the role of the mother to children in different age groups, for example how this changes as children move into adolescence and experience differing health needs and increasing independence from their parents.

Finally, it would be beneficial to explore this experience for mothers in more diverse populations or from different socioeconomic backgrounds, in particular with those who do not necessarily conform to the socially accepted role that the participants in this study did. For example, an exploration of the role of mothers from the perspective of those who are under the care of social services would be interesting to consider.

5.8 Reflections

On reflection of my personal position as the mother of a child with on-going medical needs, I feel the enthusiasm for this subject area provided by this position enabled me to apply the necessary rigour and commitment to complete this project. Throughout the analysis process this enabled me to consistently revisit the voices of the mothers in the study to ensure the themes reflected the accounts given. As a mother and researcher I was also aware of the potential for my own experience to influence how I analysed the accounts given by participants. I was therefore cautious throughout the process to question methods and findings and employ a critical and reflexive approach to the project. I also ensured that

constructs, themes and an annotated transcript were reviewed by the project supervisors in order to provide an independent, impartial view thus applying diligence to the process.

Throughout the study I have been mindful of advocating the voices of mothers, who through their role are subject to expectations, criticism and oppression. I have aimed to present and explore their experiences recognising their power and personal agency whilst reflecting on the influences of society and culture. I hope that I have honoured their accounts and considered them thoroughly without reducing their experience to a theoretical position.

6 Conclusion

This study explored the personal construing of mothers in healthcare, including how they perceived themselves, their role and the conduct and role of the doctors in their consultations. In addition, it explored how participants believed they are perceived in these consultations. This facilitated an understanding of what constitutes a satisfactory and, in contrast, a less than satisfactory consultation.

The study offers an understanding of construing within this experience by combining the role of personal agency as well as societal and cultural influences that have shaped the perception of the roles discussed.

It is hoped that the study provides a valuable insight for those working in health care of the experiences of mothers bringing their children to consultations. This may then promote professional reflections on interactions with children and their mothers and positively shape future consultations.

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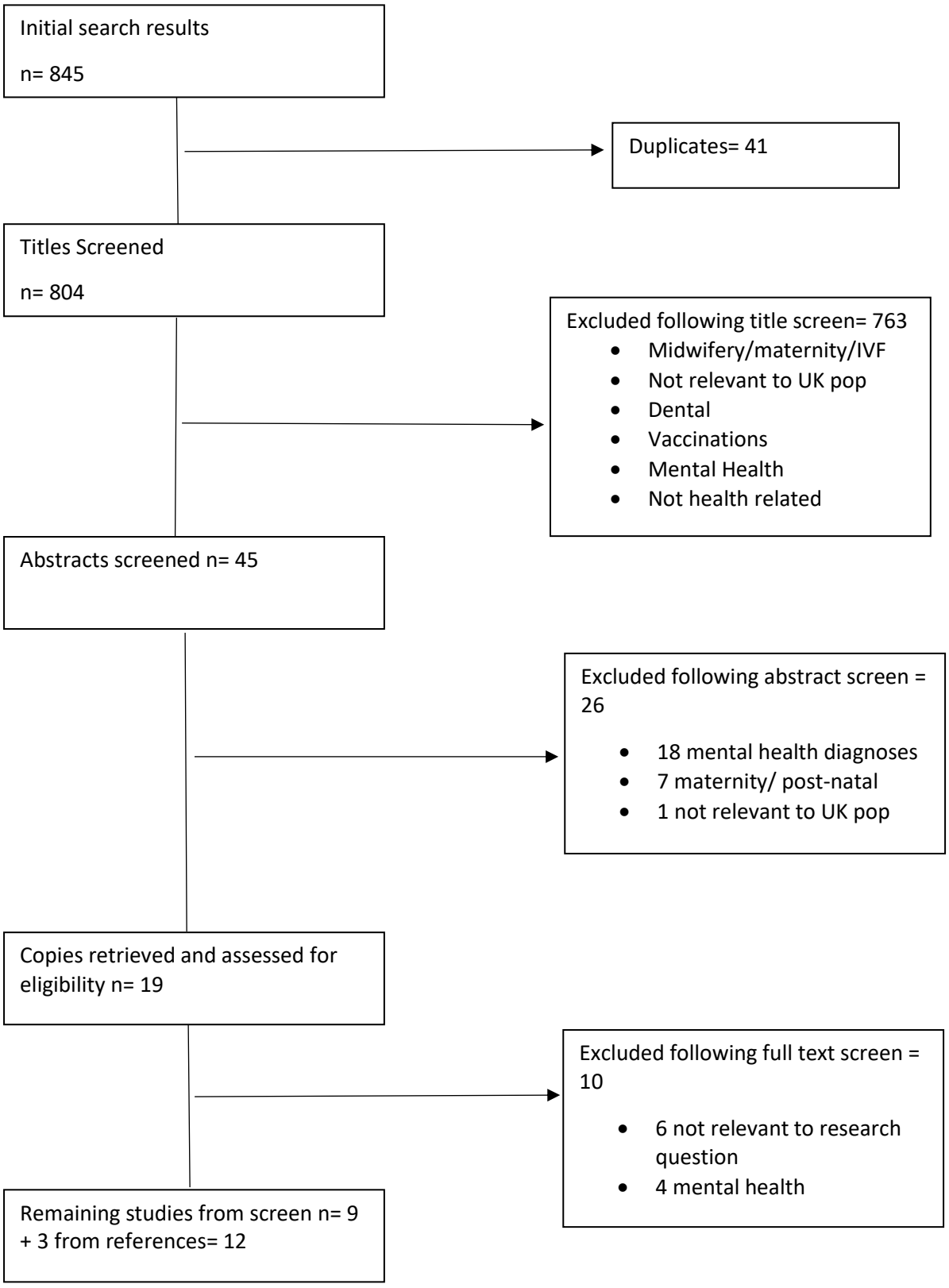
APPENDICES

Appendix I: Literature Review Flow Chart



Appendix II: Summary of review of literature

Title	Author & Date	Sample Details	Study Design	Findings	Key Implications	Critique
Mothers' evolving relationships with doctors and nurses during the chronic childhood illness trajectory	Swallow, V., & Jacoby, A. 2001	Mothers of 15 children diagnosed presymptomatically with vesicoureteric reflux and mothers of 14 children diagnosed postsymptomatically with vesicoureteric reflux (effecting kidneys).	Qualitative design exploring experiences if families. Inductively derived data using grounded theory. Participants selected using a theoretical sampling matrix. Semi-structured interviews in participants' homes. Transcripts analysed using the Framework Technique.	Relationships between mothers and medical staff influenced by perceptions of the professionals' trustworthiness and credibility and were considered important. Other important factors were identifying staff with whom mothers' felt confident in, professionals' willingness to take the concerns of the mothers seriously, and communication from the professionals. Competence and honesty of professionals also highly valued. Damaging to the relationship between the professionals and mothers was scepticism encountered	Good communication and crediting mothers' accounts as reliable as well as fostering participatory relationship for child's care results in a more positive relationship between professionals and mothers across the trajectory of the child's chronic illness.	1. Data gathered retrospectively not contemporaneously limits studies attempts to consider evolving relationship at the specific points mentioned in the study. 2. Researcher is also a professional in the team, which may have influenced candidness of participants in interviews. 3. Good consideration of positive and negative aspects of evolving relationships. 4. Does not distinguish between relationships with doctors and other health care professionals. 5. Does not state demographics of participants or consider other

				regarding a child's symptoms.		characteristics that may have influenced the mothers' experiences. 6. Very specific sample of children with this condition.
Going to the doctors: the views of mothers of children with recurrent abdominal pain	Smart. S., & Cottrell. D. 2005	Purposive sampling. Recruitment through paediatric outpatient clinics and primary schools. Sampling frame of 68 children with recurrent abdominal pain. Sampling continued until theoretical saturation was reached. 28 mothers were interviewed.	Qualitative design. Semi-structured interviews in the family home. Codes identified in transcripts using broad descriptive codes. Coding frame developed. Axial coding used to develop themes. Hypotheses derived and checked against data set.	Mothers assumed child health as their responsibility and felt competence as parent judged. All mothers in study were concerned to show they were competent at illness recognition and management- part of mothers' responsibility. Sick child as a threat to mothers' competence. Sense of inadequacy if unable to manage pain. Failure to recognise child as ill equates to neglectful, judging child as ill when not equates to overanxious. Doctors seen as only interested in physical symptoms. Mothers perceived doctors as making judgements	Doctors can improve the quality of their interactions with parents with physically unexplained symptoms by offering reassurance. Acknowledging competence of mother may help in establishing a good rapport and relationship which in turn may mean management of symptoms is more collaborative.	1. Sample composed of predominantly white middle class women so unsure if findings generalizable. 2. May have been some children with undiagnosed organic pain within sample. 3. Unclear regarding initial code generation. 4. Transcripts reviewed by two researchers. 5. Would have been interesting to consider the treatment patients were receiving and the impact of this on mothers' accounts of their experiences. 6. Specific sample of unexplained abdominal pain.

				about parenting. Mothers felt needed to legitimise concern. Some doctors experienced as dismissive. Some doctors experienced as unsympathetic to psychological symptoms.		
The everyday life information seeking behaviours of first-time mothers	Loudon, K., Buchanan, S., & Ruthven, I., 2016	Recruitment at mother and baby drop in groups of 22 first time mothers. Purposive sampling. In addition observation of six mother and baby drop in group sessions and analysis of group narratives. Interviews with 5 information gatekeepers including health visitors, project workers and librarian.	Mixed qualitative and quantitative design using ethnographic approach of observation and group interviews in mother and baby group and semi-structured interviews. Narrative approach. Interviews also conducted with local information gatekeepers who were asked to reflect on comment list compiled by mothers at mother and baby group. Data organised into categories using iterative pattern coding. Questionnaire with 5 point scales to rate common sources of information on frequency of use, usefulness and	General practitioners were not frequently used as sources of information by mothers in the study as some felt patronised or dismissed by them. Also conflicting information from different health professionals- GPs and HVs. However GPs seen as quite important and useful sources of information despite not being used frequently. “Good” health care professionals seen as being open to questions. Some fear of being judged because of parenting choices. Fear of being	Highlights some of the fears and concerns that may prevent mothers from seeking advice from doctors such as fear of being judged or dismissed and a need to present as good mothers. This may be taken into consideration by doctors seeing first time mothers, regarding the barriers they have overcome to attend appointments. Thus efforts can be made to ensure mothers feel listened to and not judged so that they will return when they have concerns or require information.	1. Demographic information generally incomplete due to participant failure to return. 2. Recruitment from mother and baby group removes mothers who are unable to attend due to socio-economic, health and accessibility reasons thus restricting sample- not therefore representative of population of first time mothers- all mothers in this study were older and well educated. 3. Researcher as mother within group sharing own experiences may have influenced data gathered. 4. Also

			importance used and analysed using quantitative methods.	perceived as over protective by health care professionals. Mothers beliefs in their unique knowledge of their children equates to good mothers. Mothers under pressure to present themselves as good mothers.	Potential training implications for trainee doctors regarding interactions with this patient group.	mother as a former group member and involved in setting up activities etc. may have biased participants accounts as they may align views to those they believe the researcher to hold. 5. No formal coding scheme used in analysis. 6. All gatekeepers directly or indirectly involved in group thus not representative of these roles in other circumstances and where researcher does not have a personal involvement. 7. Four participants were not first time mothers despite this being the remit of the study.
Family relationships with paediatricians: the maternal views.	De Carvalho, S., & Filho, J.M., 2016	Purposive sample of 200 mothers from online community using social networks.	Qualitative design using questionnaires regarding mothers perceptions of paediatric guidelines given by paediatricians. Classification of data using analysis of discourse.	Mothers' followed recommendations from paediatricians when they were clear and consistent with other sources of information. Mothers balance health professional opinions	Importance of health care professionals to understand perspective of mothers, particularly regarding role of motherhood in order to work collaboratively with	1. Participants accessed through private offices only thus homogenous sample. 2. Use of online methods reduce reliability of sample- no assurances that all

				with their own perceptions of motherhood to make decisions. Mothers struggled to trust paediatricians when they felt that they did not understand their choices as a mother. Mothers' felt empowered when they were in control for example using their intuition.	them. Maternal empowerment helps mothers make decisions regarding the care of their babies. Empathy from medical professionals is important to allow mothers' to express their concerns.	completed by mothers. 3. Established that mothers tend to use online community when experiencing problems thus questionnaire not reaching mothers who may have more positive experiences. 4. Study from Brazil may not be applicable to other geographical areas. 5. Limited details regarding analysis used
A narrative of resistance: Presentation of self when parenting children with asthma	Cohn, E.S., Cortes, D. E., Hook, J. M., Yinusa-Nyahkoon, L. S., Solomon, J. L., & Bokhour, B., 2009	Single case study sample including interview of one African American mother of four children with asthma as well as interview with the doctor. Participant selected due researchers' interest in presentation during participation in a wider research study.	Qualitative design using mixed analysis methods including sociolinguistic, narrative structure, discourse analysis and identifying patterns and links within the narrative. Analysis of four encounters of mother and doctor. Two semi-structured interviews with the mother, observation of one health care interaction between mother and doctor and interview with doctor.	The mother in the study demonstrated a desire to protect her children. Mother's behaviour typically observed as non-adherence is re-framed in the study as resilience and trying to assert control. Participant had previously been construed as problematic in her refusal to follow medical advice regarding the asthma management of her children. The	Potentially if doctors take the time to understand how the mother presents as part of her identity then interventions for the children can be collaboratively constructed. Enabling choice and control of mothers may empower their sense of self and result in a more collaborative approach to health care for the children. Opens a wider discussion about construal of	1. Single case study thus not generalizable 2. Different encounters analysed creating richer analysis of experience. 3. Including doctor in the study adds further level of understanding of the interactions. 4. Observation and inclusion of the doctor may have influenced accounts given by the mother and the interactions between mother and

				methods employed reveal protective nature of participant when considered in the cultural context, thus construing behaviour differently. Participant demonstrated being a 'good mother' by meeting the needs of her children through her attempts to make them comfortable. Control of children's care is important part of the participant's role as a mother.	presentation of mothers as problematic.	doctors thus impacting on authenticity of the interaction observed and information gathered. 4. Specifically relevant culturally to relationship of African Americans with health care in America. 5. Participant selected by researchers due to specific presentation during a larger research study. 6. In depth rich analysis
Struggling to Mother: A Consequence of Inhibitive Nursing Interactions in the Neonatal Nursery.	Fenwick, J., Barclay, L., & Schmied, V. 2001	Purposive sampling of 28 mothers across two Australian hospitals whose infants were being cared for in a neonatal nursery were recruited. Recruitment via staff from the nurseries or whilst on antenatal ward. Also, study information left in communal hospital areas. Formal interviews were also conducted with	Qualitative study using grounded theory aimed at describing and explaining from mothers' perspective, mothering in neonatal nursery. Two unstructured interviews were conducted with each participant, one prior to discharge of their infant and one following discharge between 8-12 weeks later. Observations, informal conversations and field notes as well as interviews with 20	Where nursing staff demonstrated an authoritarian style of practice focussed on protecting the infant and directing/ teaching the mother, this was considered an inhibitive nursing practice, thus preventing the mother from engaging in a collaborative caring role and placing the nurse in an expert position, retaining control.	Potential to help neonatal nursing staff better understand how to work with mothers within this context, enabling them to mother their infants in these difficult circumstances. Implications for consideration of how to balance best care for the safety of an infant with parental needs and importance of	1. Specific to mothers of neonates whilst in hospital thus not reflective of typical parenting situations. 2. Recruitment via staff from nurseries, therefore staff may select people to approach based on preconceived ideas about individuals. 3. Wide age range of mothers. 4. Concepts, categories and findings discussed with participants for their reflections. 5.

		20 nurses across the two sites.	nursing staff were also used.	Mothers experienced anger and frustration when nursing staff actively discourage them from being physically close to their infant. Mothers who felt ordered by nursing staff experienced feelings of depression and anxiety. Mothers' also reported concern that conflict with nursing staff may impact their child's care. Nursing staff reported "good" parental behaviour as being friendly, sensible and interested and visiting regularly but not staying too long. Those who did not fit these criteria were often labelled as difficult. Impact of inhibitive nursing practices increase mothers' stress levels and made it difficult for them to maintain their self-esteem and feelings of competence.	promoting caring role of mother. Understanding of the complex situation for a mother of an infant in the neonatal nursery of not knowing their role and feeling frustrated when their voice went unheard and decision making about their child was restricted. Teaching and discussion around how to empower mothers in circumstances when many of their caring roles have been restricted due to medical needs.	Two interviews with mothers gives rich data and allows for corroboration of previous discussed concepts. 6. Little information given regarding interviews with nursing staff and observations in article.

Mothers' voice: a qualitative study on feeding children with cerebral palsy	Sleigh, G., 2005	Ten participants recruited. 9 were mothers and one interview was conducted with grandparents who had care of the child. Four families were orally feeding their child and six were using gastrostomy feeding.	Qualitative design using loosely structured interviews analysed using a phenomenological approach.	Both groups treasured feeding by mouth. Some encounters with health care professionals added to the families stress. Carers reported feeling angry, demoralized and not listened to by professionals. Oral feeding was considered important because it led to mutual knowledge between carer and child as it demands undivided attention. Families felt stress when they were not in control and felt that they were not understood by the professionals. Family well-being promoted when professionals were positive and acknowledged expertise or carers and assumed expert role when required.	Implications to help professionals understand the importance to parents of maintaining 'normal' caring duties such as feeding as they contribute to relationship with child. Consideration of how health care professionals can promote family well-being by acknowledging expertise of cares and provided support when required.	1. Orally fed children in the study were considerably younger than gastrostomy fed children, therefore experiences and length of involvement in medical care was different which may have accounted for differences between groups. 2. Respondent validation from four participants (two from each group), supported the descriptions of the study thus adding support to the findings.
Motherhood and Associative Moral Stigma: The Moral Double Bind	Davis, J. L., & Manago, B. 2016	Purposive sampling using camps for children with disabilities as	Qualitative design using semi-structured interviews conducted across a 2 year period at	Mothers' who have a child with a physical or cognitive disability experience	Implications regarding the impact of giving or not giving a diagnosis when a	1. Participants recruited from camps organised for families with children with

		sampling pool. 36 mothers and 7 fathers of children with physical and cognitive disabilities.	8 camps. Analysis of transcripts conducted using abductive method based in grounded theory.	associative stigma. Mothers appear to be held responsible for the well-being of their children and thus experience moral stigma through association. Parents in the study indicated that their identities were interwoven with their child's stigma. Mothers' in the study experienced both felt and enacted associative stigma and felt socially rejected and isolated. Mothers' experienced associative stigma through two routes; child rearing and gestation. Through child rearing mothers are 'supposed' to cultivate children into productive members of society and through gestation they are responsible for the health of their child. Mothers experience both of these in association with their disabled	child presents with cognitive or physical disabilities and how a mother assumes responsibility for the child's presentation in either scenario. Insight into the stigma experienced by mothers with children with disabilities may help regarding accessibility to support and reducing experiences of isolation. Highlights need for support for mothers' of children with disabilities mental health due to the emotional consequences experienced through moral stigma. Wider cultural considerations of how we hold mothers culpable for their offspring.	disabilities. Therefore families contributing were those immersed in support systems for their children and in contact with various other systems including medical. It is therefore possible that their experience is not typical to those in similar situations who do not have access or opportunity to engage in camps of this nature. 2. Wide diagnostic inclusion ranging from ADHD to cerebral palsy, benign tumours and blood disorder. Lose definition of 'disability' used within the study therefore conclusions drawn from stigma associated with disability may be condition dependent. 3. Narrow demographic including mainly white, middle class. 4. Wide range of socio-economic and educational

				child. Where behaviour is medicalised the mother assumes moral responsibility for the health of the child due to the physical act of gestation. In the absence of medical explanations a mother assumes the moral responsibility for the child's difficulties through her child rearing duties. Mothers felt guilt and distressed due to the moral stigma they experienced.		backgrounds represented in participants.
A Narrative Approach to Understanding the Illness Experiences of a Mother and Daughter	Weingarten, K., & Weingarten Worthen, M. E. 1997	Sample is made up of authors- mother and daughter describing narrative of own illness journey. Primary author (mother) has previously had diagnoses of breast cancer and second author (daughter) has an ongoing diagnosis of a rare genetic condition that is poorly	Qualitative design using case study approach. In depth idiographic exploration of the experiences of a mother and daughter and their illness narratives.	Coping within a family when a member has a significant diagnosis is mediated by how much the illness is understood by healthcare providers, friends and family. The experiences of a rare genetic condition that is not widely understood by professionals and friends results in	The idea that the self is created through interactions via language has implications for how the medical interactions parents and their children experience may contribute the construction of the self and the understanding of themselves in this	1. Idiographic nature of research potentially reduces relevance to other experiences of parents and children in health care. 2. A very personal and reflective account which gives a rich understanding of the authors' experiences.

		understood and unpredictable.		greater isolation that experiencing a widely understood illness. The author states that the self continually creates itself through narratives that include other people… through language reality is constructed. There is some confusion for mother and child about the important aspects of the narrative of the illness journey. Mother's experience of the dominant cultural discourse of a good mother being selfless and a bad mother as selfish. Experience of some doctors as having professional satisfaction in exploring rare condition. Experience of poorly understood diagnosis can be lonely and scary as professionals have no clear protocol when	context that mothers and children develop. The author describes being unsure of which aspects of the narrative are important to tell, which has implications for how health care providers can assist patients and carers in understanding and developing a coherent meaning to their experience. How doctors communicate information in a personal and patient centred rather than disease focused way. Also medically enquiry to be conducted in a way that makes the patient feel listened to and believed not questioned which ultimately has an impact on the relationship with	

				approaching treatment. Thus compassion key characteristic of good relationship with doctor. Child in this study felt the hospital was a safe environment and that doctors were caring until they experienced a questioning of their symptoms.	health care providers and thus impact treatment and concordance. Importance of professionals in empowering patients and family in coping with medical problems.	
Mothers' accounts of healthcare encounters: Negotiating culpability and fulfilling the active mother role	Gunnarsson, N. V., Hemmingsson, H., & Hyden, L., C. 2013	19 parents (18 mothers, 1 father) selected from an original study of 215 parents. Participants purposively selected to represent a broad spectrum of those found within the original study with reference to allergy type, severity etc. and parent's social, educational background as well as age, marital status and number of children.	Qualitative design: narrative-orientated retrospective interviews with 18 mothers. Data analysis described as a case-based approach- with interviews reconstructed as a narrative about parents' experiences in healthcare encounters for their child.	Mothers make claims of moral agency (trying to show that they have done the right thing and are good and responsible) when something goes wrong and they disagree with healthcare professional about their child's symptoms. For some participants the healthcare professionals were figures of blame along with mothers blaming themselves for their child's symptoms. Mothers	The conflicting roles and expectations that mothers have to navigate when presenting with their children in health care could be explored with health care providers when children present with chronic conditions to promote a positive relationship. This could also link in to a way of working when health care professionals and parents disagree on points of care for a child.	1. Selection of participants to represent wider population open to floors given small sample number. 2. Study documents that interviews were constructed as a response to initial inquiry about the discovery of child's allergy. This is ambiguous and suggests the use of answers to fit the topic of exploration? 3. Interviews reconstructed to reflect chronology- how does this

				felt that they have to show they are competent and responsible in their role whilst simultaneously navigating cultural expectations to be passive patients thus putting them in a position of conflict. This is at odds with assertive role they feel they should represent as mothers of children with health problems. At times mothers felt rejected by health care professionals who seemingly dismissed concerns regarding the child's wellbeing this was taken as judgement of their mothering competence. Mothers' aim to make their mothering self-images fit the dominant social and cultural constructions of good mothering.	Health care professionals being aware that mother's feel their competence is judged when presenting in health care may in itself be helpful to facilitate sensitive interaction.	process influence analysis?
"But I'm a good mom". The Social Construction of	Tardy, R.W 2000	24 women from social mother and baby group.	Qualitative design using ethnographic methodology-	Healthcare conversations serve to construct women's	There are some topics considered taboo which are not	1. Ethnographic approach enabled access to more

Motherhood through Health-Care Conversations			observations, semi-structured interviews and open ended surveys.	identities as mothers- engaging in talk re: health is evidence of being a good mother. However, mothers' avoided some more sensitive topics to maintain ideal mother role in accordance with cultural expectations.	discussed as they would interfere in the enactment of motherhood as prescribed by cultural norms. This should be considered in health care as this is an arena previously demonstrated to be one where mothers are conscious of being judged and therefore may be reluctant to discuss certain matters with health professionals.	candid conversation, however consideration of impact of presence of researcher should be given to how the results may have been influenced. 2. Researcher also a previous member of the group raising ethical considerations of overlap between researcher and friend/ confidante. 3. Method of 'eavesdropping' on conversations has some ethical issues despite consent having been received. Were participants truly aware of what researcher would be recording and analysing, how trusted can unconsidered comments be as reflection of experience.
With Mothers discuss parenting stress and depressive symptoms with their child's paediatrician?	Heneghan, A. M. Mercer, M.B. &	Purposive sample of 44 mothers recruited from 5 community based paediatric practices	Qualitative design using 7 focus groups consisting of open-ended questions and a standardized	Two domains were identified: maternal domain and interaction between mother and	By identifying how mothers' feel about sharing their own stressors and depressive symptoms	1. Use of three researchers 2. Independent researchers so therefore not present

	DeLeone, N.L. 2004	and 1 hospital based practice.	questionnaire. Audiotapes and transcripts reviewed for major themes by 3 researchers using grounded theory and immersion/crystallization technique.	paediatrician domain. Within the maternal domain themes included: 1)emotional health- acknowledgement that mother's emotional well-being has an impact on that of the child, 2) self-efficacy- mothers' believed that it was their responsibility to monitor their own well-being as well as that of their child, 3) support systems- all mothers in the study identified a need to share experiences with others. Within the interaction between mother and paediatrician domain themes included: 1) communication- open communication with a paediatrician who listens well was deemed important, 2) trust- whilst the mothers in the study trusted their paediatrician with the health of their child many were reluctant	with paediatricians the article uncovers a concern from mothers that they may be judged by the paediatrician. It also identifies that paediatricians who make a mother feel listened to and who take the time to get to know them increase mothers' likelihood to share information about their own well-being. Generalising these findings suggests that if paediatricians prioritise listening to and fostering open communication with mothers they will receive more information not only about the mother but potentially about the child thus making it more likely that a collaborative relationship in caring for the child can be developed. This in turn may reflect better health and well-being outcomes	when data was collected may have less connection and insight to the interaction thus resulting in a disadvantage when reviewing data from a removed position. 3. Potentially utilising paediatricians for maternal screening may increase mothers' concerns of being judged when taking their child to the doctor. 4. Wider discussion about scope of a paediatrician's role- is it within their capacity to be expected to identify maternal mental health symptoms. 5. As an American study this article reflects a system different to that within the UK where there is routinely less interaction with paediatric services for a well child. 6. Focus group regarding maternal

				to share their own stress or symptoms of depression for fear of being judged or referred to external services for child protection. Mothers were more likely to discuss their own well-being with paediatricians who they felt knew them well. Mothers were receptive to receiving written supportive information from their child's paediatrician. Mothers expressed that discussing difficulties they were having with paediatricians would be like admitting to failure as their sense of self was so closely linked to their role as a mother. Mothers were also cautious regarding the perceived motives of the paediatricians when asking about maternal well-being. Continuity of the relationship with the	for the child as the patient. The importance highlighted in the study regarding continuity of relationship with the paediatrician, consideration could be made in clinical practice for a patient to see the same clinician at each attendance.	mental health- it is possible that mothers in these groups may not have felt comfortable discussing these topics amongst one another. Previous studies have indicated a reluctance for mothers to share sensitive ideas that may result in feeling judged which may have influenced how much they felt comfortable discussing.

				paediatrician also made mothers feel more comfortable in discussing their own well-being.		
Stigma in an era of medicalisation and anxious parenting: how proximity and culpability shape middle-class parents' experiences of disgrace.	Francis, A 2012	Purposive sample of 34 mothers and 21 fathers recruited through support and advocacy groups, non-profit organisations and schools for children with special needs, further recruitment through snowballing sampling. Maximum variation sampling was used to gather data from a diverse population within the area of interest.	Qualitative design using informally structured interviews. Inductive methodology. Data was coded and emergent patterns identified.	Parents of children with physical, psychological and behavioural problems experience courtesy stigma (from close social proximity to stigmatised children) and the stigma of being a bad parent (where they are held responsible for their children's problems). Mothers, parents of children with invisible disabilities and parents of young children are particularly susceptible to negative labelling. Mothers were found more than fathers to experience both courtesy and blame stigma this may be because they are generally more responsible for childcare and therefore more	Implications for how we consider accounts and experiences of parents with children who have poorly defined or contested conditions as these groups tend to experience parent-blame more frequently. Medical discourse can reduce parent-blame by using the terminology to absorb this, however it can then render women responsible in others ways such as injuries caused in utero that they may have no way of establishing that they are not to blame for. This leads to a complex navigation for medics through medical terminology and how it should be conveyed to parents.	1. Recruitment required self-identification of child's problem. Therefore a very broad spectrum of difficulties is considered within a small sample. 2. Recruitment via support agencies suggests that sample may be specifically of parents who problematize and medicalise difficulties of their child thus may exclude parents in similar situations with differing perceptions of these difficulties.

				proximal to the child. The stigma they experienced was often more detrimental to the mothers' social connections as these tended to be more associated with their children than the fathers. Fathers were less likely to interpret negative attention as blame than mothers. Whether or not the child was viewed as having a 'legitimate' disability shaped parents' experiences of stigma. Parent-blame was less associated in situations where children had uncontested physical conditions such as cerebral palsy. Where moral failure is considered the cause of a problem (behavioural, drug abuse) parents experience greater blame. Parent-blame was paramount amongst invisible		

				disabilities such as autism and ADHD.		

Appendix III: Evaluation of Qualitative Research (Mays & Pope, 2000)

Author & Date	Quality Criteria (Mays and Pope, 2000)	Criteria met √ Criteria not met x Criteria partially met /
Swallow, V., & Jacoby, A. 2001	Worth and Relevance of the Study Clear Research Question Appropriate Research Design Well Described Research Context Clear Sampling Method Data Collection and Analysis Reflexivity of Research Report	√ / √ √ √ √ √
Smart. S., & Cottrell. D. 2005	Worth and Relevance of the Study Clear Research Question Appropriate Research Design Well Described Research Context Clear Sampling Method Data Collection and Analysis Reflexivity of Research Report	√ √ √ √ √ √ /
Loudon, K., Buchanan, S., & Ruthven, I., 2016	Worth and Relevance of the Study Clear Research Question Appropriate Research Design Well Described Research Context Clear Sampling Method Data Collection and Analysis Reflexivity of Research Report	/ √ / √ √ √ /
De Carvalho, S., & Filho, J.M., 2016	Worth and Relevance of the Study Clear Research Question Appropriate Research Design Well Described Research Context Clear Sampling Method Data Collection and Analysis Reflexivity of Research Report	√ / / √ √ / X

Cohn, E.S., Cortes, D. E., Hook, J. M., Yinusa-Nyahkoon, L. S., Solomon, J. L., & Bokhour, B., 2009	Worth and Relevance of the Study Clear Research Question Appropriate Research Design Well Described Research Context Clear Sampling Method Data Collection and Analysis Reflexivity of Research Report	√ X √ √ / / /
Fenwick, J., Barclay, L., & Schmied, V. 2001	Worth and Relevance of the Study Clear Research Question Appropriate Research Design Well Described Research Context Clear Sampling Method Data Collection and Analysis Reflexivity of Research Report	√ √ √ √ √ / X
Sleigh, G., 2005	Worth and Relevance of the Study Clear Research Question Appropriate Research Design Well Described Research Context Clear Sampling Method Data Collection and Analysis Reflexivity of Research Report	√ / / √ / √ X
Davis, J. L., & Manago, B. 2016	Worth and Relevance of the Study Clear Research Question Appropriate Research Design Well Described Research Context Clear Sampling Method Data collection and Analysis Reflexivity of Research Report	√ / √ √ √ √ /
Weingarten, K., & Weingarten Worthen, M. E. 1997	Worth and Relevance of the Study Clear Research Question Appropriate Research Design Well Described Research Context Clear Sampling Method Data collection and Analysis Reflexivity of Research Report	/ X / √ √ / /

Gunnarsson, N. V., Hemmingsson, H., & Hyden, L., C. 2013	Worth and Relevance of the Study Clear Research Question Appropriate Research Design Well Described Research Context Clear Sampling Method Data collection and Analysis Reflexivity of Research Report	√ √ √ √ √ / /
Tardy, R.W 2000	Worth and Relevance of the Study Clear Research Question Appropriate Research Design Well Described Research Context Clear Sampling Method Data collection and Analysis Reflexivity of Research Report	√ / / √ √ / x
Heneghan, A. M. Mercer, M.B. & DeLeone, N.L. 2004	Worth and Relevance of the Study Clear Research Question Appropriate Research Design Well Described Research Context Clear Sampling Method Data collection and Analysis Reflexivity of Research Report	√ √ / √ √ / /
Francis, A 2012	Worth and Relevance of the Study Clear Research Question Appropriate Research Design Well Described Research Context Clear Sampling Method Data collection and Analysis Reflexivity of Research Report	√ / √ √ √ / x

Appendix IV: Recruitment advert

ARE YOU THE MOTHER OF A CHILD AGED 0-5? HAVE YOU HAD CONTACT WITH A DOCTOR IN THE LAST 12 MONTHS FOR YOUR CHILD?

I am a Trainee Clinical Psychologist in my final year of study at the University of Hertfordshire. I am really interested in learning about the views of mothers who have taken their child to see a doctor in the last year. I would really like to talk to you if you are a mother of a child under the age of 5. I am interested in hearing about how mothers view their role and how they feel they are perceived during consultations with doctors. This research will form my doctoral thesis in Clinical Psychology.
If you are interested in taking part in this study and would like to know more please contact me and I can provide further information about the study.

Thank you
Emma Holder (Trainee Clinical Psychologist)
e.holder@herts.ac.uk
Tel: 07393934105

This study has been approved by: The University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority on behalf of the Health and Human Sciences Ethics Committee with Delegated Authority-UH protocol number: **LMS/PGR/UH/02766**

Appendix V: Participant Information Sheet

Participant Information Sheet

I would like to invite you to take part in a research study exploring how mothers feel their roles as mothers are viewed by doctors in health care settings. To explore how these roles are perceived I am interviewing mothers who have young children that they have taken for consultation with a doctor in the past 12 months.

The aim of the study is to explore how mothers perceive themselves and how they feel they are perceived by the doctors they take their children to. In addition I will be exploring mothers' perceptions of the doctors that they consult for their children.

To explore this I am seeking your consent to take part in the study. To help you decide if you would like to take part in the study please take some time to read the following information to help you understand what taking part in the research will involve.

Title of the Study: Personal constructions of the mother role: perceptions of mothers in health care

Who is running the study? My name is Emma Holder, I am a third year Trainee Clinical Psychologist at the University of Hertfordshire. The research study is being supervised by two experienced Clinical Psychologists. The study supervisors are Professor Harry Procter (Chartered Clinical Psychologist) and Professor David Winter (Chartered Clinical Psychologist).

What is the study for? I am conducting the study as the final part of my doctoral training in clinical psychology.

What are the aims of the study? The aims of the study are to explore how mothers feel their roles are viewed by medical doctors.

What would taking part in the study involve? If you agree to take part in the study you will be asked to sign a form agreeing that you have read this information sheet and wish to participate. You are still free at any time to withdraw from the study even once you have signed the consent form.

Once you have signed the form, providing you are still happy to take part, the study will involve being interviewed. During this interview you will be asked to complete forms called Perceiver Element Grids (PEGs). This involves writing and/or drawing on pieces of paper in response to questions about how you view yourself and your role as a mother as well as specific experiences of consultations with doctors. You will also be asked about how you think you were perceived by doctors in consultations that you experienced as satisfactory and less than satisfactory. During the interview you will be asked questions about what has been written on the form. You may share as much or as little about what you have put on your PEG as you feel comfortable in doing. You will also be asked questions to help the researcher understand more about your PEGs; again you can choose whether or not to answer any of these questions. The questions will be about what your PEGs mean and what your thoughts are about your PEGs.

The study will be recorded using audio recording devices so that the researcher can listen back when writing up the study. Taking part in the study will take approximately 1 hour and 30 minutes. There will be opportunities to take breaks during this time.

Do I have to take part in the study? Taking part in the study is completely voluntary. If at any time prior to or after participating you change your mind about participating you are free to withdraw from the study. You need not provide a reason for this decision.

What will happen with the information I provide in the study? Any personal information you provide will be stored securely and will only be accessed by the researchers. The recordings of the interviews will be transcribed and these transcripts will be anonymised and stored on a password protected computer, separate from your personal information. Any information you give during the study that might be identifiable will be changed so that you cannot be recognised by it. The recordings will be destroyed upon the researcher's completion of the doctorate in clinical psychology.
The study will be confidential, meaning that information about you will only be available to the researchers. The only caveat to this confidentiality is in the unlikely event that you disclose information that leads to concerns about safety of yourself or others. If this were to occur these concerns would be discussed with the research supervisors to determine any appropriate action or support that may be required.

What will happen when the study is completed? The results of the PEGs and interviews will be used to form the researcher's thesis for doctorate qualification in Clinical Psychology. The full thesis will be available for others to access from the University of Hertfordshire Learning Resource Centre (this will not contain any personal information). In addition to this a summary paper of the research study may also be published in a journal relevant to the research area.

Other information
It is unlikely that you will experience any negative effects from contributing to this study. However, should discussions of experiences you have encountered result in any distress there will be an opportunity to discuss with the researcher any issues that have arisen after the interviews.

Who has reviewed this study? This study has been approved by: The University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority on behalf of the Health and Human Sciences Ethics Committee with Delegated Authority-UH protocol number: **LMS/PGR/UH/02766**

What happens next? Now that you have read this information, please feel free to ask the researcher any questions you may have about the study. Once you have read the information please take some time to decide if you would like to take part in the study. If you would like to participate in the study please let the researcher know and we can discuss signing the consent forms and completing the interviews.

Complaints: Although we very much hope that it is not the case, if you wish to raise concerns or make a complaint about this study or the way you have been approached to participate you can write to the University Secretary and Registrar.

Thank you for taking the time to consider this research study

Contact details:

Researcher: Emma Holder
Email address: e.holder@herts.ac.uk
Address: Doctorate of Clinical Psychology Training Course
Health Research Building
University of Hertfordshire
College Lane
Hatfield
Hertfordshire
AL10 9AB Tel: 07393934105

Research supervisor: Professor David Winter Email: d.winter@herts.ac.uk
Tel: 01707 284486

Appendix VI: Participant Consent Form

Participant Consent Form

Title of the Study: Personal constructs of the mother role: perceptions of mothers in health care

Researcher: Emma Holder (Trainee Clinical Psychologist)

Please read the following and indicate by writing your initials in the boxes that you agree with each statement. Please then sign and date the form.

1. I have read and understood the information sheet provided by the researcher detailing the aims of the study and what my participation will involve. I have been given the opportunity to think carefully about participating in the study and ask any questions I have about the study and my participation.

2. I agree to participate in the study and understand that this will involve completing Perceiver Element Grids (PEG) with Emma Holder. I understand I will be interviewed about my grids, which will involve being asked questions about what I have written and/or drawn. I understand that I am free to give as much or as little information when answering questions during the interview as I feel comfortable in doing. I understand that I do not have to answer any questions that I do not want to.

3. I understand that my participation in the study is voluntary and that I am free to withdraw from the study at any time without giving a reason and that any data I have provided will then be deleted.

4. I understand that my participation in the study will be audio recorded and transcribed. I further understand that personal information I provide will be kept anonymously and confidentially. Recordings will be kept securely on a password protected USB drive and computer. I understand that personal information will be kept locked securely away.

5. I understand that a professional transcription service may be used to transcribe the audio recordings of my participation. I understand that no personal data will be provided to the transcription service and that the recordings will be coded for identification purposes. In addition I understand that the transcription service will sign a non-disclosure/ confidentiality agreement.

6. I agree that information and quotes from my PEGs and interview may be reproduced in the researcher's thesis project and for any journal publications. I understand that these will be anonymised and any personal information will be removed prior to use to protect my anonymity. However, I understand that despite every effort taken to do so there remains a slight possibility of identification.

7. I understand that my participation in the study is confidential. However, should I disclose any information that suggests that I or anyone else may be at risk of harm, the researcher will need to share this information with appropriate professionals.

8. The researcher has provided me with contact details should I have any further questions about the study or my participation.

This study has been approved by: The University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority on behalf of the Health and Human Sciences Ethics Committee with Delegated Authority-UH protocol number: **LMS/PGR/UH/02766**

Participant Name……..…….

Participant Signature…… Date:……

Researcher's Declaration
I have explained the study to the above named participant and what their involvement will entail. I have received informed consent for their participation in the study.

Researcher's Name……..

Researcher's Signature…….. Date:……

Appendix VII: Removed from final submission

Appendix VIII: Standardised Instructions

Standardised Instructions

Thank you for agreeing to take part in this study. The following interview will take approximately 1 hour and 30 minutes. I will ask part way through if you would like to take a break. If you need a break at any other time, please don't hesitate to let me know and this can be facilitated. Also, if at any time you would like to stop participating please let me know: you are free to withdraw from the study at any time without giving a reason. Over the course of the interview I will be asking lots of questions and asking you to explain, draw or write in response to some of the questions. If at any time you do not wish to answer a question or contribute to a particular aspect of the study, please let me know and we can either stop or move on to the next question. At times I will ask you to think about the same things from different perspectives. This involves trying to put yourself in the position of someone else or think from the perspective of yourself in different roles. This may be difficult at times but please just give your best effort. There are no right or wrong answers, and I am interested in your views.

Thank you once again. Please take this opportunity to ask any questions you may have before we begin.

Semi-structured Interview Schedule

PEG Completion

I would like you to take a moment to think of two consultations you have taken your child to in the past 12 months. I would like you to recall a consultation that you felt was a satisfactory experience and one that you felt was a less than satisfactory experience.

For each consultation could you please give a brief outline of the experience?

- **How many consultations with a doctor have you taken your child to in the last 12 months?**
- **When was the consultation?**
- **How old was your child?**
- **Was this a routine or an emergency consultation?**
- **What was the speciality of the doctor you saw?**
- **Was this the first time you had met this doctor?**
- **If no, how many consultations have you previously had with this doctor?**
- **What was the nature of the complaint that you sought advice regarding?**
- **Does your child have any on-going medical needs or diagnoses, if yes please provide details?**
- **Would you describe the experience as satisfactory or less than satisfactory?**
- **Why did you choose this experience to discuss today?**

1. **How I saw myself**

In this consultation, how did you see yourself as an individual? Regardless of other jobs or roles you have, how would you describe yourself in that moment? What were your characteristics? Can you explain to me how you would best describe yourself during that experience? Would you like to add anything?

2. **How I saw myself as a mother**

Looking back to that time, during that consultation with …how would you describe yourself as a mother? Thinking specifically about your qualities and characteristics as a mother during that consultation, can you tell me how you would best describe yourself in that role during that experience? Would you like to add anything?

3. **How I saw the doctor**

Again, thinking about that consultation, how would you describe the doctor you saw? Thinking from the perspective of yourself as an individual, regardless of other roles or jobs you fulfil, and thinking of yourself in your entirety, made up of many facets and attributes, how would you describe the characteristics of the doctor? Can you tell me how you would best describe them in their role as a doctor? Would you like to add anything?

4. **How I as a mother saw myself**

For this next one, I'd like you to think specifically from your perspective as a mother as if you could single out that part of yourself or that role. From that stance, I'd like you to think about how you would describe yourself during the consultation you have described to me, so looking from the outside from a mother's perspective how you would describe you as an individual and your characteristics during this experience. Would you like to add anything?

5. **How I as a mother viewed myself as a mother in this consultation**

For this one, I'd like you to think again from your perspective as a mother during this consultation. As a mother, I'd like you to think about how you viewed your own role as a mother during this experience. I'd like you to best describe how you viewed yourself in this role and your characteristics at this point in time. Would you like to add anything?

6. **How I as a mother viewed the doctor in this consultation**

Continuing to think from your perspective as a mother to…. (almost as if you could isolate that aspect of your personality) I'd like you to think about how you viewed the doctor in this consultation. This time you are specifically thinking from the perspective of motherhood. I would like you to describe the characteristics of the doctor as you see it from your perspective as a mother. Would you like to add anything?

7. **How I believe the doctor viewed me**

Now I'd like you to try and put yourself in the shoes of the doctor you saw on this occasion. I would like you to try and think how the doctor viewed you as an individual in this situation, imagining yourself from their perspective and the way they may have seen you as an individual regardless of your role as a mother at that time. This may be a little more difficult given that you were taking your child to the consultation, but give it your best attempt. If I were to ask that doctor, how do you think they would describe your characteristics? Would you like to add anything?

8. **How I believe the doctor viewed me as a mother**

For this one, I'd like you again to try and put yourself in the shoes of that doctor. I would like you to try and think how they viewed you in your role as a mother. Imagine I were to ask them how they perceived you as a mother, how do you think they would respond? I'd like you to explain how you think the doctor viewed you as a mother. Would you like to add anything?

9. **How I believe the doctor viewed the role of a doctor**

And finally in this section, I'd like you to think once more from the view of the doctor you saw on this occasion, I would like you to try and think how you believe they would describe the role of a doctor. So, what that would look like, what are the characteristics of this role as seen from the view of that doctor? Would you like to add anything?

This should be repeated for each of the consultations that the participant has described.

Prompts/ questions to be asked during interview and PEG completion:

- Could you explain what you have described?- (Use each section of the grid at a time to allow them to fully explore what has been written/ drawn)
- What do you mean by that?
- How does that feel now you are talking about it here?
- Why do you think you view yourself/the doctor/ mother role this way?
- What do you think has contributed to the way you view this?
- Is there anything unexpected or surprising about what you have described?
- I notice that there are some differences between what you have said about how you see doctors/ mothers and the way you saw them in your own experience, why do you think that might be?
- Do you see any similarities between your grids? Discuss
- Do you see any difference between your grids? Discuss
- Has completing the grids changed the way you view mothers/doctors?
- If you were to complete the grids again, how, if at all, would they differ?
- Is there anything else you would like to add?

Appendix IX: Ethics Approval Notification

University of Hertfordshire UH

HEALTH SCIENCES ENGINEERING & TECHNOLOGY ECDA
ETHICS APPROVAL NOTIFICATION

TO Emma Holder

CC Prof David Winter

FROM Dr Simon Trainis, Health,Sciences,Engineering & Technology ECDA Chair

DATE 03/04/2017

Protocol number: LMS/PGR/UH/02766

Title of study: Personal Constructions of the mother role: Perceptions of mothers in health care.
Your application for ethics approval has been accepted and approved by the ECDA for your School and includes work undertaken for this study by the named additional workers below:
This approval is valid:

From: 03/04/2017

To: 31/10/2017

Additional workers: no additional workers named.

Please note:
If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and your completed consent paperwork to this ECDA once your study is complete.

Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1. Should you amend any aspect of your research, or wish to apply for an extension to your study, you will need your supervisor's approval and must complete and submit form EC2. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1 may need to be completed prior to the study being undertaken. Should adverse circumstances arise during this study such as physical reaction/harm, mental/emotional harm, intrusion of privacy or breach of confidentiality this must be reported to the approving Committee immediately. Failure to report adverse circumstance/s would be considered misconduct.
Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.
Students must include this Approval Notification with their submission.

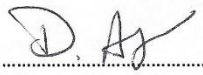
Appendix X: Confidentiality Agreement with Transcription Service

CONFIDENTIALITY AGREEMENT

Cambridge Transcriptions agrees to use the confidential information strictly for the purpose of audio transcription and to hold all information confidential during and after use, and will not make any copies or records of the confidential information without consent.

I AGREE TO THE TERMS & CONDITIONS OF THE CONFIDENTIALITY AGREEMENT

Signed for and on behalf of CAMBRIDGE TRANSCRIPTIONS:

Signature:  .....

Debra Armstrong

Dated: 17th August, 2017

Cambridge Transcriptions 17th August, 2017

Appendix XI: Participant Debrief Summary

Debrief

Thank you for taking part in this study.

Title of the Study: Personal constructs of the mother role: perceptions of mothers in health care

Researcher: Emma Holder (Trainee Clinical Psychologist)

Thank you very much for participating in this study. Through this we will be able to better understand how the roles of mothers and doctors are construed with the wider aim of considering how mothers feel they are viewed in health care when taking their children to see doctors and why they are construed in this way.

Any personal information you have contributed will be kept securely and destroyed once the research project has been completed. Your interview will be kept securely and transcripts of the interviews will be anonymised.

I hope that you found contributing to this study a positive experience. However, if you have experienced distress or feel that you would benefit by speaking to someone about what has been discussed today please speak to the researcher so that further advice about where to seek this can be given. Often speaking with colleagues, family and friends can help by providing a means of support. If you feel you need further support this can be sought through your GP or alternatively other organisations such as the Samaritans (08457 909090).

If you require further information about the study please do not hesitate to contact me:

Emma Holder: e.holder@herts.ac.uk
Tel: 07393934105

Or the research supervisor

Professor David Winter: d.winter@herts.ac.uk
Department of Clinical Psychology, University of Hertfordshire
College Lane Campus
Hatfield
AL10 9AB
Tel: 01707 284486

Thank you once again!

This study has been approved by: The University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority on behalf of the Health and Human Sciences Ethics Committee with Delegated Authority-UH protocol number: **LMS/PGR/UH/02766**

Appendix XII: Full PEGs

Gemma

Gemma's PEG: Satisfactory Consultation- Emergency department doctor for injured arm

Perceiver/ Element	Self	Mother	Doctor
Self	*How Gemma as an individual saw herself:* Calm Not panic Organised	*How Gemma as an individual saw herself as a mother:* Reassuring and caring Quite flustered Managing lots of things Showing confidence but not feeling it Sad for youngest child	*How I as an individual saw the doctor:* He knew what he was doing- knew he needed to distract my daughter Considerate Had confidence in me Calm
Mother	*How I as a mother saw myself:* Critical of myself Still be considered caring- I think I was regimented I might be quite cold	*How I as a mother saw myself as a mother:* Keeping my daughter calm Keeping things under control Intent to be a good mother -keeping things calm and in control Organised Nurturing	*How I as a mother saw the doctor:* Helping child He had to cause her distress and make her cry He did his job Smiley, chatty He didn't patronise me
Doctor	*How I think the doctor saw me as an individual:* Made right decision. Calm and not worried Not stressed Quiet and shy	*How I think the doctor saw me as a mother* Laidback In control Calm and being in control Had confidence in me Quieter than other mothers Average performing mother Caring. Appreciated my help in distracting her.	*How I think the doctor saw himself/ his role as a doctor:* Getting the job done Reassuring Managing the patient's feelings. Friendly

Gemma's PEG: Less than Satisfactory Consultation- GP appointment for fever and red/ sore eyes

Perceiver/ Element	Self	Mother	Doctor
Self	I gave facts Helpful- recorded times and things that had happen Keen to understand what problem was	I was trying to comfort my son because he was upset Talking in a calm voice, talking him through things. Helping him understand so not to upset him.	Medically, very professional Did the right things Didn't talk to the child or explain things Not chatty, didn't try to manage our feelings. Limited eye contact. Not reassuring- I don't feel like he likes me
Mother	I did well to go with my gut- he needed to see a doctor Difficult to separate self and mother	Reassuring- cuddles, contact Looking after him and focusing on what the doctor was telling me Want to look after child but don't want doctor to think I'm not listening Reassuring son but following doctor's instructions Having to do what doctor asked (lay son on bed) but wasn't making him happy- felt guilty	Doctor didn't interact with him at all I would have liked him to reassure him, tell him what he was going to do, distract him Behaves same way with adults- he should adjust for children Medically doing what had to do but not caring so much
Doctor	I was a nuisance, see me as a worrier. Concerned he thought I was a time waster I don't know that he would have viewed me differently as an individual and as a mother. I felt he didn't think I was taking his questions seriously I don't want him to think I don't care about my son's health. I want him to like me as a person- if he thinks I'm not taking him seriously, he won't like me	I'm a worrier I would hope he would say not a time waster He must be able to see that I cared about what my son was feeling and see it was important to me I was still doing what he told me There was a proper reason (to be there) It made the appointment longer- balancing my son's needs with the doctor's requests	Professional and making the right diagnosis Providing information Fixing the person

Sian

Sian's PEG: Satisfactory Consultation- Emergency GP appointment for rash

Perceiver/ Element	Self	Mother	Doctor
Self	*How I as an individual saw myself:* Concerned by not overly worried. Grateful for appointment Interested Keen for an explanation Absorbing advice	*How I as an individual saw myself as a mother:* Reassuring and caring Not that different to Self Concerned Keen for medical expert opinion- I'm not a medical expert Wanted to know how to care for her Wanted a good experience for my child- not scared Concern for other children (if contagious)	*How I as an individual saw the doctor:* Man Older doctor- senior in practice Experienced Calm Distant Unflustered Calmer and reassuring. Getting expected response Reliable knowledge
Mother	*How I as a mother saw myself:* Wanted to find out information and understand things better Value of one treatment over another Primary role- nurturing, supporting and caring Responsibility Decision making	*How I as a mother saw myself as a mother:* Responsible for seeking help for child Lucky to get help- quick appointment Look after child Questioning Decision making Evaluating need- don't want to over use NHS	*How I as a mother saw the doctor:* Initially disappointment as previously had poor experience with this doctor He made me feel empowered- gave advice and sent home. Good doctor Welcomed us to get back in touch Taking us seriously. He was uncertain- don't expect GPs to know everything. Honest
Doctor	*How I think the doctor saw me as an individual:* Responsible Give good care and advice Good self-care or care for child- successful care in the home	*How I think the doctor saw me as a mother* Capable right then Clear that this was a biological and not psychological problem. Not responsible for child's health.	*How I think the doctor saw himself/ his role as a doctor:* He embodied what he believed a doctor should be. Gentle, calm, respectful, helpful. Open communication

	Capable and competent at communicating Asked too many questions- annoying Respectful and kind A bit worried by not overly worried Could see I was interested Perhaps judges how well people take care of themselves	I was demonstrating less concern than I felt due to daughter's presence. Responsible, caring, ready to take advice.	To ensure that the experience of visiting a doctor was positive so that patients would return if necessary. Really experienced. Had recruited other people to practice that share view of what it is to be a GP.

Sian's PEG: Less than Satisfactory Consultation- Out of hours GP appointment for vomiting and weight loss.

Perceiver/ Element	Self	Mother	Doctor
Self	Awkward. In a difficult position with the two children (there on my own). A bit tense. This was a moment to get some advice. Pressure of work load of coming week.	I didn't want to put my daughter in an awkward position but wanted to help the GP. Had been monitoring (health of daughter) for a while, weighing up need for medical professional- her health was not improving. Saw role as someone who had been monitoring her. We could cope for a time at home but impact became greater so needed help. Illness was beyond acceptable level that a parent/ mother could manage- need help/ advice. It was beyond my competency.	GP didn't know about what we were presenting with. Didn't embody role of a good GP. Didn't inspire confidence. In an odd role as a GP because not seeing regular patients. Locum- one off consultation. Role as sign posting to other medical professionals. Didn't have much faith because was checking things on the computer. Very computer based. Not calming or reassuring with advice. Different role to other GP- no long term investment in performing in that role. Didn't embody role of good GP Didn't inspire confidence
Mother	Compromised feeling- wanting to protect child vs. helping doctor. There to get advice, harder if daughter didn't want to	Slightly unsuccessful. It didn't work well as a consultation.	He didn't want to take responsibility. Passed onto the next person.

	follow instructions. Think outcome would have been the same. Confusing. Conflict in role. Felt in limbo. Didn't' think much got resolved. Didn't know what expectations were for consultation,	Key intermediary between my child and the doctor. Not managing it well. Maximising care I could give to my daughter-didn't achieve goals. Wanted child to feel happy, confident going to the doctor- ok to trust doctor. Didn't manage to do investigations	Not helpful- compared to another doctor who slowly built trust with my daughter and had a sense of fun. Rapport with child not forte Disappointed it didn't work better. Felt time pressure. Worried and didn't feel like I got an answer for questions I'd come with. Thinking, what could it be, what could I do? Not satisfactory answer. Dr fixated on family history of diabetes and would consider anything else. I was being a responsible parent- didn't' think symptoms of diabetes present.
Doctor	Unassertive with my child as negotiated more, can't force child to do things. I'm not authoritarian more encouraging. Children unruly, not doing what supposed to do. Little bit scatty, all over place. Hard to be calm and collected. Stressed. Distracted- paying attention to both girls and answer doctors questions. Balancing needs- looks chaotic	Hard to separate two roles in my mind (self and mother). Not making children follow instructions. Not taking charge of situation. Not out of control but didn't want to do what asked. I wish she was able to get her daughter to follow instructions- would be helpful.	Not engaging. Checking for signs of immediate danger. In absence of danger, sign posting for help. Don't think he thought about the characteristics of a doctor. Not meaningful interaction. Role more about sorting immediate danger from those who can see the GP the following day. No strong ethos of what it means to be a GP. Busy- lots patients. Disinterested, going through motions, performing basics of role. Behaving differently to ideal characteristics.

Kate

Kate's PEG: Satisfactory Consultation- GP appointment for high heart rate and shallow breathing

Perceiver/ Element	Self	Mother	Doctor
Self	Concise and succinct because of time constraint. Prepared and aware of what needed to achieve. Respectful of the doctor Came across as having it together and sure of self. Felt bad about consultation- I missed this- guilty.	In control Understand child's needs Seemed like a good advocate for my child Didn't necessarily feel that way, very maternal character- a surprise from who I was as a child and in my twenties.	She's really nice, warm, and aloof at the same time. Professional but not stand offish. Takes me serious. Can tell her personal things. Honest, relates. Concerned by low 02 but not alarmed.
Mother	Alright. Child behaving nicely. Talking/ taking action in proper way. Looked pretty well all together- in hand. Cut through rubbish in head and did what needed to do. People are better in public- best foot forward. Don't want complaints about child.	Child's best advocate. Sixth sense about child's well-being. Mind reading. Handling. Haven't picked up all signs. Fall short of mothering instinct- unrealistic. Ideals from things you read, see and what women say, NCT. It's a fallacy but can't help but absorb it.	Partnership. Bring child in, expect to rely on her expertise. Not just handing over. Two way street. No bullshit, cut through it, good working relationship. I don't waste her time. Going to the doctor as a privilege. Rapport between us, I like the way she looks, slightly older than me with older children. Little bit of a personal relationship. She feels I mean well. Respect.
Doctor	Fairly together because brought child in to be on safe side. Might have over-estimated my ability to advocate. Grateful, obsequious.	Knowing there was an issue. Believed I understood seriousness- responsive mother. Shocked	Professional. Professionally alarmist, sounding out (severity) but not creating panic. Not stressing.

	Slightly dippy because I forget something every time we go. I looked really shocked (due to severity of child's illness). May have thought I had it more together than I did.	Warm mother Child focused mother, she was snuggled into me. Seemed mummyish.	Appropriately concerned- taken right actions. Sending me off quickly- but she wouldn't have spent the afternoon worrying. Clear.

Kate's PEG: Less than Satisfactory Consultation- ENT routine consultation for hearing.

Perceiver/ Element	Self	Mother	Doctor
Self	Nervous because first time I'd been to the ENT appointment. More of a push over than husband- will defer to someone's authority. Unsure about how to deal with doctor (if tried to persuade to have grommets). Just need time- not silver bullet. Have to explain position every time have an appointment.	I was doing all the things I should. Supportive. Answering questions. Prepared. Talking to child and getting him to talk to doctor. Prepared to advocate for him.	Going about job in a perfunctory way. Just a hearing report. Responded to request to examine ear. Routine for her but not for us. Didn't understand that not routine for the family. Just a review No idea of our history. Very routine.
Mother	Unsure of myself because of my nervousness and history of not knowing what to expect and how to handle change. Worried about making a decision- would need to talk to husband. Not equipped to deal with different news- do as I'm told. Didn't have a clue.	I'm looking after my little boy, getting him to talk to the doctor. Had all the information, I knew what was going on. If presented with different information would have thought I needed to be more prepared, dumb founded. Perhaps should have asked more questions, been clearer on my position.	She was just doing her job. I didn't relate to her. Didn't' feel like our case was an individual case. Unremarkable, seemed unclear. Not very empathetic. Not clear about next step- perhaps a locum?
Doctor	Just seen me as a typical middle class mummy from South Africa. Probably unremarkable, not trouble.- How organic can we make it?	Typical middle class mummy. Well turned out child- first world problem. A little be breast feedish, a little bit blueberry- natural, softly, non-interventionist. Many have prevented her	It's her job to analyse data and relay that in lay terms. Not experienced helping with decisions. Not to think about the future Not part of a path, horizontal not progressive.

		from taking about the future (interventions).	

Jane

Jane's PEG: Satisfactory Consultation- GP appointment for rash on cheek

Perceiver/ Element	Self	Mother	Doctor
Self	Very tired To the point, what I thought I needed to say Happy to have a conversation with Doctor Good mood, everything ok. Aware of what I wanted as a treatment	Worried. A bit upset about the rash that son had Disappointed that needed to go to the doctor. Had used cream that had worked before but not worked on the face. Disappointed that cream not working on that area. Aware he needed additional treatment.	Very nice. A bit strange Good listener Aware of previous consultations. He was tired, looked exhausted. There but not there. Saying the things that needed to be said. Caring
Mother	Aware what had been done before. Avoiding unnecessary treatments. Confident and aware. Not unnecessary consultation/ medication	Adequately concerned about the rash. At ease to explain train of thought. Why he needed specific type of cream	Less engaged with my son than usual. Looked at rash but didn't talk to him. Overall behaviour was fine He seemed tired I like him Variable in communication, sometimes chatty, others not. Nice person- unpredictable.
Doctor	Happy to agree with me- knows what I'm talking about. Unsure I knew why I asked for that cream. Reassuring. Fairly reliable. Accepted I had an idea of what of what was useful- went along with it.	Caring. Aware of his needs. Conscious of what has/ hasn't worked before.	Safe. Explaining thoroughly- pros and cons. Had listened to concerns. Aware of what tried before. Tire and over-worked.

Jane's PEG: Less than Satisfactory Consultation- GP appointment for infected finger

Perceiver/ Element	Self	Mother	Doctor
Self	Not too worried Concerned about the infection Not sure what should be done- in need of advice Doubt Comfortable Listened to	Uncertain Worried Eager to fix the problem, make sure not additional problem. Concerned about outcome- antibiotics as didn't want this.	Friendly. Professional. Good listener. A bit concerned about what meant to be doing- antibiotics or topical treatment. Not confident in decisions.
Mother	Concerned with making sure solved/ making sure nothing worse happens i.e. not becoming painful. Tired. Not keen on going to doctors. Problem solving focused. Dismissive of clinicians role/ of guideline following. Confident in saying what felt necessary, questioning doctor.	Comfortable. Confident. Listened to level of concern that I had. Knew something needed to be done- compared to other injuries. Aware of needs. Comfortable in position going to doctor- warranted. Tired. Distracted.	Very sweet with son. Engaged him in conversation. Ok with him, looking at hand. Warmth and attentiveness. Happy for her to assess him.
Doctor	Somebody they could approach with thoughts and questions re: choices of medication/ treatment. Easy going Polite. Not too complicated within a consultation.	Caring and concerned. Hopefully balanced in my concerns. As a mother can be overly concerned- not know if should be concerned. Didn't think I was being seen as someone too concerned. Worked up about.	Caring. Listened. Safe in explaining why medication. Clear why prescribing antibiotics. Clear in information.

Jo

Jo's PEG: Satisfactory Consultation- GP appointment for Chronic sinusitis

Perceiver/ Element	Self	Mother	Doctor
Self	Caring Informed Asking appropriate questions Reasonable	Caring Managing son's behaviour because he was tired and 'playing up'. In control because he did what I asked him to do. Loving, he sat on my lap, I gave him kisses and cuddles	Attentive Listened to everything I had to say Asked me appropriate questions Gave me reassurance
Mother	Wanting the best outcome for my son Asking appropriate questions Giving information- helping the doctor to make the best diagnosis	Trying to get the best outcome Really stressed- dealing with a child who was playing up Relieved he did what I told him to do Please that he listened to the concerns I was raising Didn't want my son to break anything	Very reassuring Alleviated my concerns No issue is too small He knows me as a mother He knows I won't just come at the drop of a hat He understood I'd worried about it Having known me and my son He is an attuned GP and understands as a mother you might feel anxious Gently spoken- smiles, nods, good eye contact Great job
Doctor	Reasonable and reasoned. Problem solved previously Seeking advice appropriately Best interest of my child Clam person	Caring Wanting the best for my child Able to manage him Loving I interacted with my son and encouraged him to interact with the doctor	Reassuring Asked appropriate questions He gave a good outcome for my son Advice that would follow

Jo's PEG: Less than Satisfactory Consultation- Emergency GP appointment for croup.

Perceiver/ Element	Self	Mother	Doctor
Self	Anxious A mother focusing on my son's needs Concerned Anxiety provoking Seeking reassurance	Seeking answers in relation to how my son was at that time. Anxious at the time. Keen for an outcome- medication Anxious Concerned about son's welfare Wanting him to be ok	Dismissive of my anxieties Made me feel like I was wasting time
Mother	Anxious Description of what had happened and what was happening Expressed anxieties	Advocate for your child Trying to advocate on his behalf Doctor understand salient points	Really dismissive of concerns I was raising Wasting her time What do you want me to do?

	Get the doctor to understand the severity of the situation Distressing for my son Ask relevant questions	Correct course of action	Not alleviating concerns Locum Not regular doctor Not the job for her Perhaps tired
Doctor	Anxious Pushy But I'm not overly pushy More forceful than under normal circumstances Ask can he have steroids- see me as wanting to medicate him	Asking appropriate questions Having his best interest at heart Appropriate following visit to A&E Caring	She asked appropriate questions Alleviate concerns by not over dramatizing Not needing to medicate- might be appropriate Lease interventionist approach She might have thought she'd reassured me.

Louise

Louise's PEG: Satisfactory Consultation- GP appointment topical skin irritation

Perceiver/ Element	Self	Mother	Doctor
Self	Knowledgeable (it had been a problem for some time) Thorough understanding. Confident in explaining situation In control- because of what I knew and what we were doing Relaxed Confidence in doctor Apprehensive due to examination	Calm in this situation- as it was important for my daughter Ongoing – made it easier. Prepared Predict child's behaviour In control of situation Knew likely response Experienced Good understanding of my child New what was coming Confidence in my knowledge as a mother- how my child was responding to the situation Heightened sense of nurturing to make it positive for my daughter Caring characteristics Proactive because not 'forced' to make appointment Felt needed advice	Attentive Empathetic Doctor as parent of a daughter a little older than mine Thorough Gave me confidence I her ability to assess problem Displayed knowledge of difficulties Good with child Personable manner Careful in examination Respectful of both mother and daughter
Mother	Strong bond with their child Caring and nurturing characteristics Sympathetic Confident person Able to communicate clearly Thorough understanding of what my child was dealing with Came across as positive- deliberately trying to make experience positive Assertive because asked for additional test	To care for my child in situation Look after her welfare Make sure she felt comfortable and included in discussions Clearly communicated history and relevant information and asked questions To make my daughter feel relaxed during examination	Manner of doctor important Friendliness On same level as my daughter and talked to her. She was a mother of a daughter which helped- empathy was helpful Made me feel I'd done everything I could do. Made it a positive because she agreed with what I'd done, gave me confidence

	Determined to make sure everything being done for my child	To get answers and make progress- solve problem and move things on	Thorough Listened properly and did what I expected and asked questions I hadn't thought about.
Doctor	Confident, because I felt confident Able to communicate clearly Large portion of appointment with me explaining difficulties Reasonably intelligent Common sense to solve problem Asked questions Concerned person- concerned for child and found a way forward out of consultation- wanted to rule out infections Felt like we'd made progress Made reasonable suggestions	Had a handle on things Detail Had tried a lot of stuff My daughter was very good- Communicative, responded to questions, helpful. In control of situation, both of my daughter and of her illness Bond between me and my daughter would have come across because she looks to me for reassurance Nurturing and caring characteristics would have come across Very calm appointment Calm parent	To diagnose the problem Provide medical assessment of the problem and propose possible treatments Listening to the history- parent Listen to the child describing symptoms To be empathetic and sympathetic Ask relevant questions Holistic in the approach Look at the whole child Respectful in the treatment because of examination Aware of sensitivities

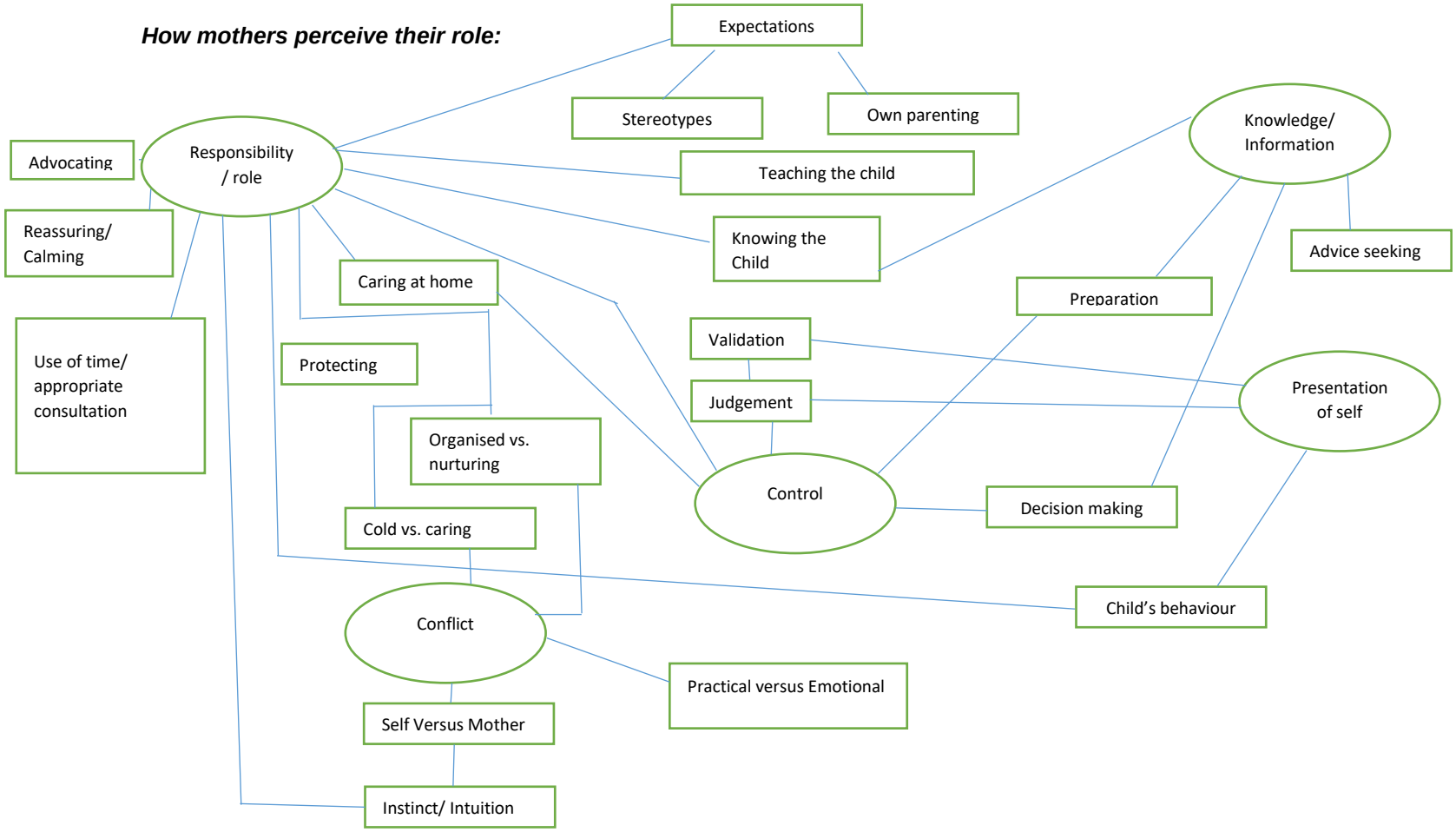
Louise's PEG: Less than Satisfactory Consultation- Emergency GP appointment for rash and tummy ache.

Perceiver/ Element	Self	Mother	Doctor
Self	Concerned because my child was poorly and upset for the duration of appointment Communicative Able to talk about problem Explain what we'd done so far Confident Slightly flustered Really proactive Attentive to doctor and to my son	Quite an experienced parent Calling on all experience to make it as beneficial as possible Looked in control but didn't feel it Stressed and worried because my son was poorly Jumped through hoops Nurturing and caring Trying to calm him- engage, relax- didn't work. Sympathetic side Practical	Calm and attentive Aware he had a child in distress Listened careful Respectful to a degree because listened and responded as I was a sensible parent Trusted what I was saying Nice manner with my son Gave me confidence that he knew what he was doing Thorough Assessed him Insensitive to a parent who was doing best in difficult situation
Mother	Nurturing and caring characteristics Sympathetic side Remained calm Practical- chocolate buttons and other methods to calm him. Communicative Confident in communicating Someone who was trying best in difficult situation Assertive side	To get a poorly child treatment and present poorly child to the doctor as quickly as possible Keep situation as calm as possible for doctor Child respond how needs to respond to get the best possible treatment Use bond with child to get best effects Caring and inventive side of me See myself as needing to have control	Listened carefully Relaxed and calm Not phased by child Gave me confidence that he knew what it was and the treatment options He was clear about what I needed to do Lacked empathy with my situation- really affected how I felt about consultation

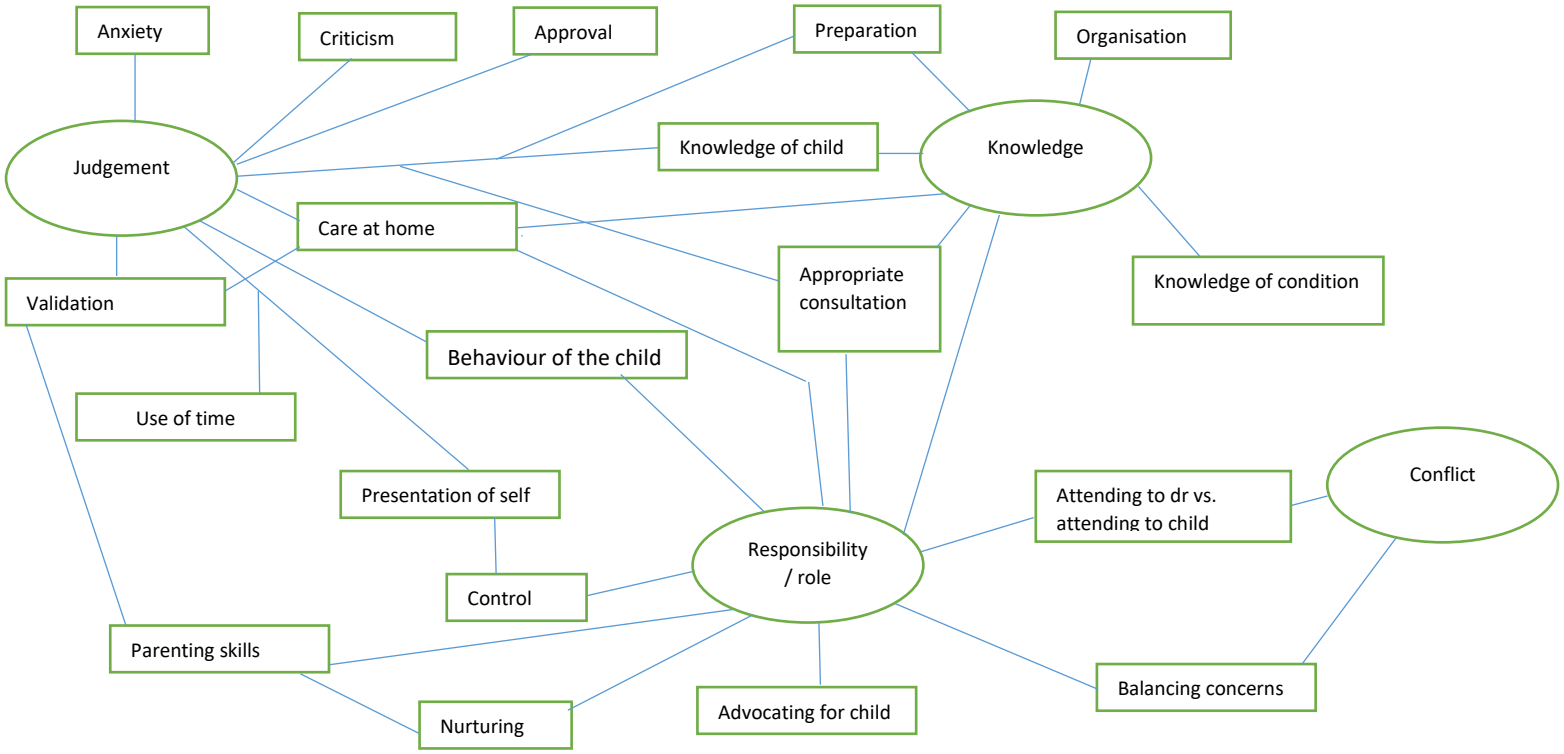
		I hadn't done my job as a mother by giving chocolate buttons	
Doctor	Fairly confident in dealing with situation Quite clear- easy to understand Slightly distracted- trying to calm child down. Experienced parent/ individual with children Assertive	Experienced parent in behaviour and types of questions I was asking. Distracted but degree of control Awareness of what doctor needed. Practical- too practical (chocolate buttons). Judgemental of mothering Relatively calm if distracted Intelligent parent Sensible	To diagnose problem and treat it Listen carefully to parent Gears approach according to experience of parent Give sensible and practical advice Make sure treating whole child Holistic approach (not care/ empathy) Practical approach More empathetic once challenged.

Appendix XIII: Thematic Maps

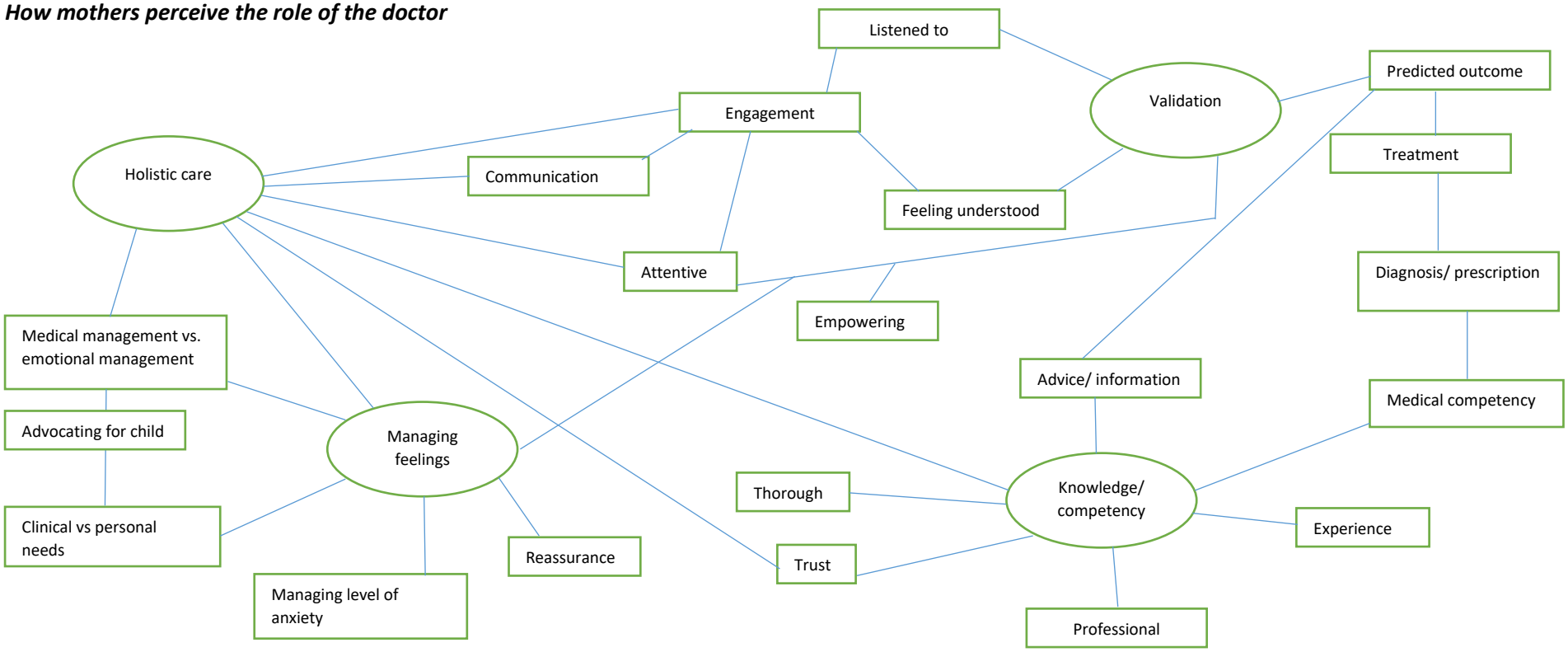
How mothers perceive their role:



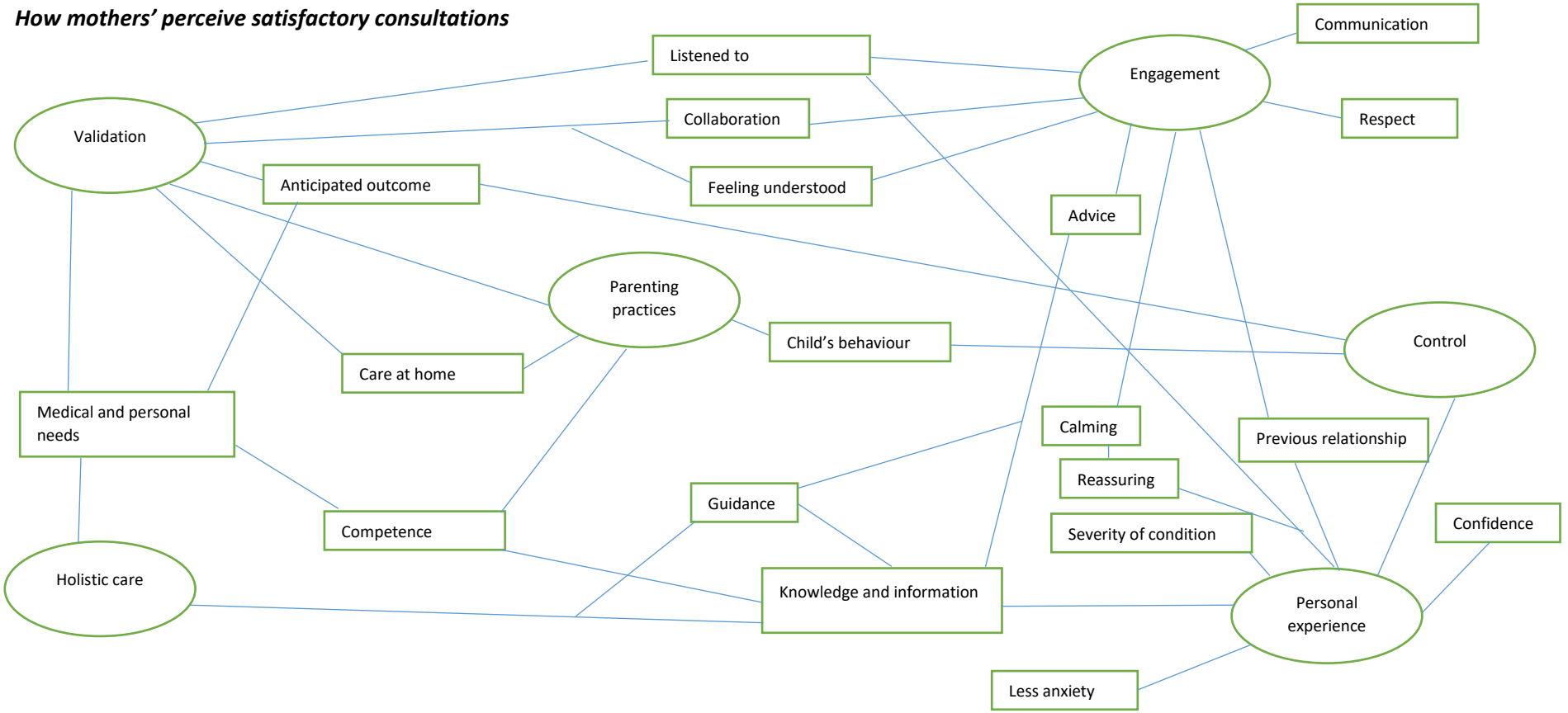
How mothers believe they are perceived by doctors



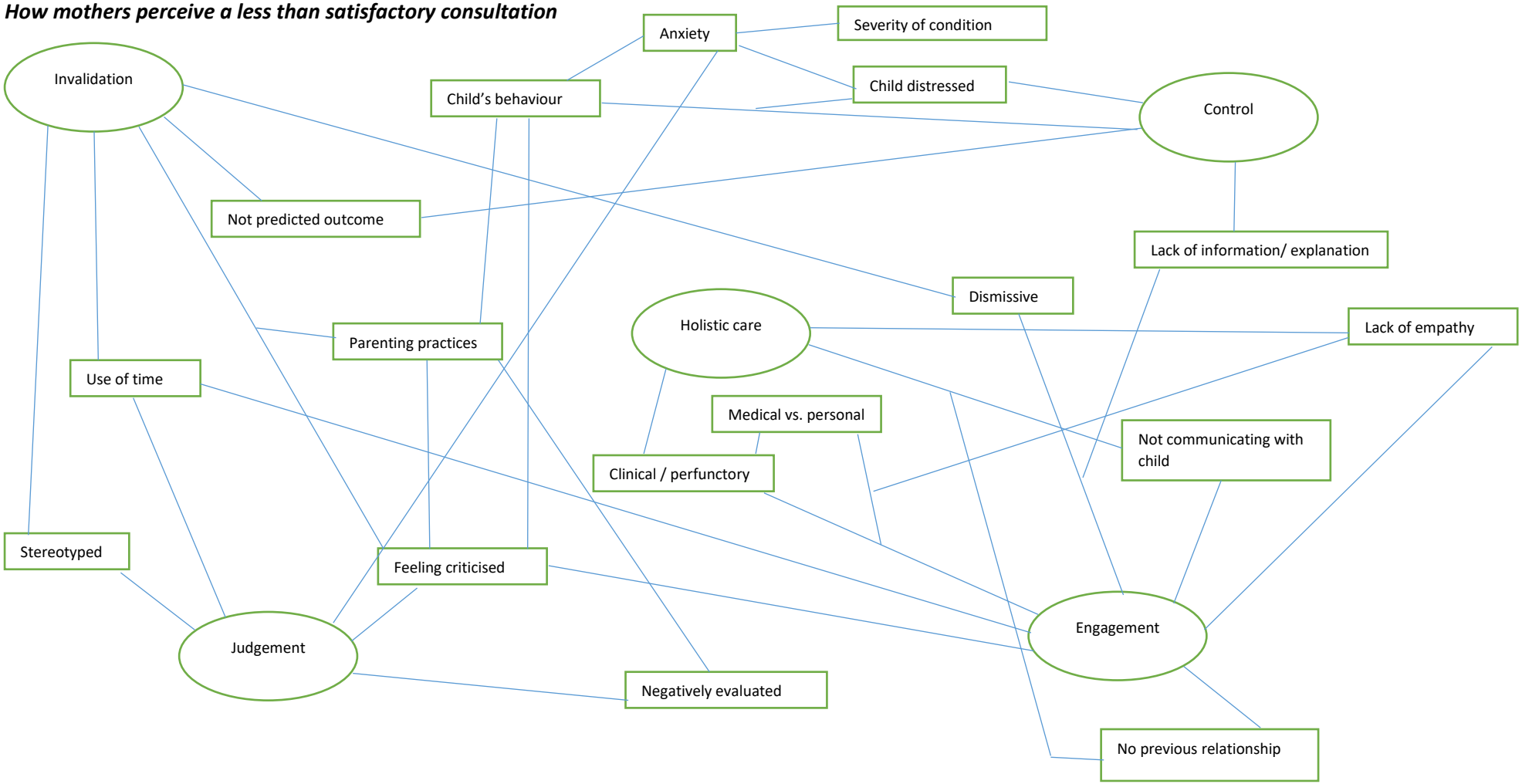
How mothers perceive the role of the doctor



How mothers' perceive satisfactory consultations



How mothers perceive a less than satisfactory consultation



Appendix XIV: Thematic Analysis Audit Trail

Gemma: ***Initial list of codes:***

Knowing the condition- knowledge as important
Knowing how to mother- in control
Easily remedied problem- positive experience
Self as calm
Predictable nature of consultation- satisfactory experience
Role to prevent panic- mother role
Self vs Mother- reflecting self characteristics independent (pre-existing motherhood) vs. characteristics employed for mothering
Self as Mother- difficult to separate roles
Reassuring- role of mother
Reassuring-role of doctor
Feeling flustered internal vs presenting as confident externally
Being confident
Being organised
Regimented vs nurturing
Cold vs caring
Organisation vs affection
Guilt at leaving/ guilt at doing
Medical competency- doctor knowing the condition
Confidence of doctor in me
Doctor as calm
Doctor as managing patient and mother's feelings
Self-criticism
Practical as mother
Practical as doctor
In control
Good mother
Sympathy- towards mother role, towards child vs Criticism of self as individual
Approval from doctor
Decision making
Worry
Putting on an act- confidence
Laidback
Calm and control
Confidence in me from doctor
Preventing panic
Distracting child/ managing anxiety
Doing job vs being friendly/ sensitive
Oversensitive
Being managed
Medical management vs emotional management
Assisting the doctor- giving facts, laying child on bed, having information
Comforting distress
Information to child- calming
Helping to understand (doctor and child)
Not talking or explaining to the child (doctor)
Being a nuisance/ time wasting

Justification of appointment/ use of time
Uncertainty from doctor
Interaction
Medical vs social
Instinct- going with gut
Attending to the doctor vs caring for child
Doctor's behaviour towards children vs Doctor's behaviour towards adults
Empathy
Explanation
Taking doctor seriously
Respecting the doctor
Time wasting
Compliance vs caring for child
Teaching child
Predicting how doctor wants me to behave
Engaging with the child
Anxiety
Putting on an act
Self as organised vs mother as caring
Being understood as a person
Holistic care
Doctor as a parent
Responsibility for child's wellbeing

Initial cluster of themes:

How I perceive myself as mother

Knowledge:
Knowledge as important- knowing the condition
Knowing how to mother- being in control
Information to child- calming
Helping child and doctor to understand
Predicting how doctor wants me to behave

Control:
Knowing how to mother- being in control
Role to prevent panic
In control
Reassurance
Acting with confidence
Being organised
Practical as mother
Calm and in control
Distracting child/managing anxiety
Comforting distress
Information to child-calming

Characteristics:
Self as clam
Role to prevent panic

Reassurance
Feeling flustered internally vs. presenting as confident
Worry
Being confident
Being organised
Regimented vs. nurturing
Cold vs. caring
Organised vs. affection
Self-critical
Laidback
Calm and in control
Oversensitive
Going with gut

Self/Mother:
Self as a mother
Self vs. mother- difficult to separate roles
Reassurance- role of mother
Sympathy towards mother role vs. Self-criticism
Organised vs. affection
Self-critical
Practical as mother
Comforting distress

Feelings:
Worry
Sympathy
Guilt (guilt from doing/ guilt from leaving)
Anxiety
Responsibility

Conflict
Medical vs. social
Sympathy towards mother role vs. self-criticism
Organised vs. affection
Regimented vs nurturing
Guilt vs compliance
Cold vs. caring
Feeling flustered internally vs. presenting as confident
Attending to doctor vs. caring for child

How I perceived the doctor

Characteristics:
Reassuring
Calm
Uncertainty
Empathy

Practical vs. emotional
Managing feelings of mother and child

Practical role of doctor
Being managed by doctor
Medical management vs. emotional management
Interacting with the child
Medical vs. caring towards the child
Holistic care
Doctor as parent

Knowledge
Medical competency- knowing the condition
Giving information to the child
Giving explanations

How I believe the doctor perceived me as a mother

Judgement
Knowing how to mother- being in control
In control
Good mother
Approval from doctor
Being liked
Responsibility
Attending to doctor vs. caring for child
Taking doctor seriously
Compliance vs. caring for child

Characteristics
As confident
As organised
Decision making

Use of time
Being a nuisance
Wasting doctor's time
Justification of appointment/ use of time

Approval
Approval from doctor
Putting on act of confidence
Assisting doctor- giving information, laying child on be etc.
Helping doctor and child to understand
Being liked
Attending to doctor
Listening
Respecting doctor
Taking doctor seriously
Predicting how doctor wants me to behave

Satisfactory vs. Less than Satisfactory Consultation
Decision making
Good mother

Medical vs. social needs

Satisfactory	*Less than satisfactory*
Easily remedied complaint	Not talking to the child
Predictable nature of consultation	Being a nuisance
Being organised	Time wasting
Being confident	Justification of appointment
Doctor having confidence in me	Only attending to medical needs

Doctor as calm
Doctor managing feelings of mother and child
Feeling in control
Approval from the doctor
Being managed
Doctor giving information to the child-calming
Being liked
Doctor as parent
Interaction with child and mother
Holistic care
Empathy
Explanation
Engaging with child

Emerging themes with relating codes:

How mothers perceive the role of the doctor			
Reassurance	**Knowledge**	**Approval**	**Doing job vs being sensitive**
• Managing feelings • Preventing panic	• Medical competency • Practical	• Being liked • Having confidence	• Interacting with the child • Medical management vs. emotional management

How mothers believe they are perceived by doctors		
Temperament	**Approval**	**Use of time**
• Laidback • Calm • Worrier	• Being liked • Confidence in me • Putting on an act	• Wasting time • Justification of use of time

How mothers perceive their role				
Knowledge	**Conflict in role**	**Control**	**Calm**	**Nurturing**
• Knowing the condition • Predictable nature of consultation • Organised • Assisting the doctor • Teaching the child • Responsibility of role	• Guilt when leaving • Guilt when doing • Attending to doctor/listening vs meeting needs of the child • Cold vs. caring	• Knowing how to mother • Being reassuring • Feeling flustered vs. presenting as confident • Feeling confident • Being confident	• Preventing panic • Reassuring • Presenting as confident when flustered • Caring	• Nurturing vs. regimented • Organised • Sympathy • Cold vs caring • Organised vs affection • Comforting

	• Regimented vs. nurturing • Organised vs. affection			

How do mothers perceive a satisfactory vs less than satisfactory consultation	
Satisfactory	**Less than satisfactory**
• Feeling listened to • Doctor interacting with children • Doctor as: friendly, sensitive, chatty, engaging • Doctor attending to social/emotional/ psychological needs as well as medical needs • Doctor managing feelings of patient and mother • Mother feeling confident • Feeling calm • Child not distressed • Feeling in control	• Perceived to be wasting time • Perceived to be a worrier • Doctor only attending to medical needs • Doctor not explaining things to child or engaging with child • Perceived to not be taking the doctor seriously or not listening to them • Child in distress • Uncertainty from doctor

Sian: Initial list of codes:

Doctor as kind
Doctor as reassuring
Doctor as sympathetic
Preference for minimal intervention
Validation of importance of care from mother (take her home for care)
Concerned about child's health
Level of worry
Low worry in satisfactory appointment
Grateful for appointment
Interested in understanding problem/ receiving explanation
Absorbing advice
Care for child beyond consultation
Concern about appropriate use of doctor's time
Self as mother- cannot separate the two roles
Responsibility of correctly identifying problem
Wider concern for protecting other children- collective responsibility
Ensuring thorough medical check
Doctor as expert
Creating a good experience for my child
Making child feel comfortable during consultation
Protecting from being scared or intimidated/ stranger
Invasive nature of consultations and examinations
Identification with doctor- similarities (female/young) vs. difference (male/older)
Rapport
Interaction
Level of experience of the doctor- impact on satisfaction?
Appropriate level of concern and worry- doctor
Calm temperament- doctor

Predictable consultation- telling you what you want to hear/ getting the response you expect
Power of intervention- e.g. prescription
Responsibility as a parent
Caring
Mother-ness vs. individual-ness
Information seeking
Primarily nurturing and supporting
Impact of asking questions- part of mother role vs. inconvenient for doctor
Medical opinion reinforcing mothering role- no intervention= take home for care
Managing
Decision making
Doctors to give advice
Understanding- facts, treatment, action
Seeking help
Looking after child
Appropriate help seeking
Intervention vs. care
Uncertainty of child's wellbeing
Appropriate use of NHS resources- justification of use
Feeling empowered- confidence in caring abilities
Best thing to be able to look after child
Capacity to cope with looking after child
Validation of abilities
Option of ongoing contact with doctor if needed
Realistic expectations of doctors' ability
Honesty and transparency
Successful care in the home- part of mother role
Calm and reassuring- characteristics of doctor
Asking too many questions- annoying
Respectful
Doctor giving information and explanation
Interest in medical explanation
Patient self-care and responsibility for health
Being responsive to advice
Making mistakes in parenting
Feeling capable
Responsibility/ blame for child's health complaint
Psychological vs medical complaint and link to blame
Behaviour of doctor embodying belief about being a good doctor
Helpful, clear, respectful, calm reassuring- characteristics of good doctor
Open communication and continuity of care
Role of doctor to ensure positive experience so patients will return
Level of experience of doctor
Lack of action= less than satisfactory
Importance of 'doing' something
Child's level of cooperation impacting on level of satisfaction of consultation
Signposting as unhelpful
Balance between doctor's need to do investigations with empathy for child's feelings

NHS resources
Role of mother in guiding child- encouragement and building confidence
Decision making based on instinct
Doctor's level of understanding about condition presenting with
Reluctance to force child to submit to examinations
Wanting to assist doctor with job
Feeling compromised between helping doctor and nurturing child
Impact of child's level of distress on satisfaction with consultation
Feeling tense
Pressure on use of time- chance to get advice
External pressures such as work
Wanting to 'fix' problem
Not understanding rationale for some of doctor's actions
Role of mother- monitoring child's well-being
Mother's judgement- when to seek advice
Managing at home vs. seeking help- decision making
Justification for seeking medical advice
Impact of not having met doctor previously
Signposting as unsatisfactory outcome
Different roles of doctors- regular GP vs. out of hours GP
Confidence in doctor
Commitment to job/ motivation
Not inspire confidence/ reassurance
Protecting child from pressure of doing something uncomfortable
Doctor taking responsibility for child's well-being
Feeling confused (less than satisfactory) about doctor's role
Expectations not met
Not definitive answer
No strong guidance
No resolution
Unsuccessful consultation
Mother as intermediary between the child and the doctor
Felt responsibility that it wasn't working
Responsibility of consultation- doctor vs mother
Maximising care for child
Medical well-being and general well-being
Teaching child about going to doctor- safe
Failing to complete checks
Good doctor- drawing child out, being gentle – engaging
Building up trust in relationship
Time constraints of consultation
Disappointment
Child not cooperating
Doctor attending to other aspects not subject of consultation
No satisfactory answer
Feeling chastised
Responsible parent- role challenged/ criticised
Compliance

Disagreeing on focus of consultation
Self-criticism- disagreeing as arrogance
Balancing mothers judgement with doctors judgement
Parent role as crucial to assessing child
Parent's perception of need- decision making
Judgement of mothering- unassertive
Parent styles authoritative versus encouraging
Behaviour of child as a reflection of parenting
Disorganised/ scatty/ distracted/ chaotic
Frustrating for the doctor when child not compliant
Doctor as distant
Unable to make child cooperate
Doctor sorting immediate danger from not- main goal (out of hours)
Disinterested/ going through the motions
Not meaningful interaction- basics, no reassurance, confidence, not listened to.
Doctor- as overwhelmed
Mother as caring and supportive
To get answers- in search of guidance
Guidance and reassurance vs no guidance and reassurance
Learning something new
Adding to ability to care
Engaging child in process
Compromise and balance
Transitory role of doctor
Impact of long-term relationship
Complexity of complaint
Existing expectations
Managing at home vs. seeking advice
Self and mother entwined
Role model to child
Knowing when to seek advice
Link between characteristics of self as individual and self as mother
Advocating for self = better outcome
Preparing child for adulthood
Taking responsibility for own health
Learning how to articulate wants and needs
Mothers and daughters- gender role models
Mothers assuming responsibility for children
Inequality between genders
Comparison of cultural norms of motherhood in previous generations

Initial cluster of themes:

How I perceive myself as mother

Responsibility
The importance of caring for a child at home (as opposed to seeking medical intervention)
Concerned about appropriate use of doctors' time

Responsibility of correctly identifying problem
Wider responsibility for other children (infectious)
Creating a good experience for the child
Information seeking
Managing- child and health complaints + other commitments (work etc.)
Decision making
Appropriate help seeking
Capacity to cope
Responsive to advice
Mothers' taking on majority of parenting responsibility
Preparing child for adulthood
Responsibility for child's health complaint
Blame for child's health complaint
Appropriate use of NHS resources
Assisting the doctor
Appropriate use of time
Monitoring child's well-being
Mother's judgement- when to seek advice
Intermediary between doctor and child
Feeling responsible when consultation not working
Maximising care for child
Parent role is crucial in doctor assessing child
Behaviour of child as a reflection of mother
To make child cooperate

Role of a mother
Protecting child
Creating a good experience for the child
Caring
Decision making
Managing at home
Looking after the child
Best thing to look after a child
Making mistakes in parenting
Role model to child
Preparing child for adulthood
Teaching child to articulate needs
Responsibility for child's health complaint
Decision making based on maternal instinct
Wanting to 'fix' problem
Monitoring child's well-being
Judging when to seek advice
Intermediary between doctor and child
Maximising care for child
Crucial in assessing child
Caring
Supportive

Conflict
Wanting to assist the doctor vs. reluctance to force/ pressure child
Helping doctor vs nurturing/ protecting child

Responsible use of time vs getting advice
Intermediary between doctor and child
Disagreement vs. arrogance
Mother's judgement vs. doctor's judgement

Knowledge
Interested in understanding the problem/ explanation given
Absorbing advice
Information seeking
Asking questions
Responsive to advice
Learning something new

Emotions
Concern about child's health
Worry
Grateful (for appointment)
Uncertainty re: child's well-being
Empowered
Confident in abilities
Feeling capable
Pressure

Self/Mother
Can't separate two roles
Being a mother vs. being an individual
Link between characteristics of self and characteristics as a mother

How I perceived the role of the doctor

Characteristics
Reassuring
Sympathetic
Calm
Respectful
Honesty and transparency
Helpful
Clear
Behaviour embodies characteristics of good doctor
Gentle
Engaging
Frustrated when child not compliant

Relationship with
Validation of importance of care from mother
Care for child beyond the immediate medical consultation
Rapport
Interaction
Validating abilities
Makes mother feel empowered

Open communication
Continuity of care
Ensuring positive experience so that patients return if need to
Commitment to job
Motivated

Competency/ knowledge
Ensuring thorough medical check
Doctor as expert
Level of experience
Give advice
Realistic expectations of doctor's ability
Giving information and explanation
Confidence in abilities

Actions
Importance of doing something
Not just signposting
Validating
Drawing child out

How I believe the doctor perceived me as a mother

Characteristics
Worried
Concerned about child's health
Caring
Nurturing
Unassertive
Disorganised
Scatty
Distracted
Chaotic

Parenting abilities/ judgement
Validation of role and care provided at home
Medical opinion reinforcing mother's care at home
Seeking help
Looking after child
Appropriate help seeking
Parent role to monitor well-being of child
Criticism
Judged as not being responsible
Behaviour of child as reflection of mother's ability
Child not compliant

Knowledge
Interested in understanding

Annoying- asking too many questions

Satisfactory vs. Less than satisfactory consultation

Satisfactory	*Less than satisfactory*
Doctor:	Doctor:
Kind	Level of experience
Reassuring	Lack of knowledge about condition
Sympathetic	Perceived lack of commitment to job/ going through motions
Appropriate level of concern	Perceived lack of motivation
Calm	Perceived to avoid taking responsibility for child's welfare
Level of experience	Lack of reassurance
Respect	Attendance of factors other than the subject of the consultation
Honesty	Distant/ disinterested
Transparency	Overwhelmed
Behaviours embodies characteristics of good doctor	
Taking responsibility for child's welfare	
Mother:	Mother:
Less worry	High level of worry
Interaction:	Interaction:
Rapport	Limited interaction with child
Validation of mothering/	Not understanding rationale for some actions
Care at home	No previous relationship with doctor
Validation of mother's abilities	Perceived criticism of role/ responsibility of mother
Open communication	Child not compliant to examinations
Engaging	Disagreement of focus of consultation
Drawing child out	
Building up trust in relationship	
Advocating for self = better outcome	
Consultation:	
Predictable	Compromise between helping doctor and nurturing child
Expected response	Increased level of child's distress
Option to contact again if needed	Not knowing doctor
Giving information	Signposting
Explanation	Feeling confused about role of doctor
Continuity of care	Expectations not met
Ensuring positive experience	More complex medical complaint
Guidance given	Lack of answer for medical concern
Complaint not perceived as complex	Lack of guidance
	No resolution
	Unable to complete medical examinations

Emerging themes with relating codes:

How mothers perceive the role of the doctor		
Characteristic	**Relationship**	**Competency**
• Reassuring • Calm • Respectful • Honesty • Gentle • Helpful	• Engaging/rapport • Validating • Empowering	• Thorough • Experienced • Advice • Confidence

How mothers believe they are perceived by doctors		
Characteristics	**Judgement of abilities**	**Knowledge**
• Worried • Concern • Caring/ nurturing • Unassertive • Disorganised • Scatty • Chaotic	• Validation • Care at home • Monitoring • Criticism • Non-compliant child- reflection of mother	• Interested • Questions

How mothers perceive their role				
Knowledge	**Conflict in role**	**Responsibility**	**Role**	**Emotions**
• Advice seeking • Information • Learning • Understanding	• Assisting the doctor vs. protecting/ nurturing • Us of time vs. need to get advice • Responsibility of mother vs. responsibility of doctor	• Care for child at home • +ve experience for child • Decision making • Information seeking • Assisting doctor • Child's behaviour • Child's health complaint • Use of time and resources	• Protecting • Caring • Role model • Teaching • Monitoring • Support • Self and mother entwined	• Concern • Worry • Gratitude • Empowered • Uncertain • Pressure

How do mothers perceive a satisfactory vs less than satisfactory consultation	
Satisfactory	**Less than satisfactory**
• Less worry • Reassurance • Doctor taking responsibility • Honest • Kind • Rapport/ engaging • Validating • Predictable/ expected • Information/ explanation • Guidance	• Increased worry • Doctor as distant/ going through motions • Increased child distress • Decreased child compliance • No resolution/ guidance • Conflict between nurturance and compliance • Criticism • Lack of engagement with child • Complexity of complaint

Kate: Initial list of codes:

Existing relationship
Reassurance seeking
Previous similar experience- informing expectations
Understanding with GP allowing reassurance seeking
Feeling understood by the GP
Mutual relationship
GP as respectful
Use of time
Not wasting time
Preparing for consultation
Knowing what want to achieve in consultation- goal/ expectation
Respecting timeframe of Dr
Feeling listened to
Appearing more confident/ competent than feeling
Importance of demonstrating competence
Appearing to knowledgeable
Guilt
Making appropriate decisions for child
Uncertainty re: decision making
Appearing in control
Understanding child's needs
Being an advocate for the child
Enormity of motherhood- responsibility
Nice- GP
Warm- GP
Aloof- GP
Professional-GP
Approachable- GP
Comfortable in discussing personal issues
Feeling taken seriously
Honesty-GP
GP as a mother
Relatability
Appropriate level of concern from GP
Proactive as a mother
In control
Prioritising child's need
Public and private presentation of self/ mothering
Child's behaviour as a reflection of parent
Control of child's behaviour
Performing the role of mother
Intuitive understanding of child
Pressure to understand child's need intuitively
Not being aware of severity of child's health needs
Ability to anticipate child's needs
Not meeting standards of mothering

Expectation of mother role
Comparison to other mothers
Influence of media and popular presentations of mothering
Mothers' responsibility within the family
Mother as always right
Idea that men don't understand
Outside influences regarding the narrative of childbirth and mothering
Mothering intuition as a fallacy
Impact of popular understanding of role
Not feeling sure of needs of children
Ambivalence around mothering role
Guilt regarding ambivalence around mothering role
External pressures
Importance of father's role
Tendency for father's role to be dismissed
Impact of bereavement of own mother
Comparison of role to own mother
Own mother as an advocate
Impact of absence of role model of mothering
Worth of stay at home mother- use of skills
How mothering is perceived
Consultation as a partnership
Reliant on expertise of doctor
Trust in abilities of doctor
Collaborative relationship
Realistic expectations
Own responsibility in the consultation
Generational differences in perception of doctor
Doctor as expert vs. doctor as collaborator
Doctors view of own role- responsibility for solving problem
Reciprocal relationship with doctor
Direct communication
Not wasting doctor's time
Behaviour of child
Using time efficiently
Going to doctor as a privilege
Responsibility of using facilities appropriately
Rapport
Appearance of doctor
Education/ training of the doctor
Self-disclosure of doctor
Personal relationship
Appreciative of consultation
Opinion taken seriously
Mutual respect
Grateful for consultation
Interaction with child
Appearing forgetful

Presentation of self- disorganised vs. competent
Severity of situation
Calming
Understanding the severity
Perceived as a responsive mother
Warmth- mother
Child focused- mother
Nurturing
Affection
Appropriate level of concern
Professional
Lack of e existing relationship
Most appointments satisfactory
Feeling unacknowledged
Lack of historical understanding
Nervous
Lack of clarity
Caution regarding interventions
Reluctance to engage in more complicated process
Impact of authority of medic- pressure
Presentation of self- hippies
Expectations of consultation
Different doctor- lack of continuity of care
Fulfilling role
Communicating with child
Asking child to communicate with doctor
Preparation
Information
Perfunctory
Not holistic approach
Medical vs. personal
Routine
Not understanding impact of appointment for family
Lack of empathy
Anticipating conflict/ decisions
Feeling unsure in less than satisfactory appointment
Previous bad experience
Unpredictable consultation
Concern about investigations
Uncertainty about own reaction
Lack of confidence
Decision making
Feeling unprepared
Understanding information
Unprepared- mother
Out of control
Too much information
Self-critical

Defensive about parenting decisions
Clarification- information seeking
Not feeling like an individual case
Not relating to doctor
Doing job- not more
Unremarkable
Unclear
Lack of empathy
Guilt about criticism of doctor
Lack of support
Lack of validation
Feeling stereotyped
Stereotype of middle-class mothering (conflict)
Rebelling against stereotype and prescribed practices
Natural/ organic mothering
Caution viewed as conflict
Descriptor of stereotype- blueberry, hippy, organic, anti-vaccine etc.
Caricature
Deflection of caricature
Inner conflict of embodying role
Role to analyse data and convey information
Help/ support with decision making
Not relaying information/ explanation of data
What predicted didn't happen
Pathway
Relationship
Context
Narrow amount of information
Doing the right thing as a mother
Second guessing self
Lack of confidence
Responsibility of mothering
Pressure
Presenting self to doctor
Diligent
Responsibility to children and husband
Societal influence
Esoteric connection to children
Role of NCT
Uncertainty
Compliance
Similar parenting to own mother
Need for relationship
Certainty in familiar context
Unrealistic expectations of relationship
High expectations of doctor
Collaborative
Mechanical approach

Impersonal
Unremarkable consultation
Feeling unimportant
Expectations of what a mother should be
Falling short of expectations
Difference between actual and ideal self
Judging self
Concerned about how viewed by others
Versions of the self
Losing narrative of self through motherhood
Motherhood as hallowed vs. motherhood as job
Need to reinforce position as 'stay at home mother'
Important vs. drudgery
Conflict between working mothers and stay at home mothers- contrived conflict
Defensive
Use of intellect
Reverence about being a mother
Importance of role of mother- pressure
Expectation of intuitive understanding
Tension about perception of mother
Fraudulent perception of mother role
A person in mothers clothing

Initial cluster of themes:

How I perceive myself as mother

Role
Reassurance seeking
Making appropriate decisions
Being an advocate for the child
Proactive as a mother
Prioritising child's needs
Being an advocate for the child
Child's behaviour as a reflection of mother
Control of child's behaviour
Intuitive understanding of role
Ability to anticipate child's needs
Child focused
Decision making

Characteristics
Warmth
Nurturing
Affection
Uncertainty
Self-critical

Presentation
Appearing more confident/ competent than I feel

Importance of demonstrating knowledge
Appearing in control
Public and private presentation of the self and mothering
Child's behaviour as a reflection of mother
Performing the role of mother
How mothering is perceived
Out of control
Concern how viewed

Responsibility
Use of doctor's time
Not wasting time
Respecting timeframe of doctor
Making appropriate decisions
Enormity of motherhood- responsibility
In control
Prioritising child's needs
Being an advocate for the child
Mother's responsibility to the family
Mother as always right
Own responsibility in the consultation
Going to doctor as a privilege
Using time efficiently
Decision making
Diligence

Knowledge
Know what trying to achieve
Expected goal
Understanding child's needs
Intuitive understanding of child's needs
Not being aware of child's needs
Mother as always right
Not feeling sure of needs of child
Preparation
Information

Emotions
Guilt
Pressure of mother role
Feeling unsure
Grateful
Nervous

Self/Mother
Public and private presentations of the self and mothering
Not meeting standards of mothering
Expectations of mother role
Ambivalence around mothering role
Impact of loss of own mother
Losing narrative of self through motherhood

Conflict re: stereotypes and prescribed practices
Inner conflict- dissonance regarding roles
Versions of the self
Motherhood as hallowed vs. motherhood as a job
Important vs. drudgery

Factors influencing perception of motherhood
Stereotypes
Expectations of mother role
Comparison to other mothers
Influence of media and popular presentations of mother role
Outside influences regarding the narrative of childbirth and mothering
Mothering intuition as a fallacy
Impact of popular understanding of the role
External pressures
Own mother
Loss of own mother
Impact of absence of role model of othering
Comparison with working mothers
Esoteric connection to children

How I perceived the role of the doctor

Relationship
Existing relationship/ lack of
Feeling understood
Mutual relationship
Feeling listened to
Feeling taken seriously
Feeling comfortable
Relatability
Consultation as a partnership
Doctor as expert vs. doctor as collaborator
Reciprocal relationship with doctor
Direct communication
Rapport
Self-disclosure of doctor
Mutual respect
Interacted with child
Feeling acknowledged
Historical understanding/ lack of
Continuity
Communicating with child
Level of support
Validation
Support with decision making
Collaborative

Characteristics
Respectful
Nice
Warm
Aloof
Professional
Approachable
Honest
Being a mother
Relatability
Appropriate level of concern
Appearance
Calming
Empathy/ lack of
Perfunctory

Competency/ knowledge
Reliant on expertise of doctor
Trust in ability of doctor
Responsibility for solving problem
Education/ training
Understanding severity
Fulfilling role

Expectations
Realistic expectations
Generational difference in perception of doctor
Doctor as expert vs. doctor as collaborator
Role to analyse data and convey information

How I believe the doctor perceived me as a mother

Knowledge/ ability/ characteristics
Competent
Confident
Demonstrating competency
Appearing knowledgeable
Appearing in control
Taken seriously
Responsible
Capable of collaborating
Forgetful
Disorganised vs. competent

Parenting practices
Advocating for child
Proactive as a mother
Prioritising child's needs

Responsible parent

Judgement
Child's behaviour as a reflection of parenting
Feeling stereotyped
Caution viewed as conflict
Stereotype descriptors: blueberry, hippy, organic

Relationship
Reciprocal
Partnership
Mutual respect
Seen as an individual case vs. not treated as individual
Feeling unimportant

Satisfactory vs. Less than satisfactory consultation

Satisfactory	*Less than satisfactory*
Feeling understood	Self-critical
Existing relationship	Defensive about parenting decision
Previous similar experience	Not relating to doctor
Mutual relationship	Doing job- not more
Prepared	Unremarkable
Knowing what wanting to achieve	Unclear
Feeling listened to	Lack of empathy
Appearing confident	Lack of validation
Appearing competent	Lack of support
Appearing in control	Feeling stereotyped
Warmth from doctor	Caution viewed as conflict
Nice	Not giving explanation
Professional	What predicted not happening
Approachable	No relationship
Feeling comfortable	Lack of confidence
Taken seriously	Lack of existing relationship
Honest	Feeling unacknowledged
Relatable	Lack of historical understanding
Appropriate concern	Lack of clarity
Proactive	Pressure of authority
Partnership trust	Not holistic
Collaboration	Routine
Realistic expectations	Perfunctory
Communications	Authority of pressure
Reciprocal	Unpredictable consultation
Rapport	Concern about investigations
Personal relationship	Lack of confidence
Mutual relationship	Mechanical approach

Interacting with child
Calming
Understanding severity
Perceived as responsive
Previous bad experience
Impersonal
Feeling unimportant

Emerging themes with relating codes:

How mothers perceive the role of the doctor		
Characteristics	**Relationship**	**Competency/ Knowledge**
• Respectful • Nice • Warm • Aloof • Professional • Approachable • Honest • Being a mother • Appropriate level of concern • Calming • Empathy	• Existing relationship • Feeling understood • Mutual • Listened to • Taken seriously • Relatability • Collaborative • Communication • Mutual respect • Interacting with child • Support • Validation	• Expertise • Trust • Responsibility • Education

How mothers believe they are perceived by doctors			
Characteristics/ Knowledge	**Judgement**	**Parenting practices**	**Relationship**
• Competent • Confident • Knowledgeable • Responsible • Disorganised vs. competent	• Child's behaviour as reflection of mother • Feeling stereotyped • Caution viewed as conflict	• Advocating for child • Proactive • Prioritising child's needs • Responsible	• Reciprocal • Partnership • Mutual respect • Unimportant

How mothers perceive their role					
Knowledge	**Factors influencing perception of mothers**	**Responsibility**	**Role/ characteristics**	**Emotions**	**Presentation**
• Expectations • Understanding • Intuition • Preparation • Information	• Stereotypes • Expectations • Comparison • Media • Own mothering	• Use of time • Making decisions • Control • Advocating	• Reassurance seeking • Decisions making • Advocating • Child's behaviour • Control • Anticipating needs • Intuitive understanding • Warmth • Nurturing • Affection • Uncertainty	• Guilt • Pressure • Uncertain • Grateful • Nervous	• Appearing confident • Appearing competent • Control • Public and private • Child's behaviour

					• Performing • Concern how viewed

How do mothers perceive a satisfactory vs less than satisfactory consultation	
Satisfactory	**Less than satisfactory**
• Reciprocal • Collaboration • Mutual respect • Prepared • Confidence • Competence • Warmth • Approachable • Interacting with child • Honest • Relatable • Control • Proactive • Calming • Validated • Supported • Predictable	• Self-critical • Defensive • Lack of empathy • Lack of validation • Lack of support • Feeling stereotyped • Not given explanation • Not holistic • Routine • Perfunctory • Unpredictable • Previous bad experience • Feeling unimportant • Impersonal

Jane: Initial list of codes:

First time of meeting GP- less than satisfactory consultation
Concern
Not too worried
Unsure about what could be done
Not sure of expected outcome
Required specific advice
Felt comfortable-LTS
Felt listened to- LTS
Uncertain
Focused on solution
Ensure no deterioration
Prescribed antibiotics- wanted to avoid this
Friendly
Professional
Good listener
Questioned competence- need for medication
GP- confident
Questioned course of treatment
Wanting immediate solution
Feeling tired
Reluctance to go to GP
Observing decision making process- LTS
Confident in communicating

Proactive- requesting course of action
Felt comfortable
Communicated clearly
Felt concern was acknowledged
Assertive
Comparison with previous consultation
Decision making- going to GP
Appropriate seeking of medical attention
Feeling distracted
Interacted with child –LTS
Warmth
Engaged
Attentive
Comfortable for child to be investigated
Felt approachable
Collaborative approach
Easy-going
Polite
Not complex
Caring
Concerned
Balanced in concerns
Not too anxious
Appropriate use of medical consultations
Safe in medical decisions
Giving explanation
Gave information
Differing opinion of required intervention
Least interventionist
Retrospect – less satisfaction
Critical of own role- could have made other suggestions
Avoid medication
Responsibility should lie with the doctor
Mild treatments considered first
Own understanding of medical system
Need to be well- informed as mother
Avoid being misguided
Need to have information prior to consultation
Preparation
Inconsistency of medical opinions
Impact of medic's experience
Thinking critically
Not following step-by-step guidance
Thinking differently
Personal characteristics of doctor
Manage risk
Making decision about what would be right for your child
Collaborative

Listened to
Own clinical experience
Own research
Quoting expensive terms
Understand perspective of doctors
Friendly response to concerns
Known to doctor
Mother as tired
Succinct
Explaining perceived appropriate intervention
Communication
Good mood- satisfactory appointment
Aware of preferred outcome
Communicated preferred outcome
Worried
Upset
Disappointed at needing doctor appointment
Disappointed that own knowledge based intervention not successful
Aware needed additional treatment
Avoiding unnecessary treatments
Doctor as tired
Aware of previous treatments- preparation
Appropriate level of concern
Specific intervention sourced
Engagement with child
Liked doctor
Communication
Professional
Doctor followed suggestions
Confidence in own ability
Reassuring
Offered follow-up
Validated abilities
Reliable- mother
Doctor complied with mother
Caring
Aware of child's needs
Conscious of what had worked previously
Doctor role- safety
Explained thoroughly pros and cons of medication
Listened despite being tired/ overworked
Prescribed as requested- therefore satisfactory
Confidence in treatment plan
Less worried in satisfactory consultation
Feeling confident makes consultation easier
Knowing problem and solutions makes it easier
Confidence in decision making
Feeling in control

Confidence helps question doctor
Confidence helps with collaboration
Being caring and concerned most important to doctor
Confidence helps receive more expert explanation
Impact of level of concern on collaboration
Dissonance between concern of doctor and mother impact on level of satisfaction
Mother less concerned- doctor more directive
Knowledge of child
Knowledge of medical condition
Adequate concern
Own experience of being mothered
Influence of friends mothers from early age
Ideals from books and popular culture
Knowledge from studying psychology
Professional understanding of best way to mother
Thinking from perspective of child
Empathy
Thinking for child
Understanding child's stage of development
Unconditional love
Be available to child
Emotional availability
Replicating vs. differing own mothering
Practices similar to own mother
Unscientific nature of medicine
Impact of previous difficult experiences for child
Differing positions of different doctors
Own knowledge vs. medical knowledge
Risk-free decisions
Informed decisions
Joint decisions
Outcome focused
Less anxiety
Mother role taken seriously
Mother knows child best
Knowledge linked to control
Role as mother strong and significant
Confidence from scientific knowledge
Knowledge vs. emotional experience
Being a mother as defining
The way perceive self as a mother- changing
Preparation
Influences of role
Confidence from previous experiences
How perceive professional

Initial clusters of themes

How I perceived myself as a mother
Being a mother as defining

Emotions/characteristics
Concern
Not too worried
Uncertain
Tired
Confident in communicating
Assertive
Worried
Upset
Disappointed
Reliable confident
Unconditional love
Emotional availability to child

Control
Solution focused
To ensure no deterioration of child's health
Proactive- requested course of treatment
Confident in communicating
Assertive
Clear communication
Decision making
Own understanding of medical system
Avoid being misguided
Need to have information prior to consultation
Preparation
Making decision about what would be right for your own child
Explaining perceived appropriate intervention
Use of own knowledge base for home intervention
Knowing problem and solution
Knowledge linked to control

Knowledge
Seeking specific advice
Solution focused
Own understanding of medical system
Need to be well informed as a mother
Need to have information prior to consultation
Preparation
Own clinical experience
Own research
Understanding perception of doctors
Disappointed that own knowledge based intervention not successful

Knowing problem and solution
Confidence in decision making
Knowledge from studying psychology
Professional understanding of best way to mother
Understanding child's stage of development
Own knowledge vs. medical knowledge
Mother knows child best
Knowledge linked to control
Confidence from scientific knowledge

Relationship to doctor
Reluctant to visit doctor
Feeling comfortable
Avoid being misguided
Understanding perception of doctors
Explaining to doctor perceived appropriate intervention
Disappointed that needed doctor
Confidence helps with collaboration
Feeling confident makes consultation easier

Responsibility
Appropriate seeking of medical attention/ use of medical consultation
Proactive
Least interventionist approach/ avoid medication
Need to be well informed as a mother
Need to have information prior to consultation
Preparation
Making decision about what would be right for your own child
Own research
Explaining perceived appropriate intervention
Thinking from perspective of child
Mother knows own child best
Role of mother as strong and significant

Factors influencing perception of mothers
Own experience of being mothered
Influence of friends mothers
Ideals from books and popular culture
Knowledge from studying psychology
Professional understanding of best way to mother
Replicating own mothering versus differing from own mothering

How I perceived the doctor
Characteristics
Listened
Professional
Confidence
Warmth

Engaged
Attentive
Approachable
Professional
Reassuring

Relationship with
Listened to
Felt concern was acknowledged
Collaborative approach
Gave information/explanation
Open communication
Validated abilities
View of Dr influenced by outcome of consultation

Competency/ experience
Professional
Competence
Gave information/explanation
Safe in medical decisions
Responsibility
Mild treatments considered first
Thinking critically
Not following step by step guidance
Managing risk
Professional
Medical opinions as inconsistent
Unscientific nature of medicine

How I believe the doctor perceived me as a mother
Control/ responsibility
Proactive
Confident in communicating
Assertive
Clear
Appropriate seeking of medical attention
Appropriate use of medical consultation
Aware of child's needs
Confident
In control
Mother knows child best
Role as mother strong and significant

Relationship
Felt acknowledged
Approachable with thoughts and suggestions
Collaborative
Validated abilities

Impact of level of concern on collaboration
Joint decision
Mother role taken seriously

Characteristics/ emotions
Caring
Easy-going
Polite
Approachable
Concerned
Balanced in concerns
Not too anxious

Satisfactory vs Less than satisfactory

Satisfactory	*Less than satisfactory*
Experienced	No previous consultations
Thinking critically	Unsure about what could be done- mother
Not following step by step guidance	Not sure of expected outcome- mother
Thinking differently	Uncertain
Friendly response to concern	Prescribed antibiotics
Known to doctor	Questioned Drs competency- need for medication?
Explaining intervention	Questioned course of treatment
	Observing decision making process
Disappointed at needing doctor	Comparison to previous consultations
Avoided unnecessary treatments	Distracted
Appropriate level of concern	Differing opinion of required intervention
Followed suggestions	Critical of own role
Confidence in own ability	Lack of experience
Reassuring	Quoting expensive terms
Offered follow-up	Dissonance between mother and doctor's level of concern
Validation of abilities	
Aware of what had worked previously	
Safety	
Prescribed as requested	
Confidence in treatment plan	
Feeling in control	
Collaborative	
Knowledge of the medical condition	

Emerging themes with relating codes:

How mothers perceive the role of the doctor		
Characteristics	**Relationship**	**Competency/ Knowledge**
• Warmth • Listened • Engaged /attentive	• Listened to • Concern acknowledged • Collaborative • Open communication	• Professional • Competent • Safe/managing risk • Information/explanation

• Professional/ confident • Reassuring	• Validation of mothering abilities • View of doctor influenced by outcome of consultation	• Responsibility • Critical thinking • Medicine as inconsistent/ unscientific

How mothers believe they are perceived by doctors		
Control/ responsibility	**Characteristics**	**Relationship**
• Proactive • Confident in communicating • Assertive • Appropriate use of medical consultation • Aware of child's needs • Confident • In control • Mother knows child best • Role as mother strong and significant	• Caring • Easy-going • Polite • Approachable • Concerned • Balanced in concerns • Not too anxious	• Felt acknowledged • Approachable with thoughts and suggestions • Collaborative • Validated abilities • Impact of level of concern on collaboration • Joint decision • Mother role taken seriously

How mothers perceive their role		
Knowledge/ Control/ Responsibility	**Factors influencing perception of mothers**	**Role/ characteristics of mother**
• Solution focused • Proactive • Clear communication • Preparation • Own understanding/ research • Confidence • Mother knows child best	• Own experience of being mothered • Professional understanding • Ideals from books and popular culture	• Reliable • Confident • Unconditional love • Emotionally available to child • Concern

How do mothers perceive a satisfactory vs less than satisfactory consultation	
Satisfactory	**Less than satisfactory**
• Experienced • Thinking critically/ differently • Not following step by step guidance • Friendly • Known to doctor • Explanation of intervention • Avoided unnecessary treatments • Appropriate level of concern • Followed suggestions • Confidence in own ability • Reassuring • Offered follow-up • Validation of abilities • Aware of what has worked previously • Prescribed as requested • In control • Collaborative • Knowledge • Of medical condition	• No previous consultation • Unsure of expected outcome • Uncertain • Questioned doctor's competency • Questioned course of treatment • Observing decision making process • Comparison to previous consultations • Doctor distracted • Critical of own role • Lack of experience of doctor • Dissonance between level of concern of doctor and mother

Jo: Initial list of codes:

Anxious
Focused on needs of the child
Concerned
Seeking reassurance from doctor
Seeking answers to questions regarding son's health
Wanting to achieve an outcome for child- medication
Concerned about child's welfare
Wanting best for child
Dismissive of my anxieties
Wasting Doctor's time
Information- giving doctor description of what happening for child
Expressed anxieties- as a mum
Level of severity/ complexity of health complaint
Empathy for child- distress/ unpleasant
Advocating for child
Asking relevant questions- information
Ensuring doctor understands
To make diagnosis
Give best advice
Prescribed appropriate medication
Judgement-use of time
Not feeling listened to
Ongoing condition
Previous A&E admission
Consultation not anticipated outcome- prescription of steroids
Lack of empathy with mother
Lack of answer/ solution
Invalidated predicted outcome
Doctor not known previously
Suitability of doctor to chosen specialty
Doctor as tired/ fatigued
Mother seen as: pushy/ forceful
Direct request- for medication
Unnecessarily trying to medicate son
Known solution not given
Asking appropriate questions
Appropriate medical consultation
Having child's best interests at heart
Caring
Doctor asked appropriate questions
Tried to alleviate concerns
Not be dramatic
Least interventionist
Welfare of child as paramount
Severity dismissed

Dissonance of perceived severity between doctor and mother
Mother: tired and worried
Followed advice
Clinically appropriate vs. meeting emotional needs/ nurturing
Nurturing/ bedside manner
Doctor not in tune with mother
Complex relationship
Doctor role: reassurance
Personal as important as medication
Mother as: caring, informed, asking appropriate questions, reasonable
Managing child's behaviour
Loving
Doctor as attentive, listened, asked appropriate questions, gave reassurance
Providing information
Help doctor make diagnosis
Control of child's behaviour
Concerns listened to
Child tired
Doctor- good understanding of children
Being known and understood by doctor
Appropriate use of time
Understanding concerns
Care at home
Attuned GP
Alleviate concerns
Validates attendance and abilities
Perceived as reasonable and reasoned
Problem-solving
Mother as calm, wanting best for child, caring
Able to manage child
Loving
Interacted well with child
Encouraged child to interact with doctor
Would follow advice
Prescription
Anticipated outcome
Explanation for treatment
Productive consultation
Improvement on expected outcome
Conflict re: making appointment
Taken seriously
Treatment efficacious
Empowering
Open to further consultation
Health needs met
Not meeting overly anxious needs
More severe problem (emergency) in less than satisfactory consultation
Perception of doctor influenced by anxiety

Perception negative in comparison to named GP
Trust
Unconventional prescribing
Importance of explanation
Asking appropriate questions
Giving information
Helping doctor make well informed decision
Role of intuition
Mothering person
Own experience of being mothered
Professional understanding of mothering
Emotional, educational health
Meeting needs of child
Demonstrating affection
Influence of own personality/ characteristics
Similarities and difference to own mothering

Initial clusters of themes

How I perceived myself as a mother

Emotions
Anxiety
Concern
Expressed anxieties- as a mum
Tired
Worried
Calm

Role/responsibility
Focused on needs of the child
Concern
Seeking reassurance
Seeking answers regarding the health of the child
Wanting to achieve an outcome for the child- medication
Wanting best for child
Use of time
Information- giving description
Empathy for child- distress/ unpleasant symptoms
Advocating for child
Ensuring doctor understands
Having child's best interests at heart
Caring
Welfare of your child is paramount
Following advice
Informed
Asking appropriate questions
Managing child's behaviour

Loving
Care at home
Attempting own problem solving
Encourage child to interact
Interacting with child
Conflict regarding making appointment
Help doctor make well informed decision
Affection

Knowledge/ Information
Seeking answers regarding the health of the child
Information- giving description
Asking relevant questions
Ensuring doctor understands
Following advice
Informed
Asking appropriate questions
Providing information
Help doctor make well informed decision

Factors influencing perception of mothers
Role of intuition
Mothering person
Own experience of being mothered
Professional understanding
Own personality and nurturing characteristics
Similarities and difference to own experience of mothering

How I perceived the doctor

Relationship/ Characteristics
Dismissive of my concerns
Listened to vs. not listened to
Empathy vs. lack of empathy with experience of being a mother
Tired/ fatigued
Trying to alleviate concerns
Clinical needs vs. emotional needs
Nurturing
Reassurance
Medical vs. personal
Attentive
Listened to
Attuned
Alleviated concerns
Validation
Empowering

Judgement

Use of time
Attendance
Abilities

Role/ knowledge
To make diagnosis
Give best advice
Prescribe appropriate medicine
Suitability to role
Ask appropriate questions
Least interventionist
Clinically appropriate vs. meeting emotional needs
Medical needs vs. personal needs
Good understanding of children
Explanation for treatment

How I believe the doctor perceived me as a mother
Characteristics
Anxious
Pushy
Forceful
Caring
Reasonable
Calm

Responsibility
Use of doctor's time
Direct requests
Asking appropriate questions
Having child's best interests at heart
Appropriate decisions
Able to manage child
Encouraging child to interact with doctor
Follow advice

Judgement
Wasting time
Unnecessary medication
Able to manage child
Interacting well with child
Taken seriously

Relationship
Knows me as a mother
Understanding anxiety
Validation of mothering

Satisfactory vs Less than satisfactory

Satisfactory	*Less than satisfactory*
Routine	Anxious
Informed/ questions	Concerned
Doctor as attentive	Outcome focused
Reassurance	Child's welfare
Information	Dismissive
Collaboration	Wasting time
Control	Severe/ complex complaint
Listened to	Child's distress
Understanding of child	Not feeling listened to
Being known and understood	Ongoing condition
Appropriate use of time	Previous emergency treatment
Attuned GP	Not as anticipated
Alleviated concerns	Lack of empathy
Validating	No solution
Interaction with child	Not known to dr.
Prescription	Perceived as forceful/ pushy
Productive	Least interventionist
Efficacious treatment	Dissonance of perceived severity
Empowering	Tired
Needs met	Not feeling understood
Trust	Anxiety impacted perception
Unconventional	Anticipating deterioration

Emerging themes with relating codes:

How mothers perceive the role of the doctor		
Characteristics/ relationship	**Judgement**	**Knowledge/ role**
• Listened to vs. dismissed • Empathy • Clinical/ medical vs. emotional/ personal needs • Nurturing • Reassuring • Attentive/ attuned • Validating • Empowering	• Appropriate use of time • Validation of abilities • Attendance	• Diagnosis • Advice/ explanation • Prescribing • Suitability to role • Information/ questions • Least interventionist • Clinical/medical vs. emotional/personal needs

How mothers believe they are perceived by doctors		
Responsibility/ judgement	**Characteristics**	**Relationship**
• Use of doctor's time • Direct requests • Asking appropriate questions • Having child's best interests at heart • Appropriate decisions • Encouraging child to interact with doctor	• Anxious • Pushy • Forceful • Caring • Reasonable • Calm	• Knows me as a mother • Understanding anxiety • Validation of mothering • Taken seriously

• Follow advice • Unnecessary medication • Able to manage child • Interacting well with child • Taken seriously		

How mothers perceive their role			
Knowledge/ Information	**Factors influencing perception of mothers**	**Role/ responsibility**	**Emotions**
• Seeking answers regarding the health of the child • Information- giving description • Asking relevant questions • Ensuring doctor understands • Following advice • Informed • Help doctor make well informed decision	• Role of intuition • Mothering person • Own experience of being mothered • Professional understanding • Own personality and nurturing characteristics • Similarities and difference to own experience of mothering	• Seeking reassurance • Seeking answers • Wanting to achieve an outcome for the child- medication • Use of time • Information- giving description • Empathy for child • Advocating for child • Ensuring doctor understands • Welfare of your child is paramount • Following advice • Informed • Asking appropriate questions • Managing child's behaviour • Loving • Care at home • Attempting own problem solving • Encourage child to interact • Interacting with child • Conflict regarding making appointment • Help doctor make well informed decision • Affection	• Concern • Expressed anxieties • Tired • Worried • Calm

How do mothers perceive a satisfactory vs less than satisfactory consultation	
Satisfactory	**Less than satisfactory**
• Routine • Informed/ questions • Doctor as attentive • Reassurance • Information • Collaboration	• Anxious • Concerned • Outcome focused • Child's welfare • Dismissive • Wasting time

• Control • Listened to • Understanding of child • Being known and understood • Appropriate use of time • Attuned GP • Alleviated concerns • Validating • Interaction with child • Prescription • Productive • Efficacious treatment • Empowering • Needs met • Trust • Unconventional	• Severe/ complex complaint • Child's distress • Not feeling listened to • Ongoing condition • Previous emergency treatment • Not as anticipated • Lack of empathy • No solution • Not known to dr. • Perceived as forceful/ pushy • Least interventionist • Dissonance of perceived severity • Tired • Not feeling understood • Anxiety impacted perception • Anticipating deterioration

Louise: Initial list of codes:

Routine vs. emergency
Complex vs. simple problem
Satisfactory outcome= satisfactory consultation
Knowledgeable- mother
On-going problem
Thorough understanding of the situation
Confident in explanation
Confident in knowledge
Relaxed
Confidence in the doctor
Previous consultations vs. unknown to dr.
In control
Apprehensive
Concern for child- examination
Concealed apprehension
Calm
Planned consultation vs. spontaneous
Confidence in knowledge as a mother
Knowledge of medical condition
Knowledge of own child
Anticipating child's response
Caring
Nurturing
Making experience positive for my child
Proactive
Care at home
Decision making
Seeking advice
Previous experience
Anticipated response
Predictable
Prepared
Doctor: attentive, empathetic, as a mother

Doctor- competence/ability.
Awareness and knowledge of problem
Interaction with child
Careful
Sensitive
Respectful
Strong bond with child
Caring
Nurturing
Sympathetic
Confident
Communicated clearly
Knowledge-thorough understanding
Positive
Making experience positive for child
Assertive- requested test
Determined- doing everything for my child
Look after child's welfare
Communicating problem and history
Questioning and thorough
Make sure child comfortable and relaxed
Making progress
Problem solving
Friendly
Doctor communicated with child
Validating parenting
Agreement with doctor
Dr self-disclosure
Existing relationship
Rapport
Dr as thorough
Listened
Dr acted as expected
Dr beyond expectations
Dr as engaged
Intelligent
Concerned
Nothing else to be done
Felt like progress
Collaborative
Reasonable
Try something new
Realistic
In control
Child's behaviour reflection of mother
Assisting doctor
Child assisting doctor
Keep child safe

Teach child to respond effectively/ express
Give child confidence/ ability to communicate
Job or mother- teaching
Diagnosis
Medical assessment of problem
Propose treatment
Holistic approach
Respectful in treatment
Medical vs. personal needs
Level of child's distress
Severity of child's health condition
Level of concern
Flustered
Concealing feeling of flustered/ out of control
Child upset
Experienced parent
Stressed and worried
Intervention
Invalidation of parenting practices
Feeling chastised
Sensible parent
Trust
Insensitive
Practical
Trying best
Assertive
To get poorly child treatment
Present child to doctor
Needing control
No treatment
Everyone doing their part
Feeling judged- hadn't done job properly vs. feeling like I'd done all could as a mother
Lack of empathy
Judgemental
Previous experience with doctor
Interaction different from anticipated from experience
Sensible, practical advice
Holistic approach
Highly charged
Cooperation
Nurturing and caring vs. practical and sensible
Can't separate self and mother
Mother's job to provide advice and medicine
Appropriate use of time
In depth consultation
Judged positively vs. judged negatively
Sensitive
Frustrated

Practical parenting from own parenting
Role of instinct- nurturing and caring

Initial Clusters of themes

<u>How I perceived myself as a mother</u>

Knowledge/ Information
Knowledge/ explanation
Confidence in knowledge as a mother
Knowledge of medical condition
Knowledge of child/ child's likely response
Anticipating child's response
Seeking advice
Preparation
Communication of problem and history
Questioning and thorough
Intelligent
Experienced parent
Practical knowledge

Characteristics
Confident
Apprehensive
Calm
Caring
Nurturing
Sympathetic
Positive
Assertive
Determined
Intelligent
Concerned
Realistic
Flustered
Attentive
Practical
Trying best
Assertive
Inventive
Nurturing and caring vs. practical and sensible
Can's separate self and mother role
Instinct

Responsibility/ Role
Concern for the child
Covering apprehension
Anticipating child's response

Making experience positive for child
Proactive
Care at home
Decision making
Seeking advice
Anticipating child's needs
Preparation
Confidence in child
Strong bond with child
Communication of problem and history
Assertive
Determined- doing everything for my child
Make sure child comfortable and relaxed
Looking after child's welfare
Questioning and thorough
Making progress
Realistic
Child's behaviour and communication- reflection of mothering
Assisting doctor
Child assisting doctor
Keeping child safe
Teaching child- to respond/ express self
Give confidence to child
Attentive
Practical
Presenting child to doctor
Get poorly child treatment
Facilitate doctor's role
Use bond with child
Use of time

Relationship
Apprehensive
Covering apprehension
Proactive
Preparation
Communication of problem and history
Child's behaviour as reflection of mothering
Assisting doctor
Facilitate doctor's role

<u>How I perceived the role of the doctor</u>

Knowledge/ competence
Confidence in doctor
Competence/ ability
Awareness and knowledge
Thorough

Advice

Character/ relationship
Attentive
Empathic
Doctor as a mother
Interaction with child
Careful
Sensitive
Respectful
Friendly
Communicated with child
Validating
Self-disclosure
Existing relationship
Rapport
Listened
Engaged
Collaborative
Calm
Attentive
Insensitive
Clear
Understood

Role
Diagnose problem
Medical assessment
Propose treatment
Holistic approach
Critical

Judgement
Invalidating
Validating
Chastised
Understood

<u>How I believe the doctor perceived me as a mother</u>

Responsibility/ role
Strong bond with child
Caring
Nurturing
Sympathetic
Knowledge
Understanding of child and condition
Assertive- requesting test

Determined to do everything for child
Concerned
Proactive
Attentive

Presentation of self
Covered up apprehension
Confident
Communicating clearly
Positive
Making experience positive for child
Assertive- requesting test
Proactive
Intelligent
Reasonable
In control- despite not feeling it
Child's behaviour
Attentive
Sensible parent

Knowledge/ Information
Knowledge
Thorough understanding of child and condition
Intelligent
Common sense

Relationship/ judgement
Collaborative
Validated parenting
Critical of parenting
Invalidating parenting practices
Sensible parent
Trust
Feeling like hadn't done job properly

Satisfactory vs Less than satisfactory

Satisfactory	*Less than satisfactory*
Routine appointment	Emergency
With GP	With GP
Satisfactory outcome	Medically satisfactory
On-going problem	Medical vs. personal needs
Thorough understanding	Concerned
Confident in ability/ explanation	Child distressed
In control	Severity of health condition
Relaxed	Communicative
Confidence in doctor	Confident
Previous consultations	Flustered
Concealed apprehension	Concealed feelings of flustered and out of control

Less severe problem
Knowledge- mother/ child/ medical condition
Anticipated response
Predictable
Prepared
Empathic
Attentive
Dr as a mother
Competence/ ability
Awareness and knowledge of problem
Interaction with child
Careful
Sensitive
Respectful
Communicated clearly
Positive
Assertive- requested test
Determined for the child
Make child comfortable and relaxed
Questioning and thorough
Dr communicated with child
Validated parenting
Agreement
Dr disclosure
Existing relationship
Rapport
Thorough
Listened
Acted as expected
Beyond expectations
Engaged
Perceived as intelligent
Felt like progress
Realistic
Collaborative
In control
Holistic approach
Problem resolved
Communicated everything
Detailed
Everyone did their part
In-depth
Felt understood
Evaluated positively
Psychological impact positive

Trying to get child to cooperate
Child's behaviour
Experienced parent
Appearing in control vs. feeling in control
Stressed
Worried
Invalidated
Assertive
Knew doctor
Challenged doctor
Feeling chastised
Practical
Not in control
Feeling like hadn't done job properly
Lacking empathy
Distracted
Self-criticism
Judged
Anticipation of this doctor invalidated
Practical vs. emotional
Highly charged
Frustrated
Annoyed

Emerging themes with relating codes:

How mothers perceive the role of the doctor			
Characteristics/ relationship	**Judgement**	**Knowledge/ competence**	**Role**
• Attentive • Empathic • Doctor as a mother • Interaction with child • Careful • Sensitive • Respectful • Friendly • Communicated with child • Validating • Self-disclosure • Existing relationship • Rapport • Listened • Engaged • Collaborative • Calm • Attentive • Insensitive • Clear • Understood	• Invalidating • Validating • Chastised • Understood	• Confidence in doctor • Competence/ ability • Awareness and knowledge • Thorough • Advice	• Diagnose problem • Medical assessment • Propose treatment • Holistic approach • Critical

How mothers believe they are perceived by doctors			
Responsibility/role	**Presentation of the self**	**Relationship/ judgement**	**Knowledge**
• Strong bond with child • Caring • Nurturing • Sympathetic • Knowledge • Understanding of child and condition • Assertive- requesting test • Determined to do everything for child • Concerned • Proactive • Attentive	• Covered up apprehension • Confident • Communicating clearly • Positive • Making experience positive for child • Assertive- requesting test • Proactive • Intelligent • Reasonable • In control- despite not feeling it • Child's behaviour • Attentive • Sensible parent	• Collaborative • Validated parenting • Critical of parenting • Invalidating parenting practices • Sensible parent • Trust • Feeling like hadn't done job properly	• Knowledge • Thorough understanding of child and condition • Intelligent • Common sense

How mothers perceive their role			
Knowledge/ Information	**Characteristics**	**Role/ responsibility**	**Relationship**

• Confidence in knowledge • Knowledge of child • Knowledge of needs • Knowledge of condition • Anticipation of child's response • Communication • Preparation • Experience	• Confident • Assertive • Caring • Calm • Nurturing • Flustered • Apprehensive • Practical • Conflict • Instinct	• Anticipation • Decision making • Care at home • Advice seeking • Communication • Care/ safety of child • Get treatment • Teach child • Use of time	• Covering apprehension • Proactive • Preparation • Assisting • Communication • Child's behaviour • Anticipation

How do mothers perceive a satisfactory vs less than satisfactory consultation	
Satisfactory	**Less than satisfactory**
• Routine appointment • With GP • Satisfactory outcome • On-going problem • Thorough understanding • Confident in ability/ explanation • In control • Relaxed • Confidence in doctor • Previous consultations • Concealed apprehension • Less severe problem • Knowledge- mother/ child/ medical condition • Anticipated response • Predictable • Prepared • Empathic • Attentive • Dr as a mother • Competence/ ability • Awareness and knowledge of problem • Interaction with child • Careful • Sensitive • Respectful • Communicated clearly • Positive • Assertive- requested test • Determined for the child • Make child comfortable and relaxed • Questioning and thorough • Dr communicated with child • Validated parenting • Agreement • Dr disclosure • Existing relationship • Rapport • Thorough • Listened • Acted as expected • Beyond expectations • Engaged • Perceived as intelligent • Felt like progress	• Emergency • GP • Medically satisfactory • Medical vs. personal needs • Concerned • Child distressed • Severity of health condition • Communicative • Confident • Flustered • Concealed feelings of flustered & out of control • Child distressed • Trying to get child to cooperate • Child's behaviour • Experienced parent • Appearing in control vs. feeling in control • Stressed • Worried • Invalidated • Assertive • Knew doctor • Challenged doctor • Feeling chastised • Practical • Insensitive • Not in control • Feeling like hadn't done job properly • Lacking empathy • Distracted • Self-criticism • Judged • Anticipation of this doctor invalidated • Practical vs. emotional • Highly charged • Use of time • Frustrated • Annoyed

• Realistic • Collaborative • In control • Holistic approach • Problem resolved • Communicated everything • Detailed • Everyone did their part • In-depth • Felt understood • Evaluated positively • Psychological impact positive	

Appendix XV: Full Transcript with Initial Coding

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I: **Thank you for agreeing to take part in the study. The following interview will take approximately one hour and 30 minutes, and I'll ask partway through if you'd like to take a break. If you need to take a break at any other time, please don't hesitate to let me know, and this can be facilitated. Also, if, at any time, you would like to stop participating, please let me know. You are free to withdraw from the study at any time without giving a reason. Over the course of the interview, I will be asking lots of questions, and I will be asking you... Oh, sorry, and if, at any time, you don't want to answer a question or contribute to that particular aspect of the study, please let me know and we can either stop or move on to the next question.**

At times, I will ask you to think about the same things from different perspectives, so this will involve trying to put yourself in the position of someone else, or think from the perspective of yourself, but in a different role. This may be difficult at times, but please just give it your best effort and there are no right or wrong answers, and I'm just interested in your views. Thank you once again, and do you have any questions you'd like to ask before we start?

R: No.

I: **I'd like you to take a moment just to think about two consultations you have taken one of your children to in the past 12 months, preferably. I'd like you to recall a consultation that you felt was a satisfactory experience, and one that you felt that was a less than satisfactory experience.**

R: Okay.

I: **Do you have those in mind?**

R: Yes.

I: **So for the first one you're going to talk about, and it doesn't matter which one, can I ask you how many consultations you've taken the child - that child - to in the last 12 months?**

R: Oh, possibly - not about the same issue...

I: **No, just generally.**

R: ...but just in general? Perhaps three or four.

I: **When was the consultation that you have in mind?**

R: I think it was in February.

I: **So was that five months?**

R: It was six months ago, is it, or something?

I: **How old was your child when you took them?**

R: Four.

I: Was it a routine, or an emergency consultation?

R: Routine.

I: What was the speciality of the doctor you saw on this occasion?

R: A GP.

I: Was this the first time you had met this doctor?

R: No.

I: How many consultations have you previously had with this doctor for your child?

R: For this particular child?

I: Yeah.

R: Two, possibly.

I: Can I ask what the nature of the complaint you sought advice was regarding?

R: Vaginal irritation.

I: Does your child have any ongoing medical needs or diagnoses?

R: No.

I: Would you describe this experience as satisfactory, less than satisfactory or neither of those?

R: Satisfactory.

I: Why did you choose this one to discuss?

R: Because it was quite an in-depth appointment; it involved both examination of the child, and a subsequent discussion. It was a fairly complex problem, and I had fairly satisfactory outcome.

I: What I'd like you to do for the first question, is think about how in this consultation you saw yourself as an individual. So regardless of other jobs or roles you have, like being a mother, how would you describe yourself, as an individual, and your characteristics during that consultation?

R: Do I say it, or do I write it down?

I: Say it.

R: Oh, I say it.

I: Is that all right?

R: Yes, of course, it's fine. So I felt knowledgeable, because it was a problem that had been going on for some time, and I felt that I had quite a thorough understanding of the situation. I felt - so I felt confident in my ability to be able to explain the situation. I felt - as a result of that, I think, I felt quite in control of the situation, because I felt confident in what I knew and in what we had been doing. I also felt fairly relaxed in that situation, again, I think because I felt confident in what I was doing, and also because I had confidence in the doctor that I saw, based on previous consultations. Yeah, I think that's probably it.

I: Lovely. Thank you. If you wanted to write anything, or add, you're welcome to. So if you feel that you wanted to add something...

R: Okay. No, no, that's fine. Sorry, it's just...

I: No, no.

R: I suppose actually the other I might add to that, because - especially because of the nature of the complaint, because I knew it was going to involve an examination which is potentially not that nice, I did feel... Is this how I come across as an individual, or the characteristics I...

I: How you saw yourself as an individual.

R: How I saw myself? Okay, then...

I: Well, how you saw yourself coming across, I guess is one way of - how you feel that...

R: Yeah. No, in that case I don't think - I don't know that it necessarily would have come across. I personally felt a little bit apprehensive about it, because of the examination side of it, and because I felt that she wouldn't enjoy that very much. But I don't know that that necessarily - I don't, I think I probably would have covered that up quite well for the doctor.

I: But that's something you saw in yourself, so...

R: Yes. Oh yes, definitely. Definitely.

I: So, again, looking back to that consultation, how would you describe yourself as a mother? So thinking specifically about your qualities and characteristics, as a mother, during that consultation, how would you describe yourself as a mother? How you, yourself, saw yourself as a mother, if that makes sense?

R: I think I would have - as in terms of a mother, call myself calm in that situation, which I felt was quite important for her, again, partly because of the nature of the problem. She wasn't actually poorly during this examination, it was part of kind of an ongoing investigation, so that makes it a little, made it a little bit easier from that perspective. So calm and I felt in control of the situation, and I felt I had good understanding of my child that I was bringing with me. So I felt I had confidence in my knowledge, as a mother, in that situation. So it wasn't just my knowledge of the specific medical problem, but it was about how she was responding to it. So I felt...

I: How your daughter was responding to it?

R: Yeah. I felt like a heightened sense of caring and nurturing, I would say, in that sort of environment, because I was keen to make the experience as positive a one as we could for her at the time. So I think I was probably displaying more of those characteristics in my behaviour than normal.

I: Can I just ask you a little bit about control? So you said that you felt in control of the situation, can you just tell me a little bit about what that control means when you use that word, what do that mean to you?

R: To me, it meant that I felt like I knew - I had made the appointment, not as an emergency, but as a routine, because I felt that we'd built-up enough experience and symptoms, and stuff to warrant an appointment. So, to me, I had - so from the start, I had been proactive in making the appointment, rather than being forced into making the appointment because we had come...we were really struggling at home. So we were in a period where the problem actually wasn't there, but I felt that we needed to, but I felt that we needed further advice. But because I had already had quite a lot of experience in dealing with this at home as well, I felt, I suppose my feeling of control stemmed from the fact that I had been down this road quite a few times, so I knew the parameters of what I was saying. I knew the likely response that I was going to get, so I used some of the likely response that I was going to get from the doctor, plus I had...she had already been examined in this way once before, so I felt like I knew what was coming, which I think helped me.

So I felt, I suppose, in control of myself, in the sense that I felt I had - I was as prepared as I could be in that scenario, and I felt confident in her, because I knew her and the way she tends to behave in these situations, and she'd been through it once before.

I: So almost like you could predict how...

R: Yes.

I: I'll just make some notes of things to ask you later. Are you happy with...

R: Yeah.

I: What I would like you to do now, thinking about that consultation, is think about how you would describe the doctor that you saw on that occasion. So, again, thinking from a perspective of yourself as an individual, regardless of your other roles and your roles in that situation, so just you in your entirety, make up of all of your attributes, how you would describe the characteristic of the doctor that you saw in that consultation?

R: She was very attentive, and empathetic. Having a daughter a bit older than F. She was thorough. She displayed - she gave me confidence in her ability to assess the problem, and she displayed an awareness and a knowledge of the difficulties. She was really good with F, very personable, good manner with her, and very careful in the examination. Very respectful, actually, of us both. I'm trying to think what else? I think that's probably about it, really.

I: **Lovely. So this time I'd like you to think slightly differently, so whereas you've been thinking from a perspective of yourself as an individual, I want you this, for this next set of questions to think specifically from your perspective as a mother. So almost as if you could single out that part of yourself, and through a lens as a mother that you would see the world and your experiences. So I'd like you to think as a mother, how you would describe yourself during the consultation you've describe to me. So it's a little bit unusual, because it's looking, as a mother, at yourself as an individual, so from as L, as mother, looking at L as a person during that specific period of time, how would you, as a mother, describe yourself as an individual in that situation?**

R: I think - so if I'm thinking about myself as a mother, I think...

I: **So you're thinking almost through...**

R: Through a mother lens.

I: **...mother goggles as you, as an individual. As if L mother was looking at L the individual during that consultation, and how she would describe that.**

R: I think she would describe her as someone who has a strong bond with their child, because, as I said before, I was...my caring and nurturing characteristics were, I think, probably more heightened during that kind of consultation, so I think that would come across. And sympathetic, I would say, and I think I would have come across as a confident person, able to communicate clearly and with a thorough understanding about what my child was dealing with. I think I would come across as quite positive as well, because I think I would - I think I was deliberately being very positive to make, again, to make the experience positive. So I think that that would have come across. And quite assertive, actually, because I asked for an additional test, which, because I felt that we needed to cover all of the bases; and I've just remembered that. But I think that - so I think I would have come across as somebody who was determined to make sure that everything for my child was being done.

I: **Anything else, or...?**

R: That's probably about it.

I: **So this one I'd like you to, again, hold onto that perspective as looking as a mother during that consultation. This one, again, is quite tricky, and I'd like you to think about how you viewed your role as a mother during that experience. So from the perspective as a mother, how you saw your role as a mother during that consultation, how best would you describe how you viewed your roles and characteristics during that consultation?**

R: My role was to care for my child in that situation, so to look after her welfare, really. So which kind of has two parts to it: one, by making sure that I clearly communicated the problem and the history, and all the kind of relevant pieces of information that I needed to pass on; and to ask questions of the doctor once she had begun to engage with me about it, so to be questioning and thorough. And then the other side of the looking after, is then to make sure that throughout F was comfortable, that we included her where it was appropriate in our discussions, that she was as relaxed as she could be during the

examination. Yeah, I don't think... So this is looking at my - looking as a mother at my role in this situation, as a mother?

I: **Mm-mm.**

R: So I talked about looking after her, and I've talked about communicating the problem. I think to get some answers, I suppose, and to get - and to make some progress.

I: **What do you mean by...**

R: Well, I suppose that directly relates to the nature of the complaint, I suppose, because it's a slightly different type of consultation than an ordinary emergency-type of consultation, where we were really going because we have an ongoing issue that we are struggling to resolve. So it was really whether we could - and it wasn't the first time that we'd been to see the doctor, and not this particular doctor, but generally a GP, about the problem; and, yet, we still hadn't really managed to solve the problem. So it was really about whether we could manage to move things on, and find different ways.

I: **Anything else you want to add?**

R: No.

I: **Finally, in this set of questions, just holding onto that perspective as a mother to F during that consultation, I'd like you to think about how you viewed the doctor in the consultation. So this time you're thinking specifically from the perspective of motherhood, how would you describe the characteristics from that perspective of the doctor you saw?**

R: I think, as a mother, to me, the manner of the doctor was really important, especially because of the nature of the complaint. So her friendliness and the way that she communicated completely on a level with F, and talked to her as well as to me about things. The fact that she, herself, was a mother of a daughter helped me, I think, as a mother in that situation, because the level of empathy was really helpful, I found it helpful. I think partly because I - she made me feel like I'd done everything that I could do in that situation, which I think, as a mother, I felt made it a very positive experience for me, because I felt... I can't think what the word is. Reassured is not the word, but that I had - basically, she agreed with what I'd been doing to date, and which gave, which then, in turn, gave me more confidence, which, in turn, I think made it, again, a positive experience. So her manner, her own role as a mother, I think particularly in this case was really helpful.

I: **Can I ask, did she disclose that to you during the consultation?**

R: Yes.

I: **So she chose to tell you that she had...**

R: Yes.

I: **...a daughter a similar sort of age? Yeah. Why do you think she did that?**

R: I think it actually came - it was related to something... I now can't remember whether I - possibly I could have prompted it, I actually can't remember. But I think partly because a lot of what we were discussing was not actually particularly medical, it was about toilet-training children and trying to get nappies off children, and making sure they don't have big drinks before they go to bed, that type of thing: bedwetting alarms, stuff like that. So I think it was because of that, rather than because of anything specific. Plus, I also have seen this doctor many times over the years, so I think - I think also she said it to F, because we were talking about F's age and I think, again, partly as a method for the doctor developing a bit of a rapport with F she said, 'Oh, my daughter's a bit older than you now'. So I think there was a bit of that as well that went on.

I: Anything else about how you viewed the doctor from the perspective [?as a mum 24:38]?

R: I can't remember what I've said now.

I: So you said the manner of the doctor was important and friendly, they were on a level with F and they talked to her. The fact that she was a mother, and helped particularly because it meant you felt that that affected her empathy, which was really helpful. That she made you feel that you'd done everything you could do, and it made it a positive experience, because she agreed with the actions you'd taken previously, which gave you confidence.

R: Yes. And I think I would say also that she was very thorough, because she listened properly and then did all the things that I would have expected her to do, and ask some questions that I hadn't thought about. So I felt that we had had a proper discussion about it by the time the consultation was finished.

I: Now, for the next few questions, I'd like you to try and put yourself in the shoes of the doctor you saw on that occasion. So I'd like you to think about how the doctor viewed you as an individual in this situation. So imagining yourself from her perspective, and the way she may have seen you as an individual, regardless of your other roles and particularly as your role as a mother at that time. So it's a little more difficult, because you're presenting as a mother to F, but how that doctor might describe your characteristics, and how they might have perceived you as an individual?

R: I think I would have come across as confident, because I felt confident in that situation, and somebody who was able to communicate clearly; because there was quite a large section of the appointment which was just me explaining the history of the difficulties. And I think I probably would have come across as somebody like reasonably intelligent, who was able to, who had used their common sense to try and deal with a problem; and was able to ask relevant questions. I think I would have come across as a concerned person as well, so concerned for my child, in this case, and concerned for her welfare and making sure that she was okay; and, again, that we found a way forward out of the consultation. Yeah, I think that's probably it.

I: Can I ask you, you've mentioned a couple of times about the idea of moving forward in the consultation, did that happen? Did you find that you...

R: Not really. I felt that was what I wanted - I made the appointment knowing that we weren't in the middle of a...because it's an illness that seems to come and go, and come in waves. I made the decision to make an appointment, just because I felt like we needed - even though we were in a down spot at that particular moment - that we needed some advice for the next time it appeared. And I felt like I wanted to rule out there being any existing infections, or anything like that. So I felt - so although we did do the ruling out of the infections, it transpired that there wasn't really anything else that I could, that we could do, really, about it. But, ironically, even though, actually, I don't think we really did move forward, other than to rule out any infections and stuff, I think because the nature of the consultation was positive, and I felt able to communicate what had been happening, and I felt that she felt that I had done the right things, it made me feel like we'd made progress. Even though, actually, we - in reality, we do think no differently now to how we did before we saw her as part of the consultation.

I: When you said making progress, and one of the things you had in mind was - before you went in - was to rule out infection. Did you have other things in mind as a course of treatment or action that you thought might happen, or was it that it was just the idea of making progress that was going, that was motivating you?

R: I think what was motivating me, really, was trying to see if we could find a way to stop it recurring, but I was already aware that that might not be a thing. I was already - I think I was already fairly realistic about the fact that the chances were that there might not be that much more that we could do. But I felt like I needed an appointment to go through what we'd done, and to try to find if there was anything else that we could try to do that, so that we had some kind of more, some more stuff to try if we found ourselves in that situation again. Some more suggestions, or - because sometimes that in itself, for F in dealing with it, just having something different to try, like a new cream or whatever can actually be beneficial. And it's saying, right, whether or not that has any medical weight behind it, actually, is sometimes neither here nor there. And, actually, we've learnt how to deal with it over the months and stuff that we've dealt with it, and, actually, it doesn't really have a medical solution it has a psychological solution, we have worked out, but only through trial and error, and stuff like that.

So I don't think - I mean, it was when I talked before about being assertive because I asked for a certain test, it was me that asked for her test that there was no infection. Because, actually, she wasn't going to do that, and I said that I felt that while we were there we may as well just rule it out just in case. And she - again, she was very happy to do that and she didn't make me feel like I had to push for that or anything, and she was very...

I: And do you think that her being receptive to that suggestion had an impact on whether or not you thought the consultation was satisfactory, so she...

R: Definitely. Definitely, because I think wanting to rule out the infection was one of the things I wanted to get out of it, so when I realised that that wasn't on the, wasn't on her agenda, she didn't feel like it was necessary, I felt able to raise it. I felt confident enough to raise it, and then her response then made me feel...she made me feel like I had made a perfectly reasonable suggestion, rather than like a random one.

I: **Sorry, I've taken you off-track a little bit there, but...**

R: No, that's fine.

I: **...we were just talking about how you believed the doctor viewed you, as an individual. Was there anything else you wanted to add to that?**

R: I think that's probably most of it.

I: **That's fine. My writing gets a little bit more scribbly towards... So now I'd like you to think about, again, from the perspective of the doctor you saw, and putting yourself in their shoes, I would like you to try and think how they viewed you in your role as a mother. So imagine I were to ask them how they perceived you as a mother, how would you think they would respond?**

R: I think they would see me as a mother who had a handle on a thing, or had a handle on that particular thing, because, again, as I've said, I felt like I had quite a lot of...we'd tried quite a lot of stuff, I had quite a lot of detail to give them. And I had - F was very good, so I think I had...I suppose I would have come across as being in control of that situation, both of her and her illness within it, if you see what I mean? I think the bond between me and F would have come across, because she in those sorts of situations she very much looks to me to be a reassuring presence. So, again, when I talked about the heightening caring and nurturing characteristics, they definitely come out with her a lot anyway, because that's what, because she needs that. And I think - and then also in a medical situation like that, I think they would be even more heightened anyway, so I think that would have come across. I think it was a very calm appointment, so I think a calm parent would have come across.

I: **Can I ask you, one of the things you said was that F was very good, was well-behaved, is that what you mean when you say that?**

R: Yeah, she was very well-behaved and very - and she was communicative as well, and she actually, she responded to the questions pointing to where it hurts, and was helpful to the doctor in trying to assess the problem.

I: **Can I ask, what links you make with F's presentation in that situation, to your understanding of your role as a mother?**

R: I feel like one of my roles as a mother, is to - so I feel one of my main roles as a mother is to keep them safe, and one of the ways in which I feel that I can help them to keep, and I can help to keep them safe, is to help them to respond effectively in these types of situations. To give them confidence to explain what the problem is, to give them the reassurance that it's okay to express themselves in that sort of situation. So I feel like if I've got a child who is good, in the sense of being well-behaved and listening to what the doctor says, but also who is able to express themselves and to talk about what some of the difficulties that...and to talk about the problem that they've got, I feel like that's a really important part of my job.

I: **Is there anything else about how you believe that the doctor viewed you as a mother, that you would like to [over speaking 37:50]?**

R: No, I don't think so.

I: Finally, in this section, I'd like you to think once more from the viewpoint of the doctor you saw on that occasion, and I'd like you to think about how you believe they would describe their role and their characteristics as a doctor in that consultation?

R: Well, I would say to diagnose the problem, although, actually, diagnosis in this sense I don't know necessarily applies, but to provide a medical assessment of the problem, and propose possible treatments for it. To listen to the history, as given by the parent in that situation, to listen to the child in terms of describing their symptoms. To ask - to be empathetic and sympathetic, to ask relevant questions. What have I said? Diagnose, suggest treatment, to listen to parent and child.

I: Any other characteristics that you think she might have viewed in herself...

R: Oh, I see.

I: ...in their role?

R: To be quite holistic in the approach, because I think that it was a type of problem that called for that, rather than something that was a bit more one-dimensional. Yeah, and to look at the - yeah, to look at the whole child, and to be respectful in the treatment because of the examination. So to be aware of some of the sensitivities involved, and, yeah, empathetic I've already said that.

I: And just, finally, and you may have already covered this in some of the things you've said, but you mentioned that you felt that this was a satisfactory consultation. What do you think is the reason you believe this was a satisfactory consultation?

R: I think it is because - one of the reasons I think it's a satisfactory consultation, is because, actually since, ironically, it's got nothing to do with the consultation. Which is that we actually haven't had a true recurrence of the problem, so I think if we - six weeks down the line - we had had the whole thing rear up again, I might feel a bit differently about it; but I think because...so I think that's one thing. But I think also one of the reasons I think it was satisfactory, was because I felt that I had, I felt I'd got everything across that I needed to communicate, because sometimes I think that can be a barrier to satisfactory medical consultations, if you feel like you haven't remembered to say everything. But I felt like I had managed to get everything across that I needed to say, and I felt that...so it was a very thorough consultation, so I felt, for me, that was quite important, because we'd gone, it had been going on for quite some time, so I felt like we really needed to go through things in some detail.

I think that the fact that she made me feel like I had done all I could do, helped me to feel that it was satisfactory, because I think I then felt satisfactory as a result. Because it hadn't been - it had, at times it had been quite an upsetting thing to watch her deal with, as a mother, so I think that to feel that I - at the end of the consultation - to feel like I had really done everything I could, and that we... Actually, we had - obviously didn't rule out infection there and then, but subsequently rule out the infections as well, then made me feel like,

well, okay, we've done everything that we can. So I think that was what - and then, because then we haven't had any problems, that's also helped me to...

I: **Do you think infection - you've not had any other problems is linked in any way to the consultation?**

R: No.

I: **No, okay.**

R: I don't think so, no. I mean, I suppose what you can't underestimate though is the psychology of it, as I've said before, I don't...it's not really a problem with the medic-, it might have started off as a problem with a medical solution, but now it doesn't have a medical solution, a lot of it is psychological. So I think possibly the fact that we went to the doctor, that we went through it all, she was examined, there's nothing there; I don't think you can...it's impossible to know, really, whether that has actually had an impact or not. But I think having been down that road has also given me - I've realised that my method of dealing with it is actually just not to... Because she still occasionally will get upset with it, but it's more isolated incidences now, rather than weeks and weeks at a time where she will wake, is actually just not to make anything of it at all. And, actually, and almost make light of it in a way, and actually that in itself has been the single biggest factor in improving it, I think. But it's only through jumping all the other - jumping through all the other hoops that I think eventually we've come down on that side, yeah.

I: **I'm going to pause for a minute there.**

[Recording Pause]

I: **So this time I'd like you to talk about the other consultation that you had in mind, so the less satisfactory consultation. For the child that you're going to talk about in this situation, can I ask you how many times you've taken that child to the doctor in the last 12 months?**

R: Three.

I: **Three, yeah. How long ago was the consultation that you're going to talk about?**

R: Nine months ago.

I: **How old was your child?**

R: Two.

I: **Was it a routine or an emergency consultation?**

R: Emergency.

I: **What was the speciality of the doctor you saw?**

R: A GP.

I: **Was this the first time that you'd met this doctor?**

R: No.

I: How many consultations had you taken this child to the doctor before?

R: Two.

I: Two. And what was the nature of the complaint that you sought advice regarding?

R: Rash, tummy ache, yeah, it turned out to be a virus.

I: Does your child have any ongoing medical needs or diagnoses?

R: No.

I: Would you describe this as a satisfactory, not satisfactory or neither? Sorry, less than satisfactory or neither?

R: Less than satisfactory.

I: Why did you choose this experience to discuss today?

R: Because although medically I think the consultation was satisfactory, I think the way in which it was conducted, and the way I felt at the end of it made me feel that it was less than satisfactory.

I: I'm going to ask you similar questions to the ones I've asked you previously. So, firstly, in this consultation I'd like you to think about how you saw yourself as an individual. So, again, regardless of other jobs or roles you have, how would you describe yourself in that moment; what were your characteristics?

R: Concerned, because the child was really upset in the - really, clearly, really quite poorly, and upset; and upset really for the duration of the appointment. I would say communicative; I still felt able to talk about the problem, to explain what we'd done so far. And confident still, slightly flustered... I have to think.

I: How would I know that you were flustered; what would I see if you were flustered?

R: That's an interesting question. I don't know if you would see it, actually. I think because J was upset and not really able to sit - not happy to sit still, not happy to be examined, I was having to really pull out all of my mothering stops to try to get him to cooperate. And so I, myself, I felt quite flustered, and I don't actually know if that would come across particularly. I think I might have come across as just really proactive, in that I was trying lots of different methods to get him to try to cooperate. So I was being - I would have come across as pretty attentive, I think, both the doctor, because I was really trying to ascertain what on earth was the matter; and to J, because I was trying to find ways around the problem, I would say.

I: Again, looking back to this consultation with J, how would you describe yourself as a mother, so thinking specifically about your qualities and characteristics, as a mother, during that consultation, how would you, as an individual, describe yourself as a mother? Or how you saw yourself as a mother during that consultation?

R: So this is me, as an individual, seeing myself as a mother? I think I would have come across as quite an experienced parent at that point, because I think, as I said before, I was really having to call on all my experience to try to get through, and try to make the experience as beneficial as we could make it. So I think I could have come across as a person relatively in control of quite a difficult situation, although I didn't feel it, actually, but I think I might have given the impression of being. And someone who was, again, relatively confident in that situation, although I didn't feel it.

I: How - knowing yourself in that situation, how would you have said...you said you felt different to how other people might have perceived you, so thinking about how you felt as well, or how you saw yourself that other people might not have seen. What - how would you describe that?

R: As in how would you describe the diff-, as in how would you describe the differences? Well, I felt stressed and worried, and because he really was clearly quite poorly. And then also we had this incident at the end of the consultation where the only way that I eventually got him to sit still for whatever, I forget what it was that we had to do, was for me to let him have chocolate buttons. And the doctor said that - because he was also having some issues with constipation at the time, and he said, 'The chocolate buttons aren't going to help the constipation,' and I said, 'No, I appreciate that, but I can't - I've ran out of ways to get him to sit still'. So, as a result, I ended up feeling like - I did sort of, we did manage to get through and I can't actually remember now what the...I think there was nothing to be done, and we just had to sit it out. But I just felt like I'd jumped through a lot of hoops, only to be told at the end that, actually - and we'd had a semi-successful conclusion to it - only to be told that, actually, my solution to it wasn't appropriate. So which I think contributed to my less than satisfactory feeling at the end of it.

And, actually, I challenged it at the end, because I know that particular doctor, and I know that he has four children of his own. And I said, 'I appreciate exactly what you're saying,' I said, 'But you have four children, what would you be doing?' and he said, 'I would be doing what you're doing,' and I said, 'Okay, well, there we go'. But it didn't actually - even though I said that, and even though he agreed it didn't get rid of the feeling that I had about the fact that I felt like I'd kind of been told off. So, anyway, sorry, I've forgotten the question.

I: So it's how you saw yourself as a mother, how you [over speaking 54:55].

R: What have I said? Sorry.

I: You said that you felt that you were quite an experienced parent, because you were calling on all your experiences to make the consultation as beneficial as possible. That you probably looked in control, but didn't necessarily feel it. That you were stressed and you were worried, because J was very poorly. And you said also that you felt that you jumped through hoops, so you did what you needed to do.

R: Yeah, I think that's true.

I: Anything else about how you saw yourself as a mother?

R: I think I would have seen myself as pretty nurturing and caring again, because a lot of the stuff that I was doing was about trying to calm him, and finding ways to engage with him, to relax him. None of which worked. And so I think that kind of sympathetic side would have been quite obvious, and I think my, that my more practical side would have been quite obvious as well, because I think I would just have been...although I was trying to be quite nurturing and caring, I was trying to just keep moving on to try and get through, essentially. Yeah, so I think that probably was the case as well.

I: Now I'd like you - again, concentrating on this consultation, to think about how you, as an individual, would describe the doctor that you saw. So thinking from your perspective as an individual, regardless of your other jobs and roles, in your entirety, made up of all different facets and attributes, how would you describe the characteristics of the doctor that you saw on that occasion, for that consultation?

R: So this is me, as an individual, with the doctor?

I: Yeah.

R: So he was calm and attentive, and he was very aware that he had a child in distress. He listened carefully to what I was saying. He was respectful, to a degree, in terms of - as I say, he listened carefully to what I said, and I felt that he was responding to me as a sensible parent. Like I felt that he trusted what I was saying to him, and he gave me that feeling that he respected what I was saying. His manner was nice with J, although J was not nice back. And he gave me confidence that he knew what it was, and with the treatment pattern that he suggested I felt that he had assessed him properly and thoroughly, so I felt he was thorough. But that I felt that, ultimately, he was kind of insensitive to a parent who otherwise had been...apparently who was doing their best to get through quite a difficult situation, and then there was, at the end, a bit that was - this bit with the chocolate buttons - that was kind of completely unnecessary, really. So, yeah, that was how I felt about it.

I: Now for this series of questions, I'd like you to think from your perspective, as a mother, so almost as if you could single out that part of yourself, or that role. So, from that stance, as L the mother, I'd like you to think about how you would describe yourself during the consultation that you have described to me. So looking from that mother's perspective, how you would describe yourself as an individual, or your characteristics as an individual?

R: I think, again, the sort of nurturing and caring characteristics would come to the fore, and this sympathetic side as I tried to...I think I remained pretty calm, to be honest, so I think calm probably would come out. Practical with the chocolate buttons, and the various other different stuff that I tried. Communicative - confident communicator, I would say. I think somebody who was trying their best in quite a difficult situation, and I don't know what that characteristic is, but that... What have I said?

I: Nurturing and caring characteristics. Sympathetic side. You remained calm. You were practical, because of the different methods you used to try and calm J. You were confident in communicating, and you're a good communicator; and someone who was trying their best in a difficult situation.

R: I suppose with my whole - slight confrontation over the chocolate buttons, I might have come across as on the assertive side as well. Yeah.

I: So for this one I'd like you to think, again, from your perspective, as a mother, during this consultation. So, as a mother, I'd like you to think about how you viewed your own role as a mother during this experience, so how would you best describe how you view yourself and your role as a mother, and your characteristics at this point in time?

R: So I would see my role as a mother in that situation, being to get a poorly child the treatment, to help present the poorly, a poorly child to the doctor, and to get him the treatment he needs as quickly as possible. So to keep the situation, I suppose, as calm as possible to allow the doctor to do what he needs to do, and to allow the child to respond in the way that he needs to respond, in order to get the best possible treatment. So I need to use my - the bond that I have with my child to the best possible effects, to get the best result, I guess. So the caring side of me, and the inventive side of me to try and find ways around it.

I: Is that how you saw yourself in this situation?

R: Inventive?

I: Mm.

R: Yes, actually.

I: Nothing else about how you, as a mother, viewed yourself as a mother in that situation?

R: Is it my role as a mother, or myself as a mother, or is it both?

I: It's sort of - I guess how you saw yourself in that role, and your characteristics in that role as a mother, and that might encompass what you see as that role.

R: Yeah. So I think I would see myself as needing to have control of that situation. That's partly because I always feel - I feel better if I'm in control of the situation, so I think one of the reasons why I didn't find this a particularly satisfactory experience, was not only because of the way that the doctor responded to me, but also because I didn't feel in control of the situation. So in contrast to the other experience that I've talked about, where I did feel in control of the situation, actually, as we talked about, and we didn't really, necessarily, actually get anything medical that really improved things in the longer-term. But I think because the whole experience was controlled, everyone was able to do what they needed to do as part of it, I think I felt like it had been a more satisfactory experience. In this experience, which I feel is less satisfactory, actually, medically, I think there was really no difference in that, actually, both cases ended up with no treatment, but I ended up feeling like I somehow hadn't done my job properly as a mother, because I ended up sitting feeding my child chocolate buttons.

Whereas in the other experience, I felt like I had been made to feel like I'd done everything I could, as a mother, and, yes, my child still had this problem, but that actually there wasn't really anything I could do. Whereas somehow, I felt like even though I knew that, me, at that

approach as well, which was that, actually, we just had to...this was a child that was not really going to be happy whatever we did. So we just had to keep - just cut to the chase, really, with some of it. Whereas in the other situation, which I felt I had more control over, there was more time and the atmosphere was such that it was easier to discuss, and so I didn't really need to be particularly practical in that situation, other than to call for a swab for an infection to make sure that we'd discounted that, that was as practical as I'd got. Whereas this, I was both being - both physically practical and kind of mentally practical about what we were, how we were going to play this and manage it.

I: **Anything else you'd like to say about how you believed the doctor viewed their own characteristics, and their own role during this?**

R: No.

I: **I'm going to take another - we're going to take another break now.**

[Recording Pause]

I: **So as you're looking and reading, and noticing, if anything just springs out at you, do feel free to comment on things that you notice, or that are interesting in what you notice on the grids. So, obviously, if you think of each line as how you viewed - so this was you as an individual, you as a mother and you looking for the doctor's perspectives...**

R: Doctor, yeah.

I: **...and how he viewed you as an individual, as you as a mother and how you viewed the doctor from an individual. And so each one of these lines sees it from those perspectives.**

R: All the kind of nurturing and caring stuff always is at the top of all the mother questions.

I: **Is that something that you particularly identify with as a mother, those characteristics?**

R: Well, it's - yeah, I suppose it is, really, but it's interesting that I... It is, but I don't know that I necessarily would have always pulled them out as being the first things that I would say; but maybe in this particular type of environment, then maybe, yes.

I: **What do you think would have been the things that you would have [over speaking 1:24:32]?**

R: I don't know, it's interesting, isn't it? I - because nurturing and caring, obviously, is a really important part of being a mother. I don't know what I would have put first, necessarily, but it's interesting that they always seem to come out top. But then I suppose there's kind of a healthcare type of environment and it makes perfect sense that they would, because that is where you are. I don't know, I always feel in these types of environments that I am - that it is really important to be nurturing and caring, but also really sensible and practical, because that I feel like they almost have equal weighting in these types of environments. In that you're there because you need something, and you just want to make the situation better. So I feel like I am half a sensible, practical person, and half a caring, nurturing person in

terms of looking after the child that's with me. But when - but it's the caring and the nurturing stuff that comes out most strongly, in all of this.

I: **When you say the - you talked about those things being weighted, from whose perspective are they weighted equally when you talk about them?**

R: I think probably my own.

I: **As a mother?**

R: Yes, I would say probably as a mother, because it's quite - I don't know, that's the thing, it's quite hard to separate those two things out, really, isn't it?

I: **So hard to separate being a mother, and...**

R: Being - yeah.

I: **...being an individual?**

R: Yeah, yeah, in that sense. I think, yes, yeah, I do think so, I think it's probably me that puts that weighting on, and I think it's because, yes, somebody is poorly, but in order to make them better we need to get the advice that we need, and the medicine, whatever. The medicine, whatever we need. So it's my job to provide both of those things.

I: **In equal measure?**

R: Mm.

I: **What do you think the weighting of those things, from the perspective of the doctor's is, in terms of nurturance and caring versus practicalities, and pragmatism?**

R: I don't know, really. I would have thought from - well, I would have thought it would be kind of similar, really, in that they would want, they'd want a child that is cared for and nurtured and looked after, because that is, generally speaking, a healthier and happier child. But that they need - especially with children, I would have thought, they need the practical input from the parents about exactly what the situation is, in order to be able to treat their child properly. So I would have thought - I guess, partly my own weighting of those characteristics, is partly because that's what I think the doctors need, thinking about it. I think I am essentially trying to think of all the things that the doctors will need to know, and to do in order to get in and out...

I: **Anticipating what they...**

R: I think so, yeah. I find myself doing that at the doctor's with the children quit a lot, actually, giving them a list of stuff that I think they might want to know before they've asked me for it. Because I'm essentially just trying to get in and out as quickly as I can.

I: **And who - and why are you trying to get in and out as quickly as you can?**

Appendix XVI: Thematic Analysis Quotes

1: Jo- *"[my son] was really tired, so he started playing up a little bit, so I guess I had to manage his behaviour…"*

2: Jo- *"…I probably came across as being quite in control of him because he did do what I asked him to do. But also I guess probably loving, because he sat on my lap and I gave him a cuddle and kisses".*

3: Jane- *"… to be able to give that kind of unconditional love, and to just be there for them, and, yeah, be available to them emotionally"*

4: Gemma- "*…as a mother it was my role to reassure …"*

5: Gemma- *"…I see that very much as me trying to show [my daughter] how we should behave in this situation. Trying to show her how to be confident, and teaching her."*

6: Gemma- *"… so a bit sort of guilty towards [him], like I was betraying him, but I knew that he needed to let the doctor see him properly"*

7: Louise- *"I think [I was] slightly too practical…"*

8: Gemma- *"…as a mother, and you obviously want to look after your child, but you don't want the doctor to think you're not listening to what he's saying…"*

9: Jane- *"… a bit disappointed that I needed to go to the doctor about it."*

10: Louise- "…*I would see myself as needing to have control of that situation…I always feel- I feel better if I'm in control of the situation."*

11: Louise- *"… I felt in control of myself…I knew her [daughter] and the way she tends to behave in these situations…"*

12: Jane- *"… so I was pretty clear on what I wanted to see as a treatment"*

"…and that's what I was hoping that they'd prescribe and they did"

13: Jane- *"…people do listen to my opinions and what I think…I think they listen to me, because they think I have some clinical background"*

Louise- *"… I felt knowledgeable, because it was a problem that had been going on for some time, and I felt that I had quite a thorough understanding of the situation…"*

Louise- *"I felt confident in my ability to be able to explain the situation… as a result of that, I think, I felt quite in control of the situation…*

14: Louise- *"I was as prepared as I could be in that scenario…"*

Gemma- *"I mean, I felt quite organised about it…"*

15: Jo- *"…loving, because he sat on my lap and I gave him a cuddle and kisses."*

16: Jane- *" they do tend to say that you're the mother and you know the child best… I think generally that feels like they accept you, that your role as a mother is a very strong and significant one."*

17: Kate-*"…it does feel like that it is a societal thing, and now with …all the medical stuff, it was always about the mother knows, the mother knows. You're going to feel this childbirth, you can feel the labour and you're going to know. Yeah there's a lot pressure"*

18: Gemma- *"I don't like thinking that he thinks I'm a time-waster… I think I really worry about what people think about me, and I really worry whether people like me or not."*

"There's always this thing as a mother, and you obviously want to look after your child, but you don't want the doctor to think you're not listening to what he's saying."

19: Louise- *"…I might have been slightly distracted… I still think I would have seemed like I had a degree of control. …[my son] was really poorly and struggling, and we were struggling to find a way … to examine him properly…"*

20: Louise- *"… I ended up feeling like I somehow hadn't done my job properly as a mother, because I ended up sitting feeding my child chocolate buttons"*

21: Gemma- *"I feel like maybe he sees me as a worrier, I think the reason for me going was completely valid, but that's just the way he makes me feel… I mean, he did a prescription, so, obviously, there was a reason for us to go. So it was clearly valid…"*

22: Louise- *"[on role of doctor]…to diagnose the problem, and to treat it. I would say to listen carefully to the parent… Diagnosing, listening, advising. To make sure he was treating the whole child, so like, well its' that holistic approach."*

23: Jane- *"…I just wondered whether or not they were a bit just concerned about what they were meant to be doing, in the sense of going for an antibiotic straightaway*

24: Jo- *"I felt she was really dismissive of the concerns I was raising…"*

"…she wasn't' a normal doctor in the surgery, so I don't know if she was a locum or on rotation…maybe being a GP wasn't for her…"

"I probably just wanted him to have the steroids…"

25: Gemma- *"…he could see that …I cared about her, the anxiety she might have had if she knew what he was about to do."*

"…getting the job done so to speak but also reassuring and managing the patient's feelings."

"…he managed us well-both of us".

26: Jo- *"I think he is a much more attuned GP,…I think, understands, as a mother, that you might feel a level of anxiety; and then he knows how to sort of alleviate the concerns."*

27: Jane- *"…in retrospect that annoyed me that he was taking antibiotics, when maybe there could have been something else that we could have done."*

28: Jo- *"…the doctor took it seriously, and then gave advice, and then prescribed him something, which well, has actually helped with the situation. So I feel it was a really productive consultation".*

29: Kate- *"…I think we have this rapport between us…I feel like I have a little bit of a personal relationship with her..."*

30: Jane- *"…oddly enough [he was] less engaged with [my son] …he didn't' really talk to him that much"*

"…I was hoping that they'd prescribe and they did;…I think that's the reason I felt it was satisfactory."

Appendix XVII: Reflective Diary

Friday 31st March 2017

I am left somewhat conflicted by the research I have been exploring. Whilst I agree that there are many social constructions of motherhood that are unjust and oppressive to women and that have been unhelpfully perpetuated. I am also acutely aware and attached to my own sense of maternal compassion. Feeling a deep and profound connection to my children that does in honesty feel innate and biological in nature. Whilst I'm aware that the research does not dismiss an emotional and biological connection it does offer some scepticism regarding how and why we connect to this. In years past, I would not be looking after my own children as it is likely that would be the role of someone employed to do so, or I would be raising my children until they were old enough to embark on risky child labours. Does that suggest that the attachments to children felt different back then? Or just that customs were different thus obscuring maternal attachment. Whilst I agree that one does not have a magical understanding of their children I am also not ready to dismiss an intuitive link I may have. However, I recognise that this intuition may be a product of my proximity to my children as like most other mothers I am responsible for most of their care. I took maternity leave, work part-time and shoulder the responsibility of organising and caring for my children and so may have developed this understanding by simply knowing them well. I confess this dilemma does leave me somewhat uncomfortable as I find myself seduced by the notion that only I as their mother have the knowledge and understanding to nurture them well but I am aware of the path that has led me to this conclusion causing me to questions that which feels innate.

Friday 30th June 2017

It was with some naivety that I undertook my first interview. On reflection of this experience, I realise that I had assumed a mechanical approach to this process in which I had neatly divided therapy and research into polar camps. Understandably this was a very different experience in reality and I found myself gently treading the line between therapist and researcher. I found myself managing the natural curiosity that I rely on in therapy sessions so that it fit with the purpose of the interview and the remit of the research project. When the participant I interviewed began to talk about being critical of herself I found myself eager to follow this and develop and understanding of why this was and how it had developed. I noticed the participant withdrew slightly when I enquired a little further. On reflection this was to be expected as those I see in the therapy room, though there with differing levels of engagement come with an awareness of the expectation that they will discuss matters of a personal nature. A more tick box approach could be taken to a research project, filling out a questionnaire as it were, rather than an analysis of processes. It is an interesting balance to navigate, in order to remain within the confines of the research remit whilst following new and interesting ideas brought by the participants and remaining aware of their boundaries and respecting what they feel comfortable talking about.

Saturday 11th November 2017

As I sit face to face with my themes for how the mothers I interviewed perceive their roles, I am somewhat paralysed with responsibility. At once enthralled and burdened by the importance of what I type. With the pressure of wanting to give voice in an accurate and respectful way whilst also engaging in a thoughtful and deeply interpretative process with the information I have collected. The weight of this conflict feeling heavier than ever before. I respect and admire each of the individuals I have met through this process, not least for their courageous ability to honestly and thoughtfully

engage with the questions I have asked. At times this has been a painful process for those who gave their accounts. They connected with self-criticism, doubt, bereavement and scrutiny to enrich this process of understanding. With such a valuable and privileged collection of accounts I am mindful that I must bring my own understanding to the analysis whilst being acutely aware of how that will influence the perceptions of these accounts. However, to create a meaningful conclusion to this journey I must commit to this process in full and with awareness that this understanding is from my perspective with the literature and epistemology I carried in to the project.

Thursday 7th December 2017

Having initially battled with concerns about not having enough content for the project, I'm now faced with a huge amount of data to analyse and the task of what to highlight and reflect on is really proving a struggle. Feeling unsure about what is important and what is less essential to explore and wanting the end result to reflect a really thoughtful interpretation of what I have collected from the women who agreed to speak with me. I want to explore everything in depth and think about the links and interpretation of each piece of data but am constrained. I am feeling particularly constrained by the word limit but on reflection I can appreciate that I will lose something of what's important if I endeavour to report everything.

Thursday 18th January 2018

As I find myself pushing on through the tiredness and stress in this final furlong, my biggest battle is not with how to combat my growing exhaustion or how to manage the time between my job, caring for my own two children and writing and editing in a bid to finish. It is in fact a battle with my word count. Being succinct and to the point is not a skill that necessarily comes naturally, I feel very constrained on a number of fronts. I obviously want to produce a good piece of research that is thorough and well considered and as such do not want to miss any important information out. I am also mindful of how my project will be evaluated and that by shouldering the responsibility of what to include and what to omit I feel the pressure that when called to justify my work I may have omitted something of great import. I am also burdened by the rich and detailed accounts given by the participants and that hold so many avenues of exploration from which I must choose to pursue. Finally I want to give voice to those who participated, to infuse the analysis with the energy provided by each participant when sharing their narratives.