**DOCTORAL THESIS**

## *Parent-Trainee Experiences of Child and Adolescent Mental Health Training: An Interpretative Phenomenological Analysis*

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**Dedication**

*I dedicate this work to my own mum, whose own role as mother will always live on through me.*

*You'll never be forgotten.*

# Contents

# Abstract

**Aims**: Research examining the process of clinical psychology training has essentially focused on the outsider perspective and given little consideration of the trainee's lived experience. Using qualitative methodology this project aims to listen and privilege personal narratives of individuals who occupy the role of trainee clinical psychologist and parent simultaneously during CAMHS training (i.e. placement and associated teaching) in order to increase awareness of the challenges and existing resources of this population.

**Method:** Six parent-trainees were interviewed using semi-structured interviews. Transcripts were individually analysed using methodology drawn from Interpretative Phenomenological Analysis (IPA; Smith, 1996a) to identify emergent themes and complete cross-case analysis.

**Results**: This study demonstrates how the occupancy of a parental role during Child and Adolescent Mental Health training has significant implications for individual trainees within both their professional and parental role. The three main themes emerging from the study are: i) A changed Identity: seeing and being seen in a different light ii) A journey from dependency towards autonomy and iii). Cutting the cord doesn't destroy the bond: The inseparable nature of the parental and professional self.

**Implications**: This study highlights the significant impact that the occupancy of a parental role may have in the experience of a trainee clinical psychologist's CAMHS training, and how such findings may have been overlooked in the available literature base. Findings suggest that to optimise professional and personal wellbeing and minimise potential for compromised professional conduct the impact of the relationship between parent-trainees' personal and professional self needs to be widely recognised by individual parent-trainees, training providers and the wider context of clinical psychology. The results from this study may also have wider implications for the ethical practice of those occupying any dual role in the training context as well as the broader field of therapeutic work.

## *Preface*

Without doubt, two of the most significant things that have occurred for me personally within the past few years have evolved around the adoption of new roles; one in the personal context and one in the professional. I became a parent and gained a place on clinical psychology training. Both events were planned...both were entered into with much anticipation and both, perhaps a little unexpectedly, have had a profound effect on how I view myself, my world and how I relate to those around me. By definition, being a 'parent-trainee' has meant that these events (i.e. being a parent and being on clinical training) have run parallel to one another. Consequently, I have gained personal experience of how an occupied role may influence thought, action and overall perception of another role.  Such experience left me curious to gain further insight into the experiences of others who occupy, or have previously occupied, the role of parent-trainee during child and adolescent mental health training.

# *Introduction*

Whilst it is generally acknowledged that clinical training represents a challenging and often stressful time to the individuals who engage in it, there has been somewhat less consideration given to the personal experience of training or how specific roles or personal contexts may influence the process. In line with the growing emphasis of the reflective-practitioner model in clinical psychology (Lavender, 2003) this project aims to look specifically at the experiences, in both personal and professional contexts, of the trainee psychologist who also occupies a parental role during their child and adolescent mental health services (CAMHS) training. This is defined as a 'parent dual role' (PDR).

## Literature Review

There is a distinct lack of literature in clinical psychology exploring the direct experiences of trainee clinical psychologists, the occupancy of dual roles in clinical psychology training or the influence of parental roles during the training period. It is therefore necessary to consider a wider literature base to include information from other relevant professional fields (e.g. talking therapies, caring professions, and the field of research).

This review of the literature specifically considers 1) differing perspectives of identity 2) concepts surrounding identity and roles, 3) parent dual roles in clinical psychology training 4) the complexities of clinical psychology training 5) anecdotal accounts of trainee experiences 6) the role of self in training 7) the role of self in therapy and alternative professions 8) parent dual roles and professional work and also 9) the implications of learning and experience in parent dual roles; all within the context of the parent-trainee. It will begin by exploring historical perspectives of the self and identity before moving on to define different types of role and under what circumstances the parent-trainee adopts the position of a 'parent dual role', as defined by this project.

**Differing Perspectives of Identity**

Understanding and interpretation of identity, roles and the self is complex. Overtime, there has been substantial change in the way in which these are or have been conceptualised within the confines of western society. Whilst pre-modern philosophy defined the self externally and to exist in relation to the community, the modern perspective considered the concept of self and identity to be internally constructed and associated with new narratives relating to choice, decision and rationality (McLeod, 1997). As a consequence the modern view perceived the self to be relatively stable, definitively and objectively identifiable, and hence discoverable through scientific observation (Potter and Wetherell, 1987). The postmodern perspective, however, provides a critical stance for pre-modern and modern traditions. It represents a challenge to fixed discourses, universal truths and objectivity (McLeod, 1997) and regards the self and identity as social constructions which are pluristic and narrated in language through stories told to self and others. As such, postmodernity regards identity and the self to be dependent upon the existence and co-operation of others and therefore a joint product resulting from the process of social interaction (Burr, 1995).

Postmodern ideas are evident across different approaches and theories within contemporary literature, including that relating to humanistic philosophies (e.g. Giddens, 1990), models of self knowledge (e.g. Self-Complexity Theory; Linville, 1985; 1987) and theories focusing specifically on social aspects of self and identity (e.g. Social Identity Theory; Tajfel and Turner; 1979). If it is assumed that any form of training presents the individual with new challenges and exposure associated with social and interpersonal context, which in turn modify existing knowledge experience and identity, such theories may have significant relevance to the parent-trainee undertaking CAMHS training. The above identified models have, however, been selected due to their specific reference given to the emergent self and consequently, each is briefly discussed here.

Humanistic models (e.g. Giddens, 1990), reveal the self to be a symbolic projection that is actively created by the individual, through a process of monitoring and reflection of

psychological and social information about possible life trajectories. As a result, social practices are considered to be constantly examined and reformed in the light of new information. Given that the parent-trainee may be entering into an arena that exposes the self to new ideas, social practices and experiences such models may hold interesting considerations for parent-trainees undertaking CAMHS training.

Self-Complexity Theory (Linville, 1985; 1987), a model of self knowledge, however, may be useful for thinking about the different aspects of self and how the experiences of the parent-trainee in CAMHS training may impact on other aspects of identity and vice versa. Specifically, this model proposes that individual differences in knowledge about various aspects of self are predictive of a person's emotional stability and reaction to stress. This is because if one element of self is denigrated other aspects of self can compensate provided that good self knowledge exists. Although it should be noted that Rafaeli-Mor and Steinberg (2002) found little evidence for social complexity as a social buffer, the bearing this model has on the emerging self in association with the external contexts highlights its potential relevance for the parent-trainee moving into new fields of experience within CAMHS. Furthermore, the model of Social Identity (Tajfel and Turner, 1979) may be appropriate for considering how parent-trainees identify and relate to others with whom they are in contact whilst undertaking CAMHS training. This three stage psychological process model considers how categorisation based on social, cultural and historic constructions allow individuals to organise and make sense of their perceptions of the self.

Such perspectives highlight the potential implications for the identity and roles of the parent-trainees whilst they attempt to make sense of their professional training and clinical work within the CAMHS setting. Such concepts may also help therefore to understand the potential implications of parent-trainee experiences for those supporting parent trainees or accessing CAMHS services.

### Concepts Surrounding Identity and Roles

A distinction can be drawn between roles and identity in that identity may be viewed as an internal biographical continuity in which different aspects of identity, including roles, may compete but still relate to the individual's story (Craib, 1998). However, the overlap between these elements of self (i.e. identity and roles; Tan and Campion, 2007) and the role that identity and self perception may play in parent-trainees experiences make it appropriate within this review to consider in more detail the concept of roles.

Roles are social constructions that provide a meaningful way in which people are able to define themselves. They are dependant upon the existence of others and defined by the social contexts in which we present. Given that each of us is essentially a socially-dependent being (Foulkes, 1948), it may be suggested that roles are an inevitable and often valued part of human life (e.g. Haywood et al, 2010). By the nature of existence, however, each of us will not occupy only a single role, but more likely a multitude of roles within any context (e.g. the familial context may construct one's roles of daughter, mother, wife and sister concurrently) and across contexts at different times. Whilst many of these roles will be personal in nature (i.e. related to gender, familial positions, peer memberships, interests etc.), the majority of adults also occupy a position, or positions defined by the professional or occupational contexts within which they operate (i.e. roles defined by job title, responsibilities etc).

Individuals entering into the professional role of 'trainee clinical psychologist' will bring to training a number of familiar and often idiosyncratic personal roles defined by the context of life outside work. This project acknowledges these, but is grounded in exploration of the experiences of those occupying parental roles alongside that of professional roles of trainee clinical psychologists undertaking Child and Adolescent Mental Health Services (CAMHS) training (i.e. teaching and working associated with CAMHS settings). This is an area to which little, if any, attention has been given within the existing literature. Nevertheless it may have important implications for individual trainees and those with whom they work.

Whilst there is vast literature looking at identity specific to the work context (e.g. Larsson, Aldegarmann and Aarts, 2009; Ibarra, 1999), this project will give specific consideration to the relationship between the professional and parenting self. As much of the literature is maternally biased, primarily it is the mothering self that is discussed. The limitations of this focus are however recognised.

Some suggest that the taking on of new roles, such as those within parenthood, demonstrate how individuals actively engage with opportunity for drastic change within their own identity (Elliot, 2001; Jenkins, 1996; Hall, 2000). When looking specifically at accounting professionals transitioning into motherhood, Haynes (2008) concludes that individuals reformulate their self identity in the process of becoming a mother within the context of social and cultural practices of professional work and motherhood. She considers therefore that mothers "remain active agents in a social world constrained by social and cultural practices of motherhood and professionalism" (Haynes, 2008, p.41) which is a view shared by other authors (e.g. Hockey and James, 2003).

Whilst research has found that women experience growing integration in their personal construct systems (intrapersonal and interpersonal) during pregnancy (Smith, 1990), Haynes (2008) also notes that identity of motherhood may be problematic as not all women experience motherhood in the same way. She considers that the role of motherhood may create "emergent and politically contested identities" (Haynes, 2008, p.2) whilst individuals try to undertake the difficult and often confusing process of making sense of their lives. Subsequently, Haynes (2008) highlights how ambivalence about the coherence and value of one's sense of identity may result during or from the transition into motherhood. Although these considerations may hold relevance for any professional context or individual journey into motherhood, given that parenthood and childrearing practices are likely to form an integral focus of CAMHS training, it may be particularly interesting to consider the interface between motherhood, and more broadly parenthood, with the professional role and identity of trainee clinical psychologist.

Given varied use and meaning of terminology associated with identity, this project defines *parent-trainees* as those occupying the role of parent (biological or step) and

trainee clinical psychologist simultaneously. M*ultiple roles* are defined as different positions occupied simultaneously by an individual that may never 'meet', (i.e. conflict, relate) with the experience of another role (e.g. role of sister/secretary) and *dual roles* are defined as positions created by individuals simultaneously or sequentially participating in two role categories (Kitchener, 1986).

For the purposes of this project, distinction is also made between '*traditional'* dual roles, as defined across the literature and '*parent' dual roles*. The *parent dual role* (PDR) is a term construed for the specific purpose of this research due to an absence of any pre-existing term identified for such position. It exists simply due to an individual parent undertaking work or training in a professional context, in which parenting issues are relevant.

Traditionally, however, therapeutic professions and in particular clinical psychology literature has defined 'dual roles', sometimes referred to as 'multiple' or 'dual' relationships (e.g. Slimp and Burian, 2002) as two roles that a therapist, researcher or clinical supervisor occupies in relation to another individual (e.g. Gottlieb et al, 2007; Pope, 1991; Kitchener, 1988; Herlihy and Corey, 1992; Gabrial, 2005; Carroll et al., 1985; Silverstein et al, 2006; Greenberg and Shuman, 1997). They are often identified as ethically problematic due to conflict of interest, incompatibility of expectation, loss of subjectivity and heightened power differentials leading to potential exploitation (Kitchener, 1988).

Although discussing the American perspective, Sonne (1994) and Gottlieb et al. (2007) identify how professional guidelines (Ethical Principles of Psychologists and Code of Conduct; APA, 2002) may acknowledge ethical difficulties created by traditional dual roles, but remain unclear about what constitutes a 'dual role', when a dual role suggests unethical practice or assume that the presence of a dual role implies unethical practice will occur. UK guidelines have presented similar challenges. For example, Professional Guidelines (e.g. BPS 2001; BPS 2004) appear to broach the subject from a very broad perspective and consequently provide little actual professional guidance regarding the

management of any dual role. Guidelines do state however that "some dual relationships may appear more innocuous than others, maybe even helpful at times, but all carry risks" (p.10). In addition, current Standards of Proficiency for Practitioner Psychologists (Health Professionals Council, 2009, p.6) recognise the need to "understand the complex and ethical issues of any form of dual relationship and the impact these may have on clients".

Therefore, while professional guidelines appear to acknowledge traditional dual roles and identify potential risks and complexities associated with such roles, they make little attempt to either clarify or address these risks directly. Furthermore, whilst guidelines hold some relevance for the PDR, given its overlap with the traditional dual role, they do little to provide detail or guidance on negotiating the roles. To explore this issue further, it is important to gain an understanding of the factors associated with the PDR within the context of clinical psychology training.

Despite the potential implication that a PDR may initiate, for both the individual occupying such a position and also the services and families with whom they work, the occupancy of a PDR during clinical psychology training is a relatively specialist consideration. It is not surprising therefore that there is a dearth of literature considering issues associated with such positions. The following section of the review will therefore briefly explore some of the background factors relevant to the parent-trainee PDR experience.

### *Parent Dual Roles in Clinical Psychology Training*

Parent-trainees are located within a minority population. Just 5% of those starting clinical training have 'dependents' (CHPCCP, 2008). Successful completion of training implies, however, that parent-trainees will need to address the position of a PDR at some point in training. This follows the introduction of the competency-based model in clinical psychology training which emphasises the need for trainees to develop core-competencies and flexible skills deemed necessary for clinical practice with clients from

different backgrounds, ages, abilities and difficulties across a range of settings (Kaslow et al., 2007; Kaslow, 2004; Rubin et al., 2007; BPS, 2008). Whilst a PDR is most likely within CAMHS and it is here that attention is fore-grounded, it is however acknowledged that PDRs may be encountered across training placements.

Practical steps taken by the profession, as a whole, to recognise and manage the relationship between the personal and professional self of the trainee clinical psychologist have filtered into professional guidelines for training. For example, current Accreditation of Postgraduate Training Programmes in Clinical Psychology guidelines (CTCP, 2002, Section 7.4) make specific reference to the need for supervisors to "…be sensitive to any personal issues that arise for the trainees in relation to clients". Such guidelines may therefore hold some relevance when thinking about the PDR occupied during training, but do little to consider how personal aspects of the trainee such as life experience shared between client and therapist can influence or impinge on the therapeutic relationship.

As no further consideration of the PDR in the context of clinical psychology training could be found, it becomes necessary to discuss the broader literature base that is relevant to the role of the trainee psychologist and PDRs. This highlights many of the challenges and potential benefits that may be associated with such positions and the potential influence of identity for individuals' experiences of these roles.

***Complexities of Clinical Psychology Training***

Training is a formative period (Kuyken et al, 2000) in which the professional role of trainee clinical psychologist is held for three years whilst a structured doctoral programme is undertaken. This is in accordance with the framework for Higher Education Qualifications and is regulated by the Health Professionals Council (HPC; 2009). Training incorporates academic teaching, supervised clinical practice, private study and research (Hall and Llewelyn, 2006) and requires trainees to occupy multiple

professional roles simultaneously, including that of health-service professional, post-graduate student, researcher and therapist.

Over the years, studies exploring the role of the trainee psychologist have gradually increased. This is possibly in response to research findings identifying negative associations between the professional and personal self of the trainee. For example, Cushway (1992), using the General Health Questionnaire (GHQ; Goldberg and Hiller, 1979), found that three quarters of the clinical trainee population reported feeling moderately to severely stressed as a direct result of training. This study also identified the value of coping strategies, need for additional support from course supervisors and organisers and need for further research into the role of trainee psychologists. Subsequent research carried out by Brooks et al. (2002) found that incidents of low self-esteem, anxiety and depression were higher for a trainee sample in comparison to the normal population. Levels did not, however, reach the range of poor psychological adaption and mean overall personality adjustment was significantly higher than normal populations. Longitudinal studies of psychological adaption, although not directly comparable (due to use of different rating scales) have found trainees to demonstrate considerable resilience against training demands, despite work-adjustment problems, depression and interpersonal conflict being reported increasingly throughout the training process (Kuyken et al., 1998; 2000). These studies demonstrate the complexity of clinical psychology training experience. Whilst the trainee population demonstrates good overall protective factors in relation to psychological adjustment, a significant proportion of trainees are exposed to considerable potential for negative outcome.

Through studying trainees' psychological adaption and professional functioning, Kuyken et al. (2003) found that the role of support from course staff and clinical supervisors helped moderate work-adjustment both directly and indirectly by enhancing the sense of self and reducing avoidance coping. Trainees who appraised training demands as manageable, in conjunction with greater access to appropriate support, engaged in less avoidance coping and reported fewer problems with psychological adaption. These individuals were also more likely to approach tasks of learning and working

appropriately and resiliently. By the author's own admission, however, this study is based on questions on appraisal, coping and learning approach; considered to be transactional and personality-biased. Other factors considered relevant to the psychological adaption of trainee psychologists include trainee personality (Brooks et al., 2002), gender, age, current placement, training courses, appraisal processes, coping and social support (Kuyken et al, 1998) self-awareness, supervision, personal values, a relationship with partner (Schwebel and Coster, 1998) and also work-life balance (Schwebel and Coster, 1998; Lee and Duxbury, 1998; Norcross, 2000).

Whilst these studies provide some insight into the personal factors relevant to the adaption of the trainee clinical psychologist, there remains little consideration in the clinical psychology literature regarding the influence of a parenting role in the process of training. It should also be noted that research discussed so far is unable to account for the 'insider' perspective of the trainee. This may be highly valuable for identifying additional needs and training considerations of trainee clinical psychologists occupying PDRs.

The following section of the review will highlight the rationale for considering the trainee perspective and identify important implications that such views may raise for training providers and individuals alike. It will also identify how substantial learning and exposure to new experiences in training may provide trainees with opportunity for self-development and personal, as well as professional, growth (Tan and Campion, 2007). These will be considered alongside the challenges individual trainees reflect on.

### Anecdotal Accounts of Trainee Experiences

Some argue that complete 'objectivity' is an impossible concept as researchers cannot be outside the world they seek to describe (e.g. Griffith, 1998; England, 1994). Historically, however the majority of literature examining clinical psychology training derives from, what is considered, the 'outsider' perspective (e.g. Lee et al., 2009, Kuyken et al., 1998, 2002; Brooks et al, 2002). Findings from these studies provide valuable insight into factors and potential outcomes associated with clinical psychology

training, yet independently provide limited, if any, insight into the lived experience of becoming a clinical psychologist in the UK. The last decade has witnessed increasing publications of anecdotal accounts written by trainees themselves (often written during the training period) and research considering lived experience of those occupying trainee roles. These accounts vary in focus and, whilst some consider specific aspects of training, (e.g. obtaining a place on a course; Lee, Vandrevala and John, 2009; racism and training; Adetimole, Afuape and Varae, 2005) others have considered training experience from a broader perspective.

Roos (2008), for example, focused attention towards the expectations associated with gaining a place on a clinical training programme in parallel to her 'reality' of her lived experience of being on the course. She highlights how the unpredictable pace and course intensity can often be hard for individuals to adjust to and although one enters into the role with high hopes and expectations, clinical work can be "draining, challenging and emotionally taxing" (Roos, 2008, p.52).

An alternative trainee account considers the experience of the first eighteen months of clinical training (Tan and Campion, 2007). The authors highlight how training can provide one with a privileged position to have time and space to reflect on the self and one's occupied roles, not only within the professional context, but also the personal. They consider this to provide opportunity for personal and professional growth and refer to a 'transient self' and the "realisation that a new sense of identity is being incorporated into the existing self" (p13). Additionally, they highlight how one may encounter conflict through feeling immersed and absorbed in new experiences one moment and a lost sense of self in the next.

Anecdotal accounts such as these discussed provide the personal perspective and emphasise the underlying consensus that clinical training can be and often is stressful for those who engage in it (Hall and Llewelyn, 2006). It should be noted however that their commentary nature gives little consideration to the wider evidence or practice of reliable and valid research processes. By exploring experiences and considerations of

professional training within the wider therapeutic field these may be addressed and a greater insight provided into some of the challenges that may be experienced, specifically when thinking about those who occupy a role initiating overlap between the personal and professional identities (i.e. a PDR).

*Trainee experiences from alternative professions*

After identifying a paucity of trainee perspectives on their experiences of family therapy training, using IPA methodology, Nel (2006) found that trainee family therapists reported significant disruption and change to their personal selves through disturbance in family life and relationships. Within this, parental roles were identified as one aspect of the self to be affected as a direct result of their training. Nel (2006) also found this population reported a desire to initiate change within the self, independently and also in relation to others; but that varying degrees of discomfort were associated with new understandings developed through training.  This research also concluded that trainee family therapists perceive there to be limited time and space available during the training period to make sense of the changes they experienced. Such findings may have important implications for those occupying any trainee role where established identities may be disturbed, such as that of the parent-trainee in clinical psychology.

To this point the review has highlighted some of the complexities of clinical psychology training and a range of experiences associated with this process. It also demonstrates however how trainee perspectives appear somewhat overlooked within the area of research. Yet, there has been little consideration of the unique positions and experiences individuals brings to the training experience. Therefore, to further explore this issue, attention will now be turned towards the consideration of the role of self in training.

**Role of Self in Training**

Although there is some variation between training programmes (Stedmon et al, 2003; Bransford et al., 2000) clinical psychology's focus towards the reflexive-practitioner

model demonstrates the profession's current position in relation to the role of self during training (e.g. Lavender, 2003). The reflective-practitioner model requires clinicians to adopt a meta-cognitive approach to their work and gives substantial weight to interpersonal factors within therapeutic relationships (Youngson, 2009). This includes thinking about the impact that personal roles may have on therapy. References in the literature highlight how the use of experiential learning, i.e. drawing on the self, may be beneficial for clinical practice within the context of training. For example, Sheikh, Milne and MacGregor (2007), discuss how a Continued Professional Development (CPD) model based on experiential learning may provide a person-centred framework "dedicated to developing a trainee's capacity to reflect critically and systematically on the work-self interface" (Gillmer and Marckus, 2003, p.23).

Alternative perspectives, in particular family therapists (e.g. Simmonds and Brummer, 1980; Aponte, 1994) have identified a value in understanding one's own position in relation to the work they do, specifically for the trainee role. Francis (1988) identified how awareness of one's own position and experiences could allow trainees to redefine their practice and increase empathy and receptiveness to clinical families. Additionally, she considered how insight should be sought regarding one's own interactions with others to prevent these from unconsciously persisting and initiating 'enmeshment' with clinical families. Conversely, Minuchin and Fishman (1981) saw self-insight as unnecessary and Haley (1980) considered how the experience of looking into oneself might have no place and possibly even act as a 'hindrance' in training. Kottler and Parr (2000) however highlighted concern regarding the lack of attempt in professional training to bridge the personal and professional script of the individual.

The field of psychotherapy presents little discrepancy regarding the role that the therapist plays in both the process and outcome of therapy (e.g. Strupp 1989; Gilbert, Hughes and Dryden, 1989; Spurling and Dryden, 1989). It is perhaps not surprising therefore that literature specific to psychotherapy training clearly identifies the importance of learning about one's own position in relation to clinical work during the training period. Steiner (1985), for example, identifies the process of personal analysis

to be the single most important element in the process of training a psychotherapist, largely due to the role he believes it has in teaching the individual to use his or her own reactions as an important instrument in their work. It is considered how, if the process of projection and introjections (often referred to transference and countertransference) is not considered, the potentially powerful effect of the interactive influence between therapist and client (Fosshage, 2000) may render it difficult for the therapist to retain his or her own equilibrium in therapeutic encounters.

The value of personal analysis (i.e. understanding the role of self) during training is further supported by Renik (1995). Renik (1995) discusses the importance of exposing a trainee to becoming a fully participating subject in the relational matrix and developing their ability to rely on the experience of the client and tolerate anxiety associated with uncertainty. In addition, psychotherapy training programmes identify how self analysis during the training period can help trainee therapists learn to recognise personally challenging issues, understand their own ways of dealing with anxiety and therefore pick up the danger signals which may lead them to 'act out' (Steiner, 1985). Other benefits of self analysis during the training period are considered to include elevated levels of maturity and the opportunity to gain personal experience of being a client and therefore a chance to sample some of the distress and reward associated with personal therapy (Steiner, 1985).

The view around personal therapy in clinical psychology training and general practice in clinical psychology however remains less straightforward. There has and continues to be significant debate around the need and value of personal therapy for the practising therapist (e.g. Macran and Shapiro, 1998; Williams, Coyle and Lyons, 1999; McEwan and Duncan, 1993; Wampler and Strupp, 1976). Individuals undertaking clinical psychology training, may elect to, be supported with or even encouraged to participate in their own process of personal therapy during the process of training. It is therefore considered how a parent-trainee's own view about personal therapy and also the role and value of awareness about his or her personal position (i.e. a parental role) in relation to clinical

work, will ultimately impact on the perceived implications of that position for those accessing services.

Whilst this provides a basis for exploring the role of the self in clinical psychology training, it is also necessary to look at the role of self in the broader clinical psychology literature base to provide greater insight into this issue.

### *Role of Self in Therapy and Alternative Professions*

Consideration of relationships between the personal and professional self is well established within clinical psychology literature (e.g. Paula, 2003; Lum, 2002; O'Loughlin, 2003; Perrin and Newnes, 2002; Gerson, 1996; Pipes Holstein and Aguirre, 2005; Kramer, 1999). It identifies potentially positive as well as negative outcomes that may result from overlap between the personal and professional. Whilst there is significant evidence to indicate that the person of the psychotherapist is "inextricably entwined" with psychotherapy outcome (Norcross and Guy, 1989, p. 215), consideration of individual views provides more detail on this issue. Gold (1999), for example, highlights the importance of holding one's position with awareness and insight into its potential to influence clinical working and relationships. She considers how, if not carefully considered, events, experiences and roles within therapists' own lives have potential to compromise the way in which they respond to clinical material. She also discusses the possibility of therapists using insights from their own lives clinically to help clients dealing with the same event; providing they maintain awareness of their own values and judgements to avoid unethical practice.

Additionally, family therapists Kottler and Parr (2000) discussed how one should not only be encouraged to consider the personal-professional relationship but, due to the difficulty in defining where one ends and the other starts, it should be mandatory to do so (Kottler, 1992, 1993). By drawing on their own experience they concluded that a therapist's work not only provides an opportunity to help each client and family seen, but also for the therapist to heal his or her own wounds. Paradoxically, they also identified

how clinical work may lead therapists to become increasingly 'battle-scarred', cynical, suspicious and generally cut-off from their feelings in order to protect themselves from "human inhumanity" (p. 146).

In other areas of professional working, some suggest that practice may be enhanced through overlaps between personal and professional roles. For example, in nursing, McIntyre (1996) discusses how personal experiences of caring for loved ones can apply context to the general theoretical principles, allow theories to 'come to life' and increase understanding of one's personal experience.

So far, focus has been given to the process of clinical psychology training and the role of self in the broad context of therapy. Attention will now be turned towards a specific aspect of 'self', that of parent. This will be considered from the perspective of the PDR within the context of professional, clinical, and training roles.

### *Parent Dual Roles and Professional Work*

Parenting is often referred to as one of the hardest (Powdthavee, 2009) and potentially most rewarding jobs in the world. Given the vast amount of literature published in relation to parenting and the parenting role, it is not the intention of this project to discuss it in any detail here. However, specifically looking at PDRs, the absence of available clinical psychology training literature makes it necessary to consider the broader literature base. This incorporates general discussion around PDRs as well as discussion of other relevant issues associated with commonality between professional dyads.

As a parent and psychotherapist herself, Basescu (1996) reflects on the impact that parenthood can have on therapists and their work. She considers how one is continually trying to differentiate between causing temporary discomfort in one's children and inflicting lasting psychological damage. She also discusses how the role of parent and therapist are integrated in fundamental ways that not only inform each other, but through difference (i.e. boundaries of responsibility, interactive modalities and focus of

need) can or seem to conflict with each other. Consequently, Basescu (1996) considers role conflict to be par for the course as definitions of work and family roles overlap in complex ways through a process of continual interplay of ideas and feelings between work and home.

References to PDRs in research literature highlight some alternative considerations. For example, an internet-based research project used mothers to interview mothers on their experience of utilising a mothering website and becoming a new mother (O'Connor and Madge, 2001). They looked specifically at the potential of the PDR to influence research processes; following its acknowledgement and disclosure to participants. This project identified how informing research participants of a shared parental role induced feelings of mutuality (due to the mutual role of mother). This in turn facilitated rapport between the researcher and participant and subsequent ease of information sharing. Smith (1996) describes this in terms of a "shared universe of meaning" (p.64). Conclusions from this study should however be considered with caution. The research was of a 'pilot exploratory nature' and consequently utilised a very small sample (n=15). A debate specifically exploring the concept of insider/outsider positions in relation to research (Griffith, 1998) initially identified how 'insiders' can initiate a tacit knowledge that produces a different understanding than is available to the outsider. On conclusion of her research, however, Griffith concluded that social similarities and differences between the experiences of mothers (researcher and participant) "obscured and at other times illuminated" the research process *(p. 375).* Although not specific to the PDR, alternative literature looking at relationships within research dyads has also concluded that shared characteristics may facilitate rapport and harbour relationships enabling freer participant disclosure (Finch, 1993; Miller, 1998; Ribbens, 1989; Oakley, 1981).

Mutuality or 'commonality' as it may be referred to, found in dual roles is not however always indicated as the sole, or defining factor in 'successful' interviewer-interviewee relationships. Finch (1993, p. 169) considers how essential ingredients of a successful research dyad may simply relate to the "sympathetic listener" having time and agreed confidentiality. Other literature, exploring this issue of mutuality within the context of

research dyads, highlights the complexities of such relationships as potential advantages (e.g. feelings of solidarity and understanding of a professional culture leading to richer data) and potential disadvantages (e.g. conceptual blindness resulting from interviewers own feelings and opinions) may arise due to a shared professional role between researcher and participant (e.g. Coar and Sim, 2006; Platt, 1981).

The above findings may have implications when considering the experience of the PDR specific to the context of clinical working due to shared roles (i.e. commonality) being a central factor. It should be acknowledged however, that they can not account directly for the experience within the clinical or training environment and much of the literature is maternally focused. It may not therefore be directly applicable to fathers.

When looking specifically at the role of commonality in the context of clinical working, Jones and Zoppel (1982) found that clients, regardless of gender, agreed that female therapists formed more effective therapeutic alliances than male therapists. This study therefore suggests that commonality may not necessarily be key to the therapeutic alliance. Other studies focusing on aspects of commonality in therapeutic relationships provide additional support for such conclusions. These studies include a project undertaken by Flaskerud (1990) who found little evidence to demonstrate an influence of client-therapist ethnicity, language, or gender matches on therapy process and outcome. Concurring with this, whilst acknowledging their study's inability to examine all therapist-client combinations, Erdur et al (2000) found therapist-client ethnicity pairings had limited impact on either the working alliance or client outcome. Sterling et al. (1998) also concluded that matching therapists and patients, with respect to gender and race, did not decrease the premature dropout rate, although they did find partial support for gender matching. Sterling et al. (1998) therefore concluded that matching therapists and substance abusing patients on gender and race may not be essential to improving retention and outcome, but may have relevance for enhanced clinical practice. This latter conclusion is supported by another study by Erdur and colleagues in 2003. Erdur, Rude and Baron (2003) found that, in some cases, ethnic similarity between client and therapist did impact on the length of treatment. However, in spite of these findings,

consideration to what makes a good therapeutic relationship must also attend to the view that the 'ideal' therapeutic relationship may actually be a variation of good interpersonal relationships in general (Fiedler, 1950).

Nethertheless, when focusing on the discussion regarding commonality in PDRs, it is also important to consider the extent to which findings are dependent upon the communication of commonality, either directly or through observable characteristics. This emphasises the role of self-disclosure in clinical work, for which there appears to be increasing interest (Bridges, 2001; Weinshel and Renik, 1996; Bussch, 1998; Pizar, 1997; Gold, 1999; Marcus, 1998). This will now be considered.

Whilst most therapists engage in some form of self disclosure, decisions to share feelings and personal views remains a complex area in clinical practice (Bridges, 2001). Many argue that therapists disclose whether or not they intend to, and others not only emphasise the centrality of the therapist's subjectivity but consider disclosure to be essential (Bridges, 2001). It is, for example, considered by some that intentional disclosure opens up new possibilities for deeply personal and transforming discussion that can advance developmental and relational therapeutic aims (Cooper, 1998a, 1998b; Ehrenberg, 1995). Others, however, suggest disclosure should be avoided if possible to prevent the subtle manipulation of the client or the process of therapy being threatened by the interference of the client's fantasy elaborations (Abend, 1982; DeWald, 1990; Lasky, 1990).

Nevertheless, on a broad level it is agreed that any therapist disclosure needs to be monitored and accompanied by continual assessment by the therapist and there should be an avoidance of any excessive disclosure, or disclosure shifting focus away from the client. Additionally, it is discussed how therapists must engage in a process of self scrutiny in association with disclosure, to allow a full understanding of their own interests and influences on the clinical process (Raines, 1996; Cooper, 1998b, Goldstein, 1994). It is considered how such literature may hold relevance for the parent-trainee during CAMHS training in relation to the parent self due to a shared identity

these individuals hold with the clinical population for which they are working (i.e. parents accessing CAMHS).

It is now important to consider the impact that professional learning may have on a parent-trainee's interpretation of their own experience, and conversely how their personal experience may influence thought and subsequent practice in the context of clinical psychology training.

### *Implications of Learning and Experience in Parent Dual Roles*

Access to parenting knowledge for the average family may be initiated through supportive networks or local community services on a customer/service-user model. However, for parent-trainees, exposure to developmental and parenting information may well be more theoretical in nature, accessed through professional rather than personal need and may often be discussed and critiqued amongst peers. Such material is also likely to be regularly accessed, revised as new evidence emerges and in need of adjustment from the individual before it is delivered to those approaching services. Whilst for the non-parent-trainee CAMHS teaching may provide their first explicit exposure to consideration of parenting issues, the parent-trainee's personal experience of occupying a parental role may initiate a process of re-consideration of pre-established beliefs and practices related to the parenting role.

Although not in the context of training, Doe and Savidge (2003) discuss the implications of occupying a PDR when working in CAMHS. They highlight, for example, how PDRs often provide clinicians with different perspectives on textbook material, facilitate a deeper understanding of psychological processes (e.g. attachment, containment), increase empathy for parents and reduce the likelihood that "childish behaviours" (Doe and Savidge, p.19) will be classified as pathological. They also consider how certain psychological concepts (e.g. 'good enough parenting') can become particularly helpful to the parent clinician if their own experience allows them to understand first hand the difficulties in getting it 'right' every time. Whilst Doe and Savidge (2003) also suggest that CAMHS clinicians with PDRs can enhance their commitment to the welfare of

children and intensify the desire to enable change if their own child is viewed to be at risk from a similar threat, they do consider how the absence of a PDR can help therapists retain a "useful distance" (Doe and Savidge, 2003, p.19) from the difficulties faced by families accessing services; particularly relevant as parent therapists may have increased risk of over-identification with clinical material. In addition, Doe and Savidge (2003) suggest that colleagues may perceive children of CAMHS workers to be immune from disorders, but in their article they query whether any evidence exists to suggest that these children are more or less adjusted than their peers. When considering the views put across within this article, it is important to consider the individual position of the authors in relation to the subject matter and their parental status and the relevance this may have when looking at the experiences of the parent-trainee.

An alternative perspective regarding the experience of a PDR and increased theoretical knowledge is discussed with Dr Tanya Byron, a renowned child clinical psychologist (O'Brien, 2005). She discusses her experiences of being a child psychologist and the relationship that this has with her mothering role. Dr Byron does not consider her background to make her a better parent, as she believes one's professional knowledge cannot prevent logical sense from becoming blurred by the emotional attachment that they have with their own children.

Whilst this provides one perspective, it is important to consider that this article was written for media interest. Additionally, Dr Byron is an experienced clinician who may have had opportunity to process and make sense of her experiences of occupying a PDR. This maybe unlikely for those occupying PDRs during clinical training.  Tan and Campion (2007) discuss how increased awareness or learning about difference can affect the way individuals view and interpret their own experience. Consequently, trainees may be left with the sense that there is a "right way of being" (Tan and Campion, 2007, p 13) which may impinge on parenting practices of parent-trainees.

A written debate (Davies and Goldbart, 2004) looks specifically at the influence that being a parent and a clinician working with children (i.e. a PDR) may have for both clinical work and ~~also~~ the parenting role. Whilst Goldbart (2004) believes her own parenting experience benefits her theoretical knowledge, by providing a 'critical lens' to reconsider and reflect on theory, the alternative perspective in the debate (Davies, 2004) identifies the professional role as having the greater influence over one's personal issues associated with parenting. Davies (2004) discusses how a professional insight can have a 'substantial role' in establishing the needs of one's own children by preventing vast misjudgement of the child's ability. It should be noted however these are also the opinions of what appear to be the experienced occupiers of PDRs. However, for the trainee occupying a PDR, it is considered how the context of training may influence the extent to which these opinions are adopted.

Research by Lucock et al (2006) found that both qualified and trainee clinical psychologists rated supervision, clinical formulation, client characteristics and client feedback as influential in their practice. However, trainee clinical psychologists were far less likely than qualified psychologists to report intuition as influential. In addition, this research highlighted that, whilst trainees did not rate evidence-based practice as more influential (perhaps surprisingly given the emphasis of research and evidence-based aspects of training) they did rate their professional training and clinical supervision as highly influential and significantly higher than their qualified counterparts. It should also be noted however 'intuition' is subjective and the authors identify a limited consideration of the complexity of therapy situations. Lucock et al (2006) identify how this study reinforces the need to evaluate the effectiveness of training, clinical supervision and personal therapy.

All of the above literature may provide insight into some of the potential issues that may be relevant when considering parent-trainees' experiences of CAMHS training. The following section of the review will go on to summarise what has been discussed and consider the implications for further research.

**Summary and Implications for Further Research**

Despite being given little consideration, PDRs appear to present an important focus for clinical psychology research. Available literature highlights the significance that personal characteristics and roles of a therapist may have for the experience within the therapeutic environment and how, sometimes, experience is significantly affected due to conflict occurring between the personal and professional self. In addition, literature on clinical psychology training identifies training to be a complex process (Hall and Llellwyn, 2006) that requires a significant level of psychological adjustment of the individual (e.g. Kuyken et al., 1998; Brooks et al., 1988; Schwebel and Coster, 1998).

Despite substantial interest in the relationship between the personal and professional self of the psychologist (e.g. Pipes et al., 2005), and the researcher (e.g. Griffith, 1998; O'Connor and Madge, 2001), little attention within clinical psychology is given directly to PDRs in either qualified or training contexts. This is significant since training is acknowledged as a 'formative period' (Kuyken et al., 2003) that will not only influence clinical practice during this time but also well into, and possibly throughout, the career of any individual psychologist (Lucock et al., 2006; Kuyken et al, 2000; Sherman, 1996).

The review of literature specific to the occupancy of the PDR during clinical psychology training therefore highlights many limitations. Much of it is from a non-UK perspective and/or maternally-biased, focused on the ethical dilemmas of dual roles, commentary in nature or drawn from professional fields other than clinical psychology (e.g. family therapy). In addition, research has often adopted the positivist stance to consider the process of clinical psychology training.

The review of literature therefore highlights the absence of voice for those occupying PDRs during their clinical psychology training and subsequent consideration of the implications that such positions may have. In line with suggestion by Miller (1998), it is therefore hoped that by listening and privileging the personal narratives of those who

occupy a PDR during clinical psychology training it will be possible to gain greater understanding about this phenomenon.

## The Researcher's Position

*"We are not separate from others and therefore do not have the choice to be unaffected"*

<div align="right">(Doane, 2003, p95)</div>

Robust qualitatative research goes hand in hand with the process of reflexivity (Elliott, Fischer and Rennie, 1999). Described as a process in which researchers turn a "critical gaze towards themselves" (Finlay, 2003. p3), reflexivity not only allows the researcher to become aware of his or her own position, but take responsibility to own it and understand the implications that it may have when looking at the experience of others (e.g. Ribbens, 1989; Smith, 1988). This derives from the assumption that researchers can never remain detached and impartial from the work they do and that truly objective perspectives are therefore impossible (e.g. Griffith, 1998; Doane, 2003; Finlay and Gough, 2003).

The practice of reflexivity, defined as *"owning one's own perspective"* (Elliot et al., 1999, p. 221) is drawn on throughout this project to consider the theoretical orientation, personal experience, beliefs and anticipations known to the researcher in advance of the project, in conjunction with those highlighted during the process. This aligns itself with autoethnographical thinking; a phenomenon grounded in postmodern philosophy (Wall, 2006) to support the use of self to meet and explore the culture of another (Pelias, 2003). Such practice does not pretend objectivity or non-bias, but anticipates the inter-subjective experience, residing between subject and object, to be studied whilst acknowledging intertwinement between the researcher, their world and the researcher's experience of the world (Finlay, 2003).

Reflexivity also anticipates locating the researcher's own assumptions and attitudes in respect to the project's focus. This may indicate why particular interpretations have

been made and allow possible alternatives to be considered. Reflective discussion and diary extracts (Appendix 15) help to illuminate the researcher's position throughout the project. To aid transparency, attention to the researcher's personal and epistemological stance (Willig, 2001) is written in the first person.

*Epistemological Statement*

Epistemology is concerned with the theory of knowledge; how it is defined, exists and gained (Willig 2001). Epistemological reflexivity therefore requires a researcher to gain awareness of and reflect on their professional and academic background in order to make sense of where they currently position them self (Willig, 2001). Until undertaking clinical training, my own experience of knowledge building through research was all based within the positivist position. This considers data production and subsequent knowledge to rely on unbiased empirical methods, free from social context and influence of interaction between researcher and participant. However, when introduced to qualitative research during training, and through increased experience of therapeutic intervention, I found increasing connection with the notion of 'epistemological pluralism'. Such position considers there to be multiple, fluid and constantly changing truths (Grbich 2007), each as valid and reliable as the next. This is personally valued alongside the concept of 'constructive alternativism' (Kelly, 1955) which considers that knowledge is never fully developed but advances through the adoption of new perspectives.

By adopting this epistemological stance, positivist or realist positions are rejected in favour of more social constructionist perspectives (e.g. Gergen, 1985) which view knowledge as situational and context specific (i.e. dependent upon the context of time, culture, history and individual meaning). I also align myself with the idea that much of what is known and felt perhaps becomes more real when it is languaged, conceptualised or explored through a form of overt expression.

Although some may consider my theoretical stance to be 'poorly controlled' and 'unscientific', this project will endeavour to actively manage these claims by drawing on

guidelines for qualitative research to help to manage issues associated with credibility (Elliott et al., 1999); discussed  under methodology.

*Personal Statement*

I was born into a white British, middle class family where I was the youngest of four children. Although many anecdotal stories are attached to being the youngest, what isn't so storied about my own experience is how, for much, if not all of my childhood I found myself watching and monitoring those around me. Although quite unknowingly, I sensed the need to adjust my own actions to maintain the equilibrium I had come to find security in. I may have been the youngest, but I carried a responsibility that, on reflection, was far beyond my years.

My sense of responsibility really became apparent following the death of my mother in my teenage years. From that time there was a very real and often explicit effort to parent, or rather to mother the family and act as the glue just as my mother had done... a position attached to enormous responsibility, and not surprisingly a position I was never able to fulfil. Such experience highlighted for me my role within the family and perhaps gave me my first true encounter of what it might be like to parent.

My daughter was born in 2006. It was an experience like no other. Although being a mother felt quite natural, a role that perhaps formally acknowledged my sense of 'the responsible one', it never did or never has allowed me to forget my responsibility and the commitment to my role. It is therefore not surprising that when thrown in the depths of clinical psychology training, a time when the self may be questioned in so many ways, that everything including my maternal role (to a then 16-month-old child) was under the spotlight.

I recall a sense of my parenting role being forced to a forefront during teachings on parenting related issues yet, except with a very dear few, I experienced a silencing of this role within the everyday conversations…such a contrast from the maternity leave I'd

recently left behind. I was one of two parents in my cohort. The other, a friend was soon to be a step-father. Yet, quite knowingly, I drew distinction between us.  My bias regarding the experience of creating and nurturing a child into existence and through every stage of their young life, in my mind, could never be matched by any position other than one of the same.

Whilst evident to varying degrees throughout my training, not until my CAMHS placement did I truly understand the intensity of emotion I carried regarding my experience of being a parent on clinical psychology training. When working directly with parents and/or their children I faced the real challenge of the integration of two relatively new roles and was shocked many times by the intensity of my emotion and the anger I encountered. Yet, I also found myself with little opportunity to talk with other parent-trainees and a sense of isolation within my experience…

Assumptions, born out of my own experience of a PDR in clinical training relate to changes in perceptions of the self as a parent, the self as a clinician, others who are worked with, the process of work and also relationships formed in professional and personal contexts. I consider such shifts may arise from increased knowledge and consideration of parenting and professional issues in comparison to those not occupying PDRs. I also consider how the belonging to a minority group within the clinical trainee population (CHPCCP, 2008) may have significant implications; as my own experience was associated with reduced opportunity to be heard and considered in wider forums of training.

It has been important throughout the research not to presuppose the above assumptions are shared or that my own experience of the PDR will be mirrored in any way by others. My own position and developing PDR script are monitored to allow curiosity and openness to the discovery of the similarities and differences that may present in the stories of others; supported by a reflexive stance and effort to stay close to the participant's own stories.

## Aims

Research examining the process of clinical psychology training and the role of the trainee clinical psychologist remains dominated by an 'outsider' non-trainee perspective. In addition, there is an absence of research and literature considering experience of trainees who occupy a PDR as result of their training experience.

This project therefore aims to gain an 'insider perspective' (Griffith, 1998) of parent-trainees during CAMHS training using qualitative methodology. It is anticipated that Interpretative Phenomenological Analysis (IPA; Smith, 1996a), will allow the researcher to obtain rich descriptive accounts, paying attention to the contradictions, complexity and context of individual experience. Attention will therefore be focused towards exploration of the challenges faced by the target population, their strengths, resources and competencies as well as the positive aspects to occupying a PDR during CAMHS training.

Consequently, the project hopes to develop a narrative for the experience of the parent-trainee undertaking CAMHS training to help increase the awareness of training providers and clinical supervisors for the challenges that may arise in relation to the PDR experience. In addition, the project hopes to highlight potential training areas that may be developed in order to support and strengthen the existing resources of this population.

## Research Question

In consideration of the above aims the research question is:

***What are the experiences of a PDR for the (parent) trainee undertaking CAMHS training?***

# Methodology

The following section identifies thinking behind methodological decisions relating to the development of the interview schedule, participant recruitment, data collection and data analysis. It also aims to demonstrate the study's consideration of credibility issues within the chosen methodology and use of self-reflexivity.

## Qualitative Approaches

Whilst Clinical Psychology has traditionally drawn on the techniques used in quantitative research methods, there has recently been increasing consideration of the use and benefits that qualitative research methods can have in health related research (Mays and Pope, 2003; Elliot et al., 1999). Unlike quantitative methods that are driven by hypothesis testing, qualitative methodology relies on linguistic rather than numerical data to reflect the complexity of an experience or psychological phenomena (Geertz, 1973) and subsequently allows for increased flexibility in the interpretation of results (Barker, Pitstrang and Elliot., 2007). Silverstein et al (2006) discusses how qualitative research is particularly good at enhancing (clinical) practice due to its ability to create rich descriptions of both local contexts and individual subjective experience. This can generate knowledge about the process and outcome of events to help improve current practices. Qualitative research approaches consider it impossible to separate completely one's own perspective (Elliot et al., 1999) and insist therefore that the researcher draw on self-reflexivity to be transparent about bias and monitor for dynamic interaction between researcher and his or her participants (Silverstein et al., 2006).

## Phenomenological Approaches

According to Barker et al (2007) phenomenological approaches provide a systematic method in order to study people's experiences and ways of viewing the world, based on four key assumptions. Firstly, perception is a primary psychological activity that influences what the individual will think, feel and do. Secondly, understanding is the true

end of science in which the goal is to provide explanations of experiences and actions in terms of intention, purposes and meanings. Thirdly, there are multiple perspectives ('epistemological pluralism'), each with its own validity and interest for study and finally, individual perceptions of the world are based on implicit assumptions which phenomenological research tries to make sense of.

## *Interpretative Phenomenological Analysis (IPA)*

Interpretative Phenomenological Analysis (IPA) is a postmodern approach to qualitative research focusing on the individual perception of an event (Smith and Osborn, 2003). It enables the investigator to gain detailed insight into the participant's world in relation to a particular phenomenon by "exploring experience in its own terms" (Smith et al. 2009, p.1).  Such methodology supports researchers' attempts to make sense of the participant trying to make sense of their experience and initiates the phenomenological and interpretative aspects of the approach; resulting in a double hermeneutic process (Smith and Osborn, 2003; 2008).

Selection of IPA methodology for this project results from consideration of the following:

- IPA is suitable for looking in-depth at personal experience.  It utilises a 'double hermeneutic' process (Smith and Osborn, 2003) and incorporates a detailed exploration of the individual's personal experience and perception (phenomenological) with interpretative element. This enables a detailed and flexible examination of individual lived experience. It considers how individuals make sense of and interpret that experience in relation to the self (Eatough and Smith, 2008). This is particularly relevant given the distinct lack of available literature providing subjective, or 'insider' (Griffith, 1998) accounts of clinical psychology training (from a broad perspective or in relation PDRs). The validity of using IPA methodology to draw out subjective experiences to gain greater understanding of the challenges and resources of this particular population is therefore highlighted.

- The main possible alternative methodologies, all considered less suitable for answering the research question, were Grounded Theory, Discourse Analysis and Narrative Analysis. Grounded Theory (Glaser and Strauss, 1967) endeavours to develop the 'truth' using the participant's voice to develop new theories. Such theory does not fit with the researcher's own epistemological stance as it denies the possibility of multiple perspectives, each as valid as the next. Discourse analysis (e.g. Potter and Wetherell, 1987) focuses on the participants' use of discourse and the effects of the positions individuals adopt (Willig, 2008). It attempts to move beyond content and understand what is said as a sample of communication, rather than an individual's thoughts and feelings. This is less relevant for answering a research question looking specifically at the experience of a particular phenomenon. Narrative analysis, like IPA does pay particular attention to the narrative aspect of research data and therefore has close epistemological connections with IPA (Smith, Flowers & Larkin, 2009). However, it was considered that IPA may offer greater opportunity to explore the similarities and differences that lay in the PDR experience whilst paying less attention towards the sequential order of events. Subsequently, IPA was considered the most appropriate method by which to answer the research question.

- Furthermore, IPA methodology is well suited to the researcher's own theoretical stance and is supported with detailed procedural descriptions (Smith, Flowers and Larkin, 2009; Langdridge, 2007; Smith and Osborn, 2008); particularly relevant given the 'newcomer' status of the researcher to qualitative research methods.

**Design**

The project uses qualitative research methodology using semi-structured interview data.

**Ethical Approval**

Full ethical approval for the project was granted from the East of England REC committee. This followed the submission of relevant documents containing details relating to the project aims and methodology.

Ethical approval followed minor amendments being made in relation to the following:

1. Participant information letter and consent forms clarifying details relating to transcription and the use of a peer IPA group (to check for themes) and minor grammatical errors
2. Method of initial contact to participants (via course administrators)
3. Clarification that interview tapes would be destroyed following transcription and verification
4. Identified method for data encryption (prior to anonymisation of transcripts)

Following ethical approval from the East of England REC committee, local Research and Development (R&D) agreement was obtained for the designated geographical localities (defined by NHS Trusts).

A subsequent (minor) amendment was made and approved through the regional ethic committee to enable the researcher to contact potential participants through a coordinator of a group for newly qualified clinical psychologists. This was to aid recruitment if interest in participation was low, however it was not necessary.

 (Appendices 1-2b contain all correspondence regarding ethical approval).

**Ethical Considerations**

The following ethical considerations were identified in relation to the project:

<u>Informed Consent</u>

The project is based on a non-clinical population. Participants were able to give informed consent (Appendix 6) to participate and have their interviews recorded. They were provided with notification of all details relevant to the project's aims, methodology, use of data etc. (Appendix 5).

<u>Confidentiality</u>

Standards of confidentiality within qualitative research can be potentially compromised due to the rich description of individual data (Silverstein et al., 2006). Confidentiality of personal or clinical material given in interview was therefore supported by secure data storage and anonymising of all data. All non-anonymised data was password-protected and at no point was it accessible or heard by unauthorised persons. All potentially identifying material (i.e. signed consent forms, demographic records) was stored securely in a locked cabinet at the researcher's home and destroyed following research completion. Ethical approval was dependent upon the agreement that all recorded interviews would be deleted following transcription and verification of interview transcripts. Transcriptions of interviews were via a recommended source and the signing of a confidentiality agreement (Appendix 12).

Interviews took place within environments where participant and researcher were assured of confidentiality. Disclosure of any information resulting from perceived risk to participant or other was to be discussed with the participant prior to disclosure; as recommended in BPS guidelines (BPS, 2006a).

<u>Potential Distress Arising From Participation</u>

Whilst some consider the process of sharing intimate knowledge through interview therapeutic (Birch and Miller, 2000), sensitive conduct of interviews and ensuring participants understood their right to decline to answer questions helped to avert any potential distress. If necessary, interviews were to be stopped and only continued when and if the participant felt comfortable to do so. Additionally, if needed, interviews were to be terminated to prevent any further distress.

Post-interview debriefing aimed to provide participants with the opportunity to talk about their experiences of the interview process and raise any concerns. This process would allow participants to be directed towards useful contacts (e.g. personal advisors, clinical tutors) if they felt they wanted/needed to talk about their experiences in more depth. However, the project considered that participants were most likely to find the opportunity to talk about their experiences useful. Subsequently, minimal risk through participation was anticipated.

**Recruitment**

Due to the researcher's geographical location and time restrictions, contact with potential participants was made to five UK clinical psychology training programmes known to have approximately 370 trainees employed at any one time.

Following regional and local (i.e. R&D) approval, contact was made with course directors of the five specified programmes through email (Appendix 3a-b). This outlined the project details and requested permission to contact their trainees (current and up to 2 year post-qualification) via the course administrator. Following permission to recruit, a further (introductory) email was sent (Appendix 4) and forwarded by the course administrator to potential participants (i.e. trainees). This included an overview of the project and issues of confidentiality in line with BPS code of conduct (e.g. disclosure of harm to self or others; BPS, 2006a).

Interested individuals were forwarded an information pack (Appendix 5) electronically. This contained further information about participation and the opportunity to discuss the project in more detail. Those who maintained interest were screened according to the inclusion and exclusion criteria (see below). Appropriate participants completed a contact sheet to facilitate arrangements for interviewing (Appendix 5).

It was assumed that participants who requested an information pack without follow up no longer wished to participate. No subsequent contact was initiated.

**Participants**

IPA research depends on the sample being theoretically consistent with the qualitative paradigm (i.e. occupying a PDR during clinical psychology training) and as homogeneous as possible. This allows for patterns of convergence and divergence to emerge and for detailed psychological variability within a group to be examined (Smith et al., 2009; Eatough and Smith, 2008). The following criteria was therefore utilised to screen participants.

*Inclusion criteria:*

➔ (Current)Trainee clinical psychologist or newly qualified clinical psychologist (i.e. 1-2 years post-qualification)
➔ Parent or step-parent to one or more children during CAMHS training
➔ Completed/was completing CAMHS training as a parent
➔ Had children under the age of 16 at the time of completing their CAMHS training (decision made due to the level of commitment needed to the parenting role above this age)

*Exclusion criteria:*

A 'parent-trainee who:

- → Belonged to the same cohort group (University of Hertfordshire) as the principal investigator (due to confidentiality considerations)
- → Had (All) children/child over the age of 16 years at the time of completing their CAMHS training
- → Became a parent following completion of CAMHS training

**Sample Summary**

Recommendations of IPA methodology (Smith and Osborne, 2003; Smith et al., 2009) identify the relatively small number of participants (i.e. 4-10) needed for IPA research. The convenience sample consisted of consenting individuals responding to research contact and meeting inclusion criteria. From an estimated 30 potential participants, a total of fifteen individuals expressed an initial interest in participation. Eight of these however did not match the inclusion criteria (i.e. had not undertaken CAMHS training at the time of recruitment or had children post CAMHS training) and one individual did not respond following receipt of the participant information pack (Appendix 5). This resulted in the remaining six interested participants being recruited. This sample consisted of five female and one male participant. Five individuals classed their ethnic origin as white British and one as white mixed (English/Irish). Participants parented between one and four children ranging from nought to ten years. Five participants were biological parents and one was a step-parent. One individual was single and the remaining five were either married or co-habiting at the times of their CAMHS placement.

Figure 1 provides a summary of participant demographics.

| Participant | Male (M) / Female (F) | Age | Ethnicity | Parent / Step-Parent | Number /Sex of Children | Age of Child/ren | Relationship Status | Professional Status |
|---|---|---|---|---|---|---|---|---|
| Jennie[1] | F | 36 | White Mixed | Parent | 1 (F) | 10 | Single | Current Trainee (Final Year) |
| Sophie | F | 31 | White British | Parent | 1(M) (+1)[2] | 1 | Married | Current Trainee (Final Year) |
| Brook | F | 29 | White British | Parent | 2 (M) | 2<br>4 | Married (currently separated) | Post-Qualified (1 Year) |
| Holly | F | 25 | White British | Step-Parent | 1 (F) | 4 | Co-habiting /married | Current Trainee (Final Year) |
| Ben | M | 30 | White British | Parent | 4(F) | 4<br>5<br>7 (2) | Married | Post-Qualified (1Year) |
| Elizabeth | F | 36 | White Mixed | Parent | 1 (F) | 9 | Co-habiting / now married | Post-Qualified (2 months) |

*Figure 1*

**Data Collection**

Coar and Sim (2006) discuss the influential nature of the researcher's identity and potential implications that holding an 'insider' role may have on the processes and outcomes of qualitative interviews completed on a peer group.  Consequently, the process of data collection gave considerable attention towards the different methodological implications of the researcher's own position (identified in reflexivity sections contained within this project). Thus concerns identified by Coar and Sim (2006) have been considered throughout the process of data collection and analysis where possible.

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[1] *All names used are alias to protect confidentiality*

[2] *Denotes pregnancy*

**Interviews**

Qualitative interviews can play a key role in helping individuals narrate their stories Barker et al (2007). Such processes allow the researcher to elicit specific thoughts and feelings associated with target phenomenon and retain intimate focus on a person's unique experience (as required for the study's research question). In IPA studies, semi-structured interviews are considered an optimum method for data collection. They allow the researcher to facilitate a comfortable interaction that enables participants to provide a detailed account of the experience under investigation (Smith et al, 2009; Smith and Osborne, 2008). They are used in the majority of IPA studies and were considered appropriate to answer the research question in this project.

*Development of Interview Schedule*

Initially, relevant available literature, guidance from research supervisors and the researcher's own experience were drawn on to identify appropriate areas of enquiry, thus potential interview questions. Andersson, Troein and Lindberg (2001) identify how one may experience 'conceptual blindness' when interviewing one's peers about a topic in which personal experience is held, due to one's own pre-conceptions about the subject. Therefore, in line with published guidance on developing appropriate interview plans for IPA research (see Smith et al, 2009) broad, open ended questions were utilised for all questions. It was hoped that this would help reduce opportunity for assumption to be made about an individual's experiences or concerns, or the participant being lead towards particular answers. External guidance regarding the structure and content of individual questions was also sought in research supervision to prevent personal bias in data collection.

The initial draft of the interview included broad interview questions focused around the participant's journey of becoming a parent, the experience of being on clinical training as a parent, the possible implications of holding a PDR from a professional and personal perspective and the potential difficulties experienced whilst occupying a PDR.

*Piloting the Interview*

The interview schedule was piloted several times to facilitate its development and rehearsal. Initially, it was piloted on the researcher herself (by a colleague with some familiarity of IPA methodology). This allowed the researcher to gain a personal experience of the interview schedule and also of the experience of sharing information via the interview format. This resulted in a number of amendments being made to the interview schedule and increased consideration given to the application of the interview. The revised interview schedule included additional introductory questions to facilitate participant rapport and generate a more gradual introduction into discussion relevant to the research phenomena and a specific question to draw out potential clinical implications of occupying a PDR.

A revised interview schedule was subsequently piloted by the researcher on a qualified psychologist working in a CAMHS setting (who occupied a PDR) and also on a fellow parent-trainee who had occupied a PDR during training. These interviews provided opportunities for further rehearsal of the interview procedure and timing and to gain insight regarding the schedule's ability to access information relevant to the research question. This process highlighted the importance of participant rapport to aid disclosure and detailed exploration of the individual experience and meaning-making of the PDR. It was subsequently considered how such process may also be supported through the pre-interview briefing as this may allow additional background and contextual information to be collected (to help provide context to responses) and opportunity to acknowledge the emotion that may be attached to parenting related issues. Interview pilots also demonstrated the value of incorporating additional (specific) prompts/probes to encourage fuller, deeper participant reflection on experience and the opportunity to practice the use of these.

*Interview Process*

Execution of interviews

Interviews were conducted at sites identified by participants. Two participants requested interviews in work settings and four requested domestic settings. Each interview lasted 60-90 minutes and was followed by post-interview debriefing and discussion. Andersson et al. (2001) discuss how the interviewer's own pre-conceptions (i.e. feelings and opinions about the subject area) may initiate a sense of conceptual blindness that influences or governs the dialogue and interpretation. The interview schedule (Appendix 9) was therefore to be used flexibly in order to encourage participants to tell their story and the experiences of a PDR without assumption or influence from the researcher. This process also provided the researcher with the freedom and flexibility to explore novel and unexpected issues, as and when they arose (Smith and Osborn, 2008).

The importance of the relationship between the participant and the researcher (Miller, 1998) and the ability of the participant to place the researcher (Edwards, 1993; Finch, 1993) meant that the participants were made aware of the researcher's peer status, but were informed that they would be able to ask questions about the researcher's position post interview if they chose to.

Pre-Interview

Interviews followed the completion of the screening measure (Appendix 7) and pre-interviewing briefing schedule (Appendix 8). This helped to establish participant rapport and gain relevant demographic and contextual information [i.e. details relating to the participant's children (number/ages), ethnic origin, relationships status, age and professional status (i.e. qualified/trainee)]. Some authors highlight how the interviewer's position, if known to participants, may assume professional scrutiny and/or assumption that the phenomenon is understood by the researcher. They also highlight how perceiving an interviewer as an 'expert' may initiate increased defensiveness, caution to sharing one's 'true' experience (Coar and Sims, 2006; Platt, 1981) and a desire to please or react against the interviewer (Robson, 1993). It was therefore decided that,

prior to interviews, participants were to be informed of the rationale for discussing the researcher's own position post-interview if they opted to (i.e. reduce researcher bias).

<u>Post Interview (1) – With Participants</u>

Immediately following the interview a de-briefing process took place. Considering the importance of the relationship between the participant and the researcher (Miller, 1998) interviewees were provided with opportunity to ask questions about the researcher's own position and experience relevant to the project. They were also asked if they had any outstanding questions or issues that were raised during the interview which they considered needed addressing. During this process, all participants were asked for feedback on the interview process and recommendations for its improvement (Appendix 10).

<u>Post Interview (2) – Without Participants</u>

Post- interview, the researcher completed personal reflections of each interview (i.e. consideration about what worked well, the strengths and weaknesses of the interview and the way in which it was conducted) (Appendix 11) and supervisor feedback was received following their reading of anonymised transcripts (of earlier interviews).

Validity of qualitative interview methods is not considered to be affected if it is modified 'mid-stream' (Barker et al., 2007). Subsequently, it was possible to review and modify the interview process between interviews based on participant feedback, supervisor feedback and personal reflections. Change to the interview process, derived from feedback, resulted in more 'in-depth' questioning of the specific experiences and associated emotions of the participants; essential to the IPA research paradigm. Subsequent reflections of the interview process were drawn from listening to a replay of each interview within the week following the interview and the recording of additional observations or comments.

**Reflections on the interview process**

During interviewing I witnessed firsthand IPA's ability to not only invite another's experience to be heard, but to command respect for a position that can never be occupied by the self. I was surprised by my 'surprise' for the things I had not anticipated hearing and considered it a privilege to listen and give voice to unique experience. As the interviews progressed I observed a sense of connection to the stories told and became increasingly aware of a rising passion for my research and the information shared.

Participants demonstrated much deliberation about their PDR experiences and a questioning of the self was evident. I noted a sense of unspoken personal vulnerability and a significant emphasis on supportive others and internal conflict. However, I was also alerted to a sense of power attached to the PDR and noted with interest that, at the time of interview, five participants were working in specialist CAMHS from choice.

Participants appeared to value the opportunity to be interviewed which they expressed directly and indirectly (i.e. through willingness to share their experience and often intimate personal knowledge). However, I was also aware that each participant seemed to hold responsibility regarding the quality of information they shared and a sense of frustration at not always being able to articulate their experiences as they wished. Whilst this process bore witness to the *in-action* processing (Schön, 1983) during interview, it also highlighted the rawness and richness of the experiences being discussed.

(Appendix 15 contains further reflections).

**Data Analysis**

The process of data analysis was informed by guidelines for ensuring quality in qualitative research (Elliot et al., 1999), supervision from experienced IPA researchers and discussion with fellow trainees undertaking other IPA research projects.

*Data Familiarity*

Due to time constraints assigned to the project, transcribing of the interviews was forwarded to an external source. As Smith and Osborn (2003; 2008) recommend familiarity of data, the researcher listened to audio recordings within a week of each interview and then again at least once following transcription. During the second listening of each interview the transcript was read to ensure its accuracy and facilitate anonymisation (i.e. the removal of all names, place names and other identifying details). This process also prompted attention of significant non-verbal behaviour such as laughter and noticeably long pauses (Smith and Dunworth, 2003) that may be relevant when interpreting the individual experience.

*Analytic Process*

Data was analysed using IPA techniques and suggested guidance (Smith et al, 2009; Smith, 2003). This identifies the need for transcripts to be analysed on a case-by-case basis to help the researcher remain open to new issues emerging, divergences in data, and convergences with analysis of previous cases (Smith and Osborn, 2003; 2008). Data was later examined collectively to draw out subordinate and superordinate themes for the data set to form the narrative framework (Elliot et al., 1999) to answer the research question. The following description of analysis was therefore repeated for each transcript in its entirety before attending to a subsequent transcript.[3]

*Initial Note-Making*

After listening to an individual transcript, it was re-read and an idiographic approach (Smith et al., 2009) was adopted. This implies that one moves from the specific to the general in order to gain a comprehensive picture of the experience in question. Initially, the transcript was read in small sections until gradually it was considered in its entirety

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[3] Appendix 16 includes a one full interview transcript for the purpose of examination. This will be removed following examination to protect the anoyminity of the participant).

for the interpretation of the experience as a whole. Within this process written comments were added to each section of a transcript. This highlighted any observed connections, preliminary interpretations and contradictions drawn from words, phrases or sections within the transcript (underlined) that were phemonological in nature (i.e. based on a detailed observation of an individual's personal experience and perception; Smith and Osborn, 2003). Initial comments were classified as either 'Descriptive' (marked 'D') or 'Linguistic' (marked 'L').

*Conceptual Commentary*

At the end of each section of transcript, additional comments or queries raised by the data were added to initial linguistic and descriptive comments; all of which were then re-considered from a broader perspective. This helped to identify the conceptual aspects of what was being communicated by phrases capturing the essence of the quote; demonstrated through descriptive language or (indirectly) through the language structure. In working through the entire transcript, previous conceptual notes were reviewed in the context of the broader interview to retain the credibility of comments. When appropriate, earlier (conceptual) comments were amended. As with descriptive and linguistic commentary, conceptual comments were written under the initial notes column, in bold font.

This process was more interpretative in nature than the initial commentary and implied that the researcher attempted to make sense of the participant's world through a process of interpretative activity (Smith and Osborn, 2003). This was supported by the researcher drawing on personal theoretical and psychological knowledge in addition to her own interpretative resources to make sense of what was being communicated by the participant. To promote credibility of this process, any interpretative commentary was subsequently checked against what was actually said in the transcript.

*Emergent Themes*

Following the above process, initial and conceptual commentary was revisited to allow comments with the same or similar themes to be grouped together to form 'Emergent

themes'. This process occurred in chronological order. Where identified themes did not fit into existing emergent themes, an existing theme was revised to incorporate the new idea or a new theme was created to capture the essence of the newly identified idea.

*Clustering Emergent Themes into Subgroups*

Emergent themes were subsequently collapsed and clustered into subgroups with other similar themes; identifiable through a collective theme which captured the essence of all the themes contained within the subgroup. The subgroup was subsequently given a title that aimed to capture each of themes it contained.

Following the formation of the subgroups, the classification (i.e. title) of the subgroup was checked against its relevance to each (emergent) theme contained within the subgroup.  Any initial emerging themes that did not fit with the overall topic of a subgroup led to revision being made to either the title of the subgroup (to incorporate the stray theme) or the removal of that theme into a better matched subgroup.  To retain credibility, any changes to the names of themes or subgroups were subsequently checked against the original words in the transcript.  (Each transcript generated 3-5 subgroups).

*Patterns Across Cases*

IPA analysis follows an 'iterative and inductive cycle' that moves from the particular to the shared (Smith and Osborn, 2008). Following the analysis of individual transcripts a list of the themes (from across all interviews) was constructed (Appendix 14). This expanded the focus of the analysis to help identify connections and patterns in themes across the cases. Subgroups (for each transcript) were then reorganised into overarching superordinate themes covering the entire data set. These provided a

framework for understanding the parent-trainee's experience of the PDR, as recommended for robust qualitative research (Elliot et al, 1999). Individual transcripts were reviewed with consideration of the newly devised superordinate themes to check for the validity of themes.

**Quality of Data Interpretation**

Standard methods for ensuring credibility in quantitative data are not suitable for qualitative research (Barker et al, 2007). Therefore, over time credibility, transferability, dependability and confirmability of qualitative research has resulted in various formulations being proposed (e.g. Lincoln and Guba, 1985; Packer and Addison, 1989; Stiles, 1993).  Due to consideration of their systematic development and suitability for research in the field of clinical psychology (Barker et al., 2002) this research follows guidelines proposed by Elliot et al (1999).

Smith and Osborn (2003) discuss the significance of being iterative and maintaining close interaction between reader and text. This identifies the need for various checks throughout analysis to ensure that the revision and clustering of themes and subgroups did not stray from the content of the original transcript. Therefore, in accordance with guidelines for qualitative research (Elliot et al., 1999) *sections of anonymised transcripts* containing the researcher's initial commentary and emergent themes were provided to the research supervisor and peer IPA researchers. Individuals were asked whether they felt that the themes were plausible and whether they could track the process of analysis to the emergent theme derived by the researcher. Where query arose regarding derived themes, themes were reviewed and subsequently re-checked. This allowed the process of analysis to be audited. The primary research supervisor also audited the process of analysis by checking the credibility of each theme derived from a complete anonymised transcript of a participant unknown to them (a measure of confidentiality).

Furthermore, to enhance credibility of data analysis, the researcher has included opportunity to follow the process of analysis in an Audit Trail of one interview (Appendix 13a-13b) and view the superordinate themes for all six interviews (Appendix 14). This is

used in addition to the use of accounts of self-reflexivity which have been provided to aid transparency about the researcher's motivation and to help the reader locate the researcher's own position in the context of the project.

## *Results*

The following section will present the findings of an Interpretative Phenomenological Analysis (IPA) of the experience of six parent-trainees who have occupied a PDR whilst completing clinical psychology training.  IPA (Smith, 1996a, 2004; Smith, Jarman and Osborn, 1999; Smith and Osborn, 2008; Smith et al., 2009) was used to develop detailed accounts of the lived experience of parent-trainees undertaking CAMHS training and their attempts to make sense of this experience.

The use of credibility checks, as suggested by Elliot et al. (1999), ensure that identified themes are credible (i.e. that they can be tracked and make sense to those other than the primary researcher). However, it is acknowledged that the following account as with all scientific investigation remains both partial and subjective. IPA's double hermeneutic cycle implies other researchers, based on their own perspective, may have highlighted different themes associated with the PDR (Smith et al., 2009, Elliot et al., 1999). IPA also acknowledges that there may often be overlap between themes and the mapping of themes and how they fit together may differ from analyst to analyst (Smith et al., 2009). In addition, the identified themes do not cover every issue or aspect associated with the PDR experience, but have been selected due to their salience in answering the research question. The three superordinate themes developed to understand how parent-trainees understood their own experiences of occupying a PDR whilst undertaking CAMHS training are:

- ***A Changed Identity: Seeing and Being Seen in a Different Light***

- ***A Journey From Dependency Towards Autonomy***

- ***Cutting the Cord Doesn't Destroy the Bond: The Inseparable Nature of the Parental and Professional Self***

Each theme will be explored in detail and illustrated with verbatim accounts provided by participants.  To enhance readability quotes have been adapted. Repeated words, minor hesitations and words such as 'umm' have been omitted, and  '[…]' is used to indicate the continuation of, or deleted text for readability. Where words have not been said, but can be inferred by earlier text or the wider context of what is being communicated, additional material may be included in square brackets [ ] to increase readability.  All identifying information has been deleted and names included are aliases.

Figure 2 provides an overview of the main themes derived from the data.

| Superordinate Themes | Subordinate Themes |
|---|---|
| *A changed identity: seeing and being seen in a different light* | *A question of credibility* |
| | *Owning exclusive toolbox* |
| | *Parental Allies: forging unique connections* |
| *A journey from dependency towards autonomy* | *Killing off the mother in me: neglect through lack of validation* |
| | *A shortcut  to recognition: the importance of shared experience* |
| | *Needing room to grow: the significance of external context* |
| | *Learning to negotiate the complexities of the PDR* |
| *Cutting the cord doesn't destroy the bond: The Inseparable Nature of the Parental and Professional Self* | *The rollercoaster ride of increased parental awareness* |
| | *Seeing an all too familiar face in the therapy room* |

*Figure 2: Table of Research Themes*

The following discussion endeavors to highlight the various experiences reflected across the data set, alongside the similarities and differences indicated between individuals. The first theme to be discussed relates to the identity of the parent-trainee undertaking CAMHS training.

### 1. A Changed Identity: Seeing and Being Seen in a Different Light

*I think absolutely that [being a parent] influenced you know how people were to me and also you know I guess it influences how I am...*

*Jennie*

*Overview*

All participants described a changed identity in the professional role during CAMHS training due to the simultaneous occupancy of a parent role. Such change seemed to be associated with differences in the way that individuals viewed themselves as a professional working in CAMHS settings and also the consideration that others (i.e. colleagues, supervisors and peers) saw them in a different light to non-parents. Participants generally found the experience to be strongly associated with altered and often improved relationships with others within CAMHS settings. However for some, changes in how they were perceived were associated with the assumed ability that they would be better equipped to work in CAMHS than non-parents.

### 1.1. A Question of Credibility

*[I'm] much more comfortable speaking to families than I had done before. And definitely, more credible as a therapist to them cos I was a parent*

*Sophie*

The first subtheme relates to how parent-trainees perceived themselves within their PDR and the question of how credible they personally felt as a CAMHS therapist during training. By drawing on what their experience was or may have been if they were not a parent and making comparisons with perceived experiences of non-parent clinicians

(i.e. peers or colleagues), all participants reported to have, at some point, experienced a sense of ease, or increased confidence within their professional role in CAMHS. Such experience was often associated with a sense that the parenting self meant that they were able to understand the broader perspective of the presenting issues and relate differently to those (parents, children and colleagues) with whom they worked. Sophie refers to the parental self as a 'qualification' and in the following quote makes uses of the term 'in my stride' to highlight a sense of ease initiated by her familiarity with families since having her own.

> *[Being a parent has] helped me to take things in my stride a little bit more [...] I think less nerve-wracking cos it's like this is a family and I know about families, I've got one of my own...*
>
> <div align="right">*Sophie*</div>

As represented in number of accounts, Brook's sense of credibility came from her perception that her mothering role enhanced her ability to relate to children.

> *Empowering I think, helpful...because it's nothing like being a mother to know how to relate to children in a way...I feel a lot more confident...*
>
> <div align="right">*Brook*</div>

Elizabeth demonstrated how despite feeling that her trainee role may have held her back in some way from obtaining true credibility, her parental self offered some protection from this experience by adding to her credibility status.

> *...even though we're trainees [...] it's kind of like I know I'm a trainee and I know that I still need to think about you know the models I'm using and formulation and you know that kind of stuff, I actually feel [...] more confident doing it because I have a child and you know and, although all children are different, you just feel that you have something there, you have an advantage...*
>
> <div align="right">*Elizabeth*</div>

However for Holly, the question of credibility was a complex experience entwined with conflict. Whilst she demonstrated a clear desire to be identified as a parent the following quote highlights her difficulty encapsulating her experience of being a step-parent during CAMHS training. She seemed to experience increased confidence due to her parenting role and attempted to distinguish herself from non-parents but also demonstrated extreme discomfort aligning herself with biological parents. Holly's experience appeared to lead to awareness that others, including herself, do not place her in the same category as biological parents. This seemed to reduce her overall perceived credibility.

> *...just personally I feel a bit more confident than I might have done if I hadn't have, if my life hadn't had taken this path...confident in knowing what I'm doing [...] confidence in my abilities [...], but I feel a little bit more like I've got a right to [silence - sighs] like I know what I'm talking about a little bit more, than I would have if I didn't have [step-daughter]...*
>
> *Holly*

For Jennie, reference to not being able to imagine working in a CAMHS setting and not being a parent highlights that the absence of a parental role, for her, almost removes one's credibility in CAMHS.

> *...I couldn't imagine working in that setting not being a parent...*
>
> *Jennie*

Overall, the experience of credibility appears to be strongly associated with how each participant felt that they were perceived by others. Both Sophie, who became a mother following her first CAMHS placement and Holly, experienced feeling more credible due to the sense that others also perceived them as credible due to parenting experience.

*...so I think it's nice, I don't know if I just feel a bit more respected and that my views might count a little bit more because I've been there, I've been through it...*

*Holly*

The question of credibility presented in Ben's perception of his professional role appeared to differ significantly across his two CAMHS placements. In relation to his first placement he described feeling like a fraud due to conflict about not practicing (at home) what he was 'preaching' in his professional role. However, such discord appeared to lessen with time. Whilst Ben's pause in speech and use of the words 'bit more' may indicate that a degree of hesitation remained, he demonstrated increased confidence in CAMHS training due to his parental role providing him with 'something worthwhile' to give.

*...quite empowering...it made me feel a bit more, certainly by the third year [laughs] more [pause] it gave me a sense of being responsible of expertise, that I had something worthwhile to give that wasn't just about knowledge and textbooks*

*Ben*

For Ben, however, the PDR also brought up the question of credibility in relation to his parenting self. He described feeling anxious about his parenting self being placed under the spotlight when first coming into training.

*I knew the course was gonna ask questions I understand that, I was slightly apprehensive about what I'd find out about my parenting skills [laughs] that I'd be doing everything wrong and I was somewhat aware of that and was kind of waiting for that [...] anxious about how much would be wrong*

*Ben*

Although Ben later describes such anxieties not being realised, an ongoing sense that he should be a better parent due to his psychologist's role is demonstrated. The quote below highlights his experience of bringing his children into the training environment for a child development day. Ben demonstrated a defensive stance and his laughter might indicate a sense of discomfort at his experience.

> *I'd kind of go oh my kid didn't get that…kind of almost want to make an excuse for them not having theory of mind…wanting to hold back the urge to give my kids the answers, or explain things differently to them [laughs]…*
>
> *Ben*

The majority of participants also recognised feelings of credibility to be, in part, related to their perceived change in their own status within professional relationships. Such experience was often associated with contact with a supervisor or colleagues who also seemed to associate parental status with increased credibility. Here, Brook describes how her experience of having a shared experience of a parental role with her supervisor seemed to flatten the professional hierarchy.

> *I think even though you're a trainee you'll, I think they feel maybe more on a level with you on that. So even though they're the expert in terms of clinical work equal grounding in other ways that they can relate to you...*
>
> *Brook*

Brook and other participants also describe how their own parental role meant they felt increasingly accepted and part of the team which, in turn, increased their sense of credibility within the CAMHS setting.

*...all the other psychologists are mothers too and it's like you're in, yeah, it [pause] yeah I just think it gives me confidence and, and an increased sort of skill base I suppose from that being a mother as well as being or, having experience of working with children...*

*Brook*

The next subtheme to be considered under a changed identity relates to the participants' skills in CAMHS training.

## 1.2. *Owning Exclusive Therapeutic Toolbox*

All participants felt their parenting role brought transferable knowledge, experience and skills to their professional role in CAMHS training. Consequently, the theme 'owning an exclusive therapeutic toolbox' encapsulates the experience of feeling able to bring a valued resource into the professional CAMHS role, portable from lived parental experience and therefore exclusive to parents.

For some interviewees the value of parental experience related to the ability to consider the broader perspective of clinical material due to a sense of having one's own experience to draw on. In the following quote Sophie's use of the word 'real' demonstrates how her parenting role has transformed her awareness from purely intellectual to a more felt sense.

*Just your awareness of systemic issues is much more real…*

*Sophie*

Brook, along with other participants, considered her parenting experience made her less naive about CAMHS work due to consideration of the broader context, which can not be 'completely' understood by a non-parent.

*...I think I, before you have a baby you're quite naive about it all and I think you can sometimes have that supernanny thought of oh well if you say no, they'll not do it, yeah right [laughs][…] you can all be very black and white about it all without quite understanding well actually the other factors are you haven't slept for six months, you're this, your that...I don't think you can completely before you're a parent understand the context of certain problems...*

<div align="right">

*Brook*

</div>

Similar to Brook, Holly's lived experience also resulted in her feeling that she was more realistic when working with clients. This created a sense of increased flexibility for her in her clinical role.

*It's made me more aware of the difficulties [...] Whereas previously I might have been a bit like well I don't really understand why dad can't do this or why mum can't do that. Whereas now I might be a little bit more flexible in my thinking and in my practise...*

<div align="right">

*Holly*

</div>

The participants' ability to relate to others differently from a non-parent provided another therapeutic tool. The following quote demonstrates Brook's sense that her ability to relate to children was a natural, as opposed to a forged skill (like that of the non-parent) and the 'advantage' this provided within clinical work.

*I just think you feel a slight advantage in being able to relate to children...once you've got children.  On a more natural level and you see that even when you like see people trying to talk to your three-year-old that aren't parents...*

<div align="right">

*Brook*

</div>

Other participants also identified the ability to transfer skills from the parenting self into professional work as an advantage, which Holly denoted as a 'bit of a leg up'. Holly made use of her parenting experience as a reference point when working in CAMHS. In

the following quote she highlights various areas in which her confidence in her CAMHS work has increased, although it should be noted that her reference to 'younger children' indicates how she perceives her parental experience may be limited when working with older children.

> *...you know developmental histories, more confident in play, like a play basis assessment I felt more confident talking to younger children [...] I had to do an initial assessment on a six-year-old girl and I knew what she might be interested in because I know what [step-daughter]'s interested in. So I was able to use [it] like reference, frames of reference. Like with you know TV shows and you know films that have just come out at the cinema...*
>
> *Holly*

Holly's therapeutic toolbox also appeared to be influenced by the practical benefits of having a child at home when it came to her professional practice. Despite her laughter indicating possible embarrassment, confidence within her clinical role appears to relate in part to her ability to utilise the parental role to rehearse clinical skills.

> *...she's been helpful in that I've been able to come, bring some of the tests, the neuropsychs home and practise them on her [laughs], that's been helpful...*
>
> *Holly*

Other participants also highlighted experience of being able to draw on knowledge of children, obtained through their own personal parenting, to work more effectively with professional cases. Ben felt his parenting experience provided a resource to enable him to 'join' with others and understand relevant terminology.

> *an ability to join successfully with kids and parents and kind of go yeah I know what you mean [...] more of an understanding of their experience of what they might have gone through or stages they've gone through and you know if you're doing an early history and somebody's talking about stages of pregnancy, or*

*what kind of the birth was like [...] I wasn't wondering about what the terms were...*

*Ben*

Some of the participants also found their parenting experience provided a platform from which to challenge theoretical concepts and teaching associated with CAMHS work in a different way from non-parents. There is sense that personal experience of parenting created a feeling of empowerment to consider information from different perspectives. In the following quote Sophie belittles behavioural interventions, and makes reference to the theory not considering the 'so many other issues' that she as a parent can.

*Behavioural interventions...it seems like such bread and butter stuff...and actually [whispering] it's such a load of rubbish [laughs]...there's so many other issues...when you're a parent you realise that it's all about a healthy balance...nothing really in psychological theory that says that...*

*Sophie*

Similarly, Ben's choice of the words 'regimented' and 'alien' in the following quote highlight his own perspective of a particular approach to working in CAMHS. Whilst demonstrating some questioning of personal 'expertise' he reverts to considering the credibility of techniques by drawing on personal experience.

*it did feel a bit regimented and it's not really about that, it wasn't really about relationships, so it did feel slightly alien to what home life was like…and I guess it always made me doubt whenever I was trying to prescribe something to a parent...I'd be anxious and doubtful of my expertise…or that it was going to wor[k]…a bit like a charlatan cos I kind of think if I tried that at home that wouldn't work...*

*Ben*

### 1.3.   Parental Allies: Forging Unique Connections

This subtheme relates to the self perception of the parent-trainee, but focuses specifically on how these individuals believed they were perceived and subsequently able to relate to others. By reflecting on the relationships formed during CAMHS training, all participants reported to have experienced a sense of unique and often instant connections being made with the other parents with whom they worked (clients and colleagues) as a result of their shared experience of a parental role. Such connections were often associated with the use of disclosure of the parental self which seemed to prompt stronger relationships, which were formed with increased ease. Parent-trainees believed such connections related to their ability to demonstrate increased understanding for issues relevant to those with whom they worked.

Sophie draws on the position of herself as a client to express the difference that she considers therapist disclosure (of a parental role) makes to those accessing CAMHS. Her use of the word 'even' suggests that being a psychologist may be perceived by CAMHS parents as negative as it initiates a feeling of judgement of the parental self which prevents true understanding being felt. Sophie's experience of the PDR however offers her the opportunity to overrule the other's sense of judgement created by her professional role.

> *Even though you are a psychologist, people are like, ah you're a parent, you understand...*
>
> *Sophie*

Sophie later goes on to say

> *I'd want to know that if I was in that position and...I was suddenly in front of a screen of therapists, I'd want to know some of them were parents...I wasn't just being judged by a weird group of shrinks...*
>
> *Sophie*

Sophie's use of the word 'shrinks' indicates again the negative association that she perceived CAMHS parents may assign to her psychologist self, if her parental self is not disclosed. The above quote may therefore highlight her need to inform CAMHS parents that she too is a parent to gain connection and prove understanding.

However, Sophie and Jennie, along with other participants also experienced unique connections being formed with CAMHS parents due to feeling that the parenting self demonstrated a genuine understanding and true empathy of the challenges of parenting.

> *...being a mother, speaking to the client who's a mother, there's a kind of empathy, an explicit understanding of, yeah...we've both been through this, we don't have to kind of explain the difficulties here...*
>
> *Jennie*

> *I think some might be reassured that I've been a parent so I know some of the difficulties that they might have experienced and I know that it's not just, that it is really, really hard work...*
>
> *Holly*

The following quote identifies Brook's cautious approach to disclosure, but how she considers it to give something (i.e. information) that CAMHS parents might want.

> *...if you're talking [to] the parents who are really concerned [...] sometimes, where it's appropriate, it does help with, because you will get a lot [...] 'have you got kids?'.* Cos I think they do want to know...
>
> *Brook*

This links with earlier reference to the parental self being an advantage to professional work and the sense that non-parents need to work harder to 'catch up'. So whilst Brook

identified that CAMHS parents 'want to know' whether she is a parent, she recognised that disclosure may not always be necessary for her to forge the unique connection.

> *...but sometimes just to go oh, you know, even the odd throw away comment can sometimes make, I think it can help with that rapport of...I think it can make people [...] it can help with the therapeutic relationship...*

<div align="right">

*Brook*

</div>

Five interviewees also identified that the shared experience of a parental role positively affected colleague relationships and resulted in unique connections being formed. In the following account Ben highlights a sense of immediate connection being formed with colleagues on his CAMHS placement resulting from this shared experience. He demonstrates how relationships appeared to form quicker and with less effort on his part due to an implied mutuality and reciprocal interest expressed.

> *Always positive...a majority of the people I'd end up working with would be parents and so it always made it easy to...link in with them and to end up being part of the team cos...they go tell me about your kids...instantly got a conversation even if you're not the same age...it was, made so much easier for me to join teams*

<div align="right">

*Ben*

</div>

The second superordinate theme relates to the journey travelled within the participants' experience of the PDR.

### 2. A Journey from Dependency towards Autonomy

*Overview*

This theme captures the sense of journey associated with the experience of occupying a PDR and being a trainee clinical psychologist. All participants found the system and wider context of their CAMHS training influenced how they considered, felt about and

managed the experience of the PDR and found a gradual and fluid transition from high dependency upon external factors towards increased autonomy. This theme therefore captures the value that individuals placed on time and the extent of their own experience of the PDR in order for them to understand its potential impact and become more at ease with its complexities and associated challenges. This theme also captures the importance placed on external consideration and validation for the PDR experience by all participants. The title's use of the word 'towards' indicates the on-going significance of external consideration for participants' PDR experience.

Across interviews, participants identify how the experiences of the supervisory relationships, relationships with peers and colleagues, the context of CAMHS, team ethos and also theoretical orientation can play a significant role in the consideration of the PDR. The first theme however relates to the external consideration of the parent-trainee's PDR.

### 2.1. Killing You as a Mother: Neglect Through Lack of Validation

*...them not wanting to listen and not wanting you to have, share that experience almost, almost it's killing you as a mother [...]what you had as a mother to the team, it was just disregarded...*

*Elizabeth*

For all the participants, the experience of entering into a PDR was often confusing and difficult to make sense of. As a result participants needed a significant amount of consideration for the impact of their PDR. All participants therefore identified the necessity of external support in order to help them to make sense of their experience as well as consider the potential implications of their PDR and negotiate its associated challenges. Specifically, participants identified the importance of having the opportunity to consider the impact of the PDR on the clinical work they undertook in CAMHS and also in relation to themselves as parents. When the PDR was not considered,

participants often experienced feeling powerless and as if part of them had been shutdown or 'killed' off. This sub-theme therefore encapsulates their need to think about, and have others think about their need to make sense of their experiences associated with occupying this role.

The need for external consideration of the PDR appears to be increasingly significant when the participants first encountered the PDR. In the following quote Sophie highlights the importance of her pending PDR and her frustration at her CAMHS supervisor's lack of consideration for her pregnancy and the potential impact that her clinical experience may have for her as a mother.

> *...a lot of anxiety, like thinking oh my gosh...this parenting thing must be really difficult and you know oh this is gonna be really hard [...] these people have got themselves into a real muddle and...I'm gonna have to make sure I'm really disciplined about parenting...and I really wanted to reflect on that in supervision but I couldn't, there wasn't the sort of facility for me to do that...which I found really hard...*
>
> *Sophie*

Sophie's frustration at the lack of consideration appears to have been further exacerbated by her preconceptions about 'how it is supposed to be'. She expressed a sense of being let down by her course for the perceived role in her difficult experience.

> *She just really, like didn't really get that I was pregnant...you know this isn't how it's supposed to be [laughs]...They could have placed me with a different supervisor if they had thought about it...It would have been nice if the course had kind of perhaps thought about that...I did feel vulnerable and I did kind of need a bit of nurturing from a supervisor and I did need to reflect on those things but I didn't have that...*
>
> *Sophie*

In the following quote Sophie demonstrates thought for why she may have experienced a lack of consideration. However, the change in her direction of speech indicates the sense that there is no justification to eliminate the course's responsibility.

> *It's difficult for them [course] because I think they don't want to seem like they making any people feel like they're special or they're different just because they are parents...but on the other hand, they could for instance do something like set up a reflective group for parents on the course...*
>
> *Sophie*

Jennie identified how a sense of shared responsibility may allow one to negotiate the challenges associated with a PDR.

> *Obviously the courses need to take some responsibility...I think the lecturers in those particular areas [child abuse] need to take some sort of responsibility...to suddenly be working therapeutically with sex offenders...is a very different shift...*
>
> *Jennie*

Brook's experience of others not considering the influence of her parental self in her CAMHS training presented a slightly different experience. The following quote indicates a feeling of temporary surrender to not being understood by others and perhaps even a questioning for the emotion she experienced as a parent. However, her response to her colleague highlights the emotion attached to not being understood and how the importance of external validation remained.

> *...she had a baby half way through when I was doing training. Before that she used to say I was really anxious and that kind of thing, afterwards she came back to me and said no you're not really anxious are you, you're just a mother and I understand that now. I didn't see it before*
>
> *AG: So how did that make you feel hearing that?*

*Y...es! [laughs]. Now you see...*

<div align="right">*Brook*</div>

Elizabeth's experience (denoted by the initial quote in this subsection) demonstrates how the experience of the parental self being disregarded felt hugely significant for her. She makes use of the phrase 'killing you as a mother' to demonstrate the strength of her experience and potentially tragic outcome that results for her if this aspect of herself is not allowed to exist by others (i.e. through acknowledgement). Elizabeth's reference to 'you' as opposed to 'me', when describing this incident is interesting. It is as though she experienced solace in thinking other mothers would also feel this way, and in doing so her feelings became validated. Elizabeth's choice of the word 'disregarded' implies a sense of her mothering self being left and unattended to, and therefore her need to attend to this independently, if not with other's support. The unwelcoming of the mother self by the team was very difficult or even impossible for Elizabeth to accept.

The seeking of validation appeared strongly associated with the fear that this process may actually bring about an invalidation of one's own experience for some participants. In the following account Jennie, the only parent in her cohort, highlights ambivalence about contact with fellow peers who occupy a PDR. She seemed to recognise contact as a way to share experience and obtain validation from others, but also demonstrates a fear that peer contact may invite invalidation of her own experience. Although an ongoing dilemma for Jennie, the following quote is taken from the onset of her interview when asked what her initial feelings about the research were.

*There's probably a level of curiosity you know about the, I[am] the only parent in my cohort really...I think for something about...there being other trainees out there who are possibly having similar or dissimilar experiences of being on CAMHS...that might be a good thing or a bad thing really...advantages and disadvantages of that...*

<div align="right">*Jennie*</div>

Four participants also considered how their experience of the PDR was or could have been influenced by the process of personal therapy. Jennie considered that personal therapy would have helped her to manage the challenges of her PDR experience, but deemed there to be external barriers, associated with resources, that prevented her from accessing it. Ben also talked about how personal therapy may have helped to make sense of his experience of the PDR during training. The following quote, however, demonstrates his perception of personal therapy being less relevant in the presence of good supervision.

*It was made to feel safe, very good supervisors kind of made it all ok...we could talk about that...and be curious...*

*Ben*

Elizabeth and Holly did make use of personal therapy and both experienced it as useful to negotiate different aspects of the PDR. For Elizabeth personal therapy was particularly useful to help her make sense of the impact of her PDR in relation to her own parenting.

*...it was good that I had the therapist there cos he was able to kind of talk through that stuff with me [...] about how learning about stuff helps you and how that makes you feel, whether that makes you feel guilty or in some areas quite proud that you've done things that reflect on you, you're parenting style and your ability to be a good parent...*

*Elizabeth*

Whereas for Holly, engagement in personal therapy was focused specifically around her desire to prevent her from repeating patterns she experienced as a child, highlighted during CAMHS training.

*I found that [therapy] really helpful in trying not to repeat patterns that I may have gone through as a child with [step-daughter] because I became aware that*

*[pause] I just didn't want her to go through some of the things that I, or her to experience things the way that I might have experienced them when I was a child*

*Holly*

## 2.2. A Shortcut to Recognition: The Importance of Shared Experience

This subtheme identifies the significance that all participants placed on having contact with other professionals, and especially supervisors who were also parents for making sense of the PDR experience. This theme differs from previous themes relating to self perception in that it focuses specifically on the relationships with other colleagues as a short cut to self recognition of the parental self and the subsequent impact this had for individual's own management of the role and personal development during CAMHS training. Subsequently, this theme captures the importance that the participants placed on having a shared experience of a PDR for their own journey towards acceptance and increased autonomy associated with the role. The title of this theme specifically denotes how shared experience of a PDR resulted in participants feeling more considered through implicit understanding and therefore a sense of being recognised by the other. As a consequence individuals reported feeling more supported by those who shared a PDR.

*I could have done with someone who was a parent themselves [laughs] who understood what I was going through […] a supervisor that I could have reflected on those things [becoming a parent] […] I didn't have that and it jus[t]…it wasn't, it wasn't possible and it just didn't happen…*

*Sophie*

*There's no doubt in my mind that that [a parent supervisor] makes a really big difference because there's an implicit understanding*

*Jennie*

Jennie makes a clear distinction between her experiences of parent and non–parent supervisors. In the following quote she associates a 'very difficult placement' directly to her supervisor, who is very quickly defined as a non-parent. Although Jennie attempts to consider alternative reasons for the difficult relationship, she soon reverts to what appears to be her initial response; that the difficulty arose due to the lack of understanding demonstrated by a non-parent supervisor.  This highlights the significance Jennie placed on the parental status of a supervisor for her own experience of a PDR.

> *…a very difficult placement …not a particularly supportive supervisory relationship…and I think that might be for many reasons and will be constructed differently for the supervisor I'm sure…but… they weren't a parent…just didn't really have that kind of understanding…so that wasn't there, I found it much more difficult…*
>
> *Jennie*

Other participants also reported feeling more supported by those who shared the experience of a parental role and Elizabeth describes a parent supervisor to be 'sensitive' to the feelings she experienced.

Similarly, when referring to a dilemma resulting from his PDR, Ben made clear reference to his supervisor not being a parent himself. This indicates the significance that he placed on such information, particularly when considering the supervisor's perspective on his dilemma. Ben's laughter indicates his sense of the supervisor missing the point when identifying the kind of support he needed.

> *...I did bring it up with my supervisor, that kind of sense of I'm not getting it right at home so how can I be an expert about this and my supervisor, who wasn't a parent, he was quite accommodating about it but he didn't quite, he couldn't reflect on it from the perspective of being a parent…it was more like is there anyway that we can help you with your parenting [laughs]...*

<div align="right">

*Ben*

</div>

Half of the interviewees also highlighted the importance of a shared parental role for providing guidance on the management of clinical situations influenced by a PDR. Here Jennie indicates the sense of permission received from a supervisor who was a parent regarding the use of self-disclosure in CAMHS.

> *Something happened on my CAMHS placements that doesn't happen on other placements I've been on...modelling and I've seen my supervisors do it...and I perceive that it's helpful...*

<div align="right">

*Jennie*

</div>

For Ben the shared experience of a parenting role meant that he found support from colleagues about the dilemmas of the parenting self.

> *I knew psychologists who were parents who would come into work and bemoan all of the mistakes that they make with their children and they would have discussions about how, you know you can talk the talk but you never, it's always different when it's your own family so that kind of.. gave me a sense of being let off the hook a bit...*

<div align="right">

*Ben*

</div>

Elizabeth however considered how her personal therapist's own role as a parent was significant for helping her to address some of the dilemmas she experienced in relation

to her PDR. She uses the phrase 'really think' to perhaps suggest that because he was a parent they were able to think at a different level.

> *It's great cos he the therapist that I had [...] has got children as well. So he would help me to really think*
>
> *Elizabeth*

For Holly and Ben the shared experience of a parental role with others also appeared to offer them some form of security in their professional role.  Whilst Holly described it as a 'social buffer', Ben highlights how shared experience of a parental role offered him familiarity that enabled him to relax and become a different type of therapist.

> *...there was some familiarity that made me feel secure and also it meant I could kind of joke or ask kind of slightly knowing questions of it*
>
> *Ben*

For some, contact with peers who had a shared experience of a parental role was also highly significant. The following quote demonstrates how, for Jennie, the importance of such contact related to explicit understanding of herself.

> *…something else beyond that which was about being parents and trainees and being able to kind of share you know quite how difficult that is without having to say this is really difficult you know, I'm finding that it was just sort of implicitly there and understood and you know that was just incredibly helpful...*
>
> *Jennie*

For Sophie contact with others with a shared experience initiated a sense of 'relief' from the challenges associated with her experience.

*...speaking to other trainees who are parents, it was just, you know, it was relief for me*

*Sophie*


*my sister is a family [whispering] therapist [laughs] and a mum so I talk to her a lot and we, we often have discussions and we sort of talk things through*

*Sophie*


Another side of the same coin is demonstrated by Brook. Her experience of peer supervision with non-parent peers was somewhat less helpful due to them not seeming to know how to contribute.


*Not helpful from the trainees who didn't have kids who would just go 'oh'...*

*Brook*


Jennie also indicates a lack of understanding from her cohort due to their non-parent status.

*Because there's a lot of my cohort kind of thirty something year old women…I thought you wait until you have children, you know…*

*Jennie*


However, Jennie, Sophie and Elizabeth all experienced how their own occupancy of a parental role during their CAMHS placement resulted in some less positive relationships with others who were superior, in terms of their professional status but who did not occupy a parental role. Each of them considered their PDR was in someway associated with a threat which parent-trainees' seemed to associate with a lack of recognition for the value of the parental self and subsequent reduced opportunity for personal development during CAMHS training.

This seemed particularly relevant to the age of the colleague. The following accounts demonstrate how some participants experienced recently qualified psychologists who

were not parents seeming less willing or able to consider and explore the relevance of the PDR, due to the presence of deeper underlying tensions.

> *That was really, really odd because she was the same age as me…I think there was some kind of tension between us…I kept wanting to reflect on [pause] the whole thing [pregnancy] but she didn't, she couldn't, she couldn't go there, she couldn't take supervision to that level, she didn't…*
>
> <div align="right">*Sophie*</div>

Elizabeth and Jennie perceived their parental roles to directly challenge the expected professional hierarchies with a negative outcome. The following quotes indicate a sense of power associated with the PDR, which in turn was perceived to be extremely threatening to some individuals higher up the professional hierarchy.

> *I had someone supervising me who may have been younger than me, only two years qualified and it was a very hierarchal setting…very hierarchal, then it becomes very important to them. Because I was the first person they'd supervised, and it was very important perhaps that that person felt in control…*
>
> <div align="right">*Jennie*</div>

> *I have a child, I'd worked in CAMHS, I felt quite confident but [...] that confidence was taken as cockiness by qualified psychologists and they didn't like it because there was this clear hierarchy, this clear structure [...] and actually you're just the trainee so you need to not mention stuff in team meetings that are personal opinions and you need to not think that you, you know, you might know stuff about children just because you have a child...*
>
> <div align="right">*Elizabeth*</div>

Elizabeth made a clear distinction between the value that was placed on the experience of parenting between herself and others. Her reference to being 'just the trainee'

highlights a sense of being put in her place by others who she perhaps feels may have been feeling somewhat put out by her portrayal of confidence.

### 2.3. Needing Room to Grow: The Significance of External Context

*Frustrated in the first one, satisfied beyond words in the second placement...*

Sophie

All participants found various external factors relating to their CAMHS placement, including theoretical orientation, team ethos and other's level of experience played a significant role in the amount of consideration and value assigned to their PDR during their CAMHS training. 'Needing room to grow' therefore denotes the importance of the placement context for the participants' thinking, exploration, subsequent learning and therefore overall experience associated with the occupancy of the PDR.

For half of the interviewees, theoretical orientation was identified as a significant influence for the consideration given to the parental self during CAMHS training. Ben and Sophie both emphasise a difference in their experiences of core CAMHS placements, where little support to explore the implications of having a PDR for either their own parenting or their professional work was received, and their experiences of specialist systemic[4] CAMHS placements.

> *...[systemic placement] very different…lovely. It was a lovely placement and really useful and I've really learnt as much there as I did in any placement because a lot of the placement stuff was about who I am as a therapist...*

*Ben*

---

[4] *Systemic placements refer to those where interventions are essentially focused around the wider relevance of families and groups and the influence that these may have for a person's beliefs and patterns of behaviour.*

Ben's use of the word 'lovely' (twice) highlights his satisfaction at the consideration given to his parenting self. The value placed on this experience and the distinction between the two placements appears clear. For Sophie, her initial CAMHS experience did not meet her expectation and flatness is felt in association with this experience. This is however in stark contrast to her description of her specialist placement. Here, Sophie indicates a sense of being energised and she refers to having 'really learnt how to connect'; perhaps indicating a sense of becoming alive.

> *...my core placement it didn't fulfil my expectations and I didn't really get a lot out of it [...] felt a bit deflated after that placement cos I'd always thought that CAMHS was where I wanted to work... I just thought oh this is actually really boring work[...] on the systemic placement it kind of [pause] I don't know [...] I was really excited about it cos I was like, yes, finally, I'm allowed to think about the systemic issues and it's actually, it's gone sort of above my expectations and I sort of really loved it, I really grew as a person and I grew as a therapist and, and I think really learnt how to connect with families...*
>
> *Sophie*

Elizabeth, who worked within a CAMHS team as an assistant, entered into her CAMHS placement, like Sophie, with high expectations. However, she also experienced theoretical orientation to play a significant role in her PDR experience during her core CAMHS placement. For Elizabeth this was unsatisfactory and disempowering.

> *...it was very un-systemic for a CAMHS placement cos CAMHS is meant to be very systemic and meant to think very social constructionist outside of the box but it wasn't like that. Yeah, it was very different. So that did make me feel quite powerless and almost quite resentful of the team and it almost made me shut down...*
>
> *Elizabeth*

Elizabeth also highlights the context of the CAMHS team and in particular the team ethos prevented the acceptance of her PDR. The following account highlights the disregard she experienced for any expertise that she may bring to the team due to her own parental role and a sense of powerlessness to change it.

*I think it's, I think it's really inherent... part of the team that's probably gone down in history of the team where you know you shouldn't be shown to, sound like you're an expert.*

*Elizabeth*

Additionally Elizabeth identified the level of experience of the other as significant when saying

*But the older psychologists recognise that...*

*Elizabeth*

### 2.4. Learning to Negotiate the Complexities of the PDR

The final subtheme of this section relates to the significance of both time and experience on the participants' ability to make sense of and negotiate their experience of the PDR; in relation to impact on self and clinical work. Whilst none of the participants suggest that the PDR would become an easy concept to manage, they identified how negotiating their way round the PDR may become slightly less challenging with time.

Brook's account demonstrates how she experienced increased confidence in her professional role with time.

*...as the years go by I think the more I think I'd be better at it CAMHS placement, yeah, yeah. And that's why I feel like being a parent does help you when you're working with children...even if it's just being how to relate, like this job that I'm going into that's working with nought to five year olds, well I feel like I'm quite*

*experienced with toddlers now...feeling much more confident at my ability to*
*relate on the right level...*

*Brook*

However, in contrast, Brook's experience also demonstrated how some things associated with the occupancy of a PDR have not got easier with time for her. The following quote identifies her need to develop strategies to help manage the strong emotions to survive and work in CAMHS, despite the personal effect remaining the same.

*You have to try and leave it as much as you can though don't you because your powerless to do any more than what you're doing. Oh it's hard, I think it just comes with experience the longer you're doing that kind of work...I just think you have to accept that you can't change...after a certain point you can't do anything else to change their lives.*

*AG: does that get easier?*

*If you think too much about it, no it doesn't...but I think you get more equipped at [pause] dealing with that fear of not being able to do what you would want to do. As a parent cos you have to separate it don't you?*

*Brook*

Similarly, Jennie also recognised the importance of strategies to help her cope with the intense emotions she experiences in CAMHS work. Jennie's previous experience of working in CAMHS as a parent prior to training meant that she placed significant value on preparing herself for challenges associated with distressing emotion (evoked in cases of child abuse). The following quote demonstrates that whilst Jennie is not necessarily affected less over time, she feels more able to prepare herself for the feelings she has.

*Because I'd already had that experience of being in a CAMHS setting...I was prepared for it and I can't imagine, well I can imagine...had I not had that experience, I think it would have been quite a shock actually...without being prepared...however prepared you are for the complexity...the fact that you have your own children...*

*Jennie*

Ben too experienced a change in his feelings about his PDR overtime. The following quote demonstrates changes in the type of challenges faced and increased opportunity to use previous experiences to help address subsequent challenges. His use of the words 'it was that thing' indicates a familiarity and that consideration that has been given to such experience. The term 'reflection' indicates how his perspective has changed with time and/or experience.

*Mostly the first year, that sense of...we're not quite getting things right with kids at home...whereas on reflection there is plenty of stuff going on that would mean that the kids might have felt disruptive...maybe it would have been helpful to reflect on...then in the third year one of the families I saw...some of their family history was similar to mine so it was kind of...it would touch on things that were kind of personal and while that was a challenge it also felt like, it was that thing of well that's good you can use that maybe...*

*Ben*

The above quote also highlights how Ben's perspective on the experience of self-resonance in clinical work has changed with time. He demonstrates how he has been able to develop new understandings about the role of personal feelings and emotion in his professional work.

*It's being ok to be engaged...you can be professional and you can still cry, but not be needy [...] if it can give you a tear in your eye...then that gives the dad in the family permission to cry*

Holly however expressed concern that she will not be affected in the same way with increased exposure through experience and time. In the following account she demonstrates a fear of becoming disconnected from her emotions which initiate a particular response in order to meet the needs of a child.

> *I don't want to have that attitude because then I'm in danger of not making the phone call. And not making the referral... I've got to keep on, keep on doing it, keep on ringing up and keep on documenting my concerns and not feel like, what's the point...*
>
> *Holly*

For Sophie, the significance of time and experience is strongly associated with the ability to manage the effect of her PDR on her own parenting.

> *...after a while, I was like actually, no, these things aren't realistic...there needs to be a balance[...]so as time's gone on, I've realised that I can be a lot more flexible...*
>
> *Sophie*

Elizabeth demonstrates a sense of trying to move forward with her feelings about herself as a parent but also highlights her on-going challenge with complex feelings, despite time.

> *So I kind of then moved on a bit but I still feel really guilty...*
>
> *Elizabeth*

A number of the participants also described how feelings about working in CAMHS shifted significantly with time. The following quotes from Sophie highlights her journey from looking forward to CAMHS training to feeling that she may be unable to work in CAMHS, to later feeling very positive about CAMHS work.

*...well I loved CAMHS work [laughs] and I thought, oh it's going to be amazing*

Sophie

*...I don't know, [pause] I felt a bit deflated after that placement cos I'd always thought that CAMHS was where I wanted to work...*

Sophie

*...actually, it's gone sort of above my expectations...*

Sophie

### 3. Cutting the Cord Doesn't Destroy the Bond: The Inseparable Nature of the Parental and Professional Self

*...psychology's not just about using tools and using models it's about the process of therapy, it's about interpersonal stuff in therapy, it's about knowing what you bring and how that affects what you do within the therapy and I think you cant, you can't be blindfolded to that [...], you can't be, you can't cut that off and just assume that's not important because it is...*

Elizabeth

*Overview*

The final superordinate theme captures the enduring relationship between the parenting and professional self. Although participants have at times encountered attempts to make these roles distinct from one another, each of them highlighted the apparent impossibility of separating these aspects of self and also their reluctance to do so; regardless of which context they are in. Across their accounts participants highlighted how their professional role was impacted greatly by their parenting self and equally their parenting self was influenced by the professional role in CAMHS training.

Captured under this theme are subthemes which look specifically at the participants' experience of the impact of the PDR on the parenting self and the impact of the PDR on the professional self.

### 3.1.  *The Rollercoaster Ride of Increased Parenting Awareness*

This subtheme is reflected across all participant accounts. It is associated with the significance that the occupancy of the PDR has had for the parenting of the participant's child/ren and also the individuals' sense of themselves as parents. The connection between the professional and parenting self is denoted by the above heading which stresses the challenging and perhaps inconclusive nature of the link (during training at least), but also the sense that there is benefit to be gained from the occupancy of the PDR.

All participants discussed how the occupancy or anticipation of PDR during CAMHS training made them look at them self as a parent. They described the experience of moving fluidly between increased awareness about their own parenting to feelings of anxiety resulting from this (sudden) increase in knowledge. Over time, however, it appears that the professional experience of participants offered a sense of reassurance to the participants about their own parenting role and actually allowed some of them to re-evaluate their own position as privileged in some way.

Although some individuals had PDRs prior to training, all were faced with new considerations for their own parenting during CAMHS training. Some individuals reported anticipating CAMHS training as an opportunity to learn about parenting issues, and in a number of cases the PDR initiated some form of internal or external conflict.

The five participants in relationships during CAMHS training highlighted experiencing the need to negotiate new parenting insight with that of their partners and in some cases other relatives. For some, this experience initiated some tension that needed to be addressed and worked through.

*I've been a lot more...no it's got to be like this and no, you can't do it like that and you can't say that to him [laughs] I sort of prick my ears up if I hear him [husband] kind of you know making any kind of, what I feel is a mistake...so it has caused tension between us, he's very laid back and takes parenting as it comes, where I've got all this theory and I'm like, in my mind, we can't do that, you know it's going to ruin him...*

*Sophie*

Not only does this quote demonstrate Sophie's increased anxiety about her own parenting but it also demonstrates the impact that her anxieties had for her husband's parenting of their child. Sophie and her husband subsequently experienced the need to negotiate their different perspectives of parenting. The next quote demonstrates how, with time and compromise Sophie and her husband were able to come together in order to manage tension between their differing perspectives on parenting. Sophie's use of the word 'rules' however stresses the on-going significance of the professional perspective in her eyes.

*We've kind of, as time's gone, we've kind of met in the middle and I have become more flexible. And I've realised that you can break the rules sometimes, that's ok...*

*Sophie*

Brook's experience was similar in that she and her husband encountered conflict in their parenting, but differed in that she and her husband were both health professionals battling for ownership of parenting knowledge.

*…my husband is a [occupation] so I suppose we did occasionally have theoretical battles. Cos [they] like to think they know it all and we psychologists like to think that we're the, you know attachment is ours, no it's ours and all that kind of thing [laughs]...*

*Brook*

Ben's experience, possibly due to his wife being the full-time carer to their four children during his clinical training, was somewhat different. He demonstrated his very clear need to respect the role of his wife when thinking about introducing new perspectives around parenting.

*I'm at work my wife's kind of the main carer so she would do the disciplining so there's kind of give and take about what fits for her as well. I can't come back with like, well you know what, you need to be doing this, you need to be [laughs]...*

*Ben*

Unlike the other participants Jennie has been a single parent during her CAMHS training. Along with Elizabeth, new knowledge lead to a sense of judgement about her parenting and the need to placate anxieties about past action. Jennie's use of the word 'rules' indicates how her professional views seem to take president over her instinctive actions.

*I had a very different approach to my daughter when she was a baby in terms of sleeping and you know, broke all the rules if you like...*

*Jennie*

The following extract from Elizabeth began by her considering how her professional experience made her feel like a 'really good parent'. However, she quickly moved on to the less positive considerations about her past parenting.

*...makes me feel like a really good parent, it really does, although on the flip side of that, there are times when I feel a really bad parent because I realise when she was first born and I didn't attach with her properly...*

*Elizabeth*

She goes on to say

*...it did make me feel guilty and it highlighted all the things I could have done better highlighted them, and the way I've brought [daughter] up you know, that I could have done a lot better you know the bonding stuff the attachment...*

*Elizabeth*

Experiencing anxiety about one's own parenting was demonstrated across all accounts and varied for different individuals at different times in their training. For Ben, anxiety was experienced in the anticipation of his PDR, due to concerns about the type of parent CAMHS training may cause him to become.

*...I'd end up being all over-technical about my parenting like it would change my relationships with my children that I'd stop being a kind of a natural father and I'd start trying to do specific things [...] end up bringing like a professional role into the household...*

*Ben*

In the following quote Brook demonstrates how her anxiety about her own parenting is related directly to her exposure to 'damaged children' in her professional role.

*I find myself analysing things, I say to them all the time, thinking oh, what are they gonna remember out of that, what are they gonna take from that and so I think seeing damaged children and seeing parents that could do better and*

> *differently makes you really...I suppose hyper-vigilant again about what your*
> *doing with your children, probably too much so sometimes...*

<div align="right">

*Brook*

</div>

Brook's reference at the end of the quote to 'probably too much sometimes' indicates the conflict her anxiety initiates. Whilst perceiving it to have had a positive effect on her awareness about her own parenting, her account also indicates that how she considers her own anxiety may actually be above a beneficial threshold.

Some of the participants have also experienced increased anxiety relating specifically to the vulnerability of their children. In the following quote, Elizabeth makes direct reference to the impact of her professional work on the feelings she had about her own daughter's activities.

> *...when I used to go home sometimes the things that my daughter used to do*
> *used to trigger stuff that I'd done at work on somebody else or...I'd have an*
> *image in my mind of something that had happened with another child and I'd be*
> *thinking you know oh you mustn't, you mustn't go outside the door...*

<div align="right">

*Elizabeth*

</div>

The following quote demonstrates Jennie's attempts to reassure herself about the worries she has in relation to her daughter's safety due to her professional experience.

> *...it brings home about the vulnerability of your own children as well.  Childhood*
> *sexual abuse is incredibly rare really but I think one of the things that can happen*
> *working in CAMHS is that it, you tend to see a very skewed patient population...*

<div align="right">

*Jennie*

</div>

For nearly all participants, however, increased anxiety was experienced intermittently with a sense of reassurance about one's own parenting, as demonstrated in the following quote.

> *AG: thinking about how your CAMHS changes how you see yourself as a parent?*
>
> *[...] I'm doing an ok job. I think it's just reassuring yourself basically, no one's perfect [...] most parents do the best that they can given the situations that they're in. I feel a bit more you know reassured I just, you know, I just feel a bit more yeah, that's ok. They're ok, they're happy children...*
>
> <div align="right">*Brook*</div>

Ben demonstrates how he has come to some form of understanding about his parental self and in the following quote he indicates some form of resolution about the anxieties associated with his own parenting

> *...the whole good enough parenting bit...it's all about being kind of somewhere in the middle 'good enough' kind of thing and not...this is right this is wrong...*
>
> <div align="right">*Ben*</div>

He later he goes on to say

> *I'm far more relaxed, I feel quite empowered in, there's lots of things that make you feel empowered about being a parent and feel like I'm doing a good job...and this is more than good enough I'm doing good things...*
>
> <div align="right">*Ben*</div>

For some interviewees, reassurance about one's own parenting seemed to be linked with the sense of an improved parental self, due to the professional experience.

*…working in CAMHS you think actually there are some really big mistakes that could be made and I'm really lucky that in actual fact those mistakes aren't gonna happen in my family **and** I'm in a really good position to be really aware of those things...*

*Sophie*

Sophie implies a better parenting self. She demonstrates an appreciation for her professional insight as a method to allow her to avoid making other's mistakes. Similarly, Elizabeth's account highlights how she believes professional experience initiated a better parent, resulting from the ability to understand the consequences of her actions for the future.

*I suppose that's what help[ed] me quite a lot, I was able to think more about the behaviour and what's gonna happen in future, you know the impact...*

*Elizabeth*

For Holly an improved parental self appears to be associated with the ability to directly transfer practical skills and use awareness gained from professional practice and personal therapy in her parenting to avoid some of the 'traps' she was falling into.

*...they [patterns of behaviour/experiences] could come into my consciousness more and I could be more explicit in my behaviour and avoid some of the traps that I was falling into and so that was really, really helpful.*

*Holly*

Some of the participants also experienced an enhanced sense of appreciation for their own parenting, child or family context due to their experiences of CAMHS training.

Holly found a new appreciation in relation to her step-daughter's behaviour.

*it's nice that she's kind of her personality is developing and she's starting to get a bit of an attitude and I think that's funny [...] I ignore the bad and reward the good and I think that [husband] might have found that a bit more challenging*

*Holly*

For other participants, the appreciation seemed to relate to the broader context of their child and own family context. This is demonstrated in the following accounts in which Sophie first demonstrates how this experience was associated with her own parenting, and then in relation to her own child and family context.

*I've met families who really are really having a shit time and where you know it is just awful and you think, gosh actually I'm doing ok, my kid's doing ok.*

*Sophie*

*I just hug him and I hold him and I just think I'm so lucky, I'm so lucky cos you, you will see people, and families who are really suffering and you just, you just count your blessings, you really do.*

*Sophie*

Similarly Brook and Jennie describe the following.

*Sometimes, I'd come home after and I'll just be showering mine with love [...] never does a day go by when I don't tell them how much I love them and you know how wonderful I think they are*

*Brook*

*... just to get home and I just can't wait to see my daughter and I just think oh my God you're so amazing and I am so lucky you know not to have some of these problems...*

*Jennie*

Ben also indicated new appreciation, although such experience appeared less prevalent for him.

> *There hasn't been much that's kind of sent me home at the end of the day and made me want to like hug my children really tight, this happened a couple of times but you know it's not like a reoccurring theme for me...*

<div align="right">

*Ben*

</div>

### 3.2.   Seeing An All Too Familiar Face in the Therapy Room

> *...snapping into mummy mode and kind of almost taking over and assuming that the child is like your child you know...*

<div align="right">

*Elizabeth*

</div>

This subtheme captures the interviewees' experience of the inseparability of their parental self when in their clinical role. Participants found that being a parent in CAMHS meant that they sometimes experienced working with clinical cases that resonated deeply with their parental self or their own children. All individuals describe intense emotion due to being a parent that, at some time within their professional role, has been overwhelming and difficult to bear. The title of this theme therefore captures the experience of seeing one's own self or child within the client they see before them in therapy.

Consequently, this theme also encompasses the challenging experience of needing to hold back a parental instinct of wanting to 'mother' or protect the children with whom they are working and the need to manage difficult emotions attached to such experience.

All interviewees describe being significantly affected by the content of CAMHS training due to the occupancy of their own parenting role.

> *You just can not grasp until you have a child… that feeling of [pause] vulnerability of your child…you can't ever anticipate what that would be like […] I was very struck by how affected I was in this lecture on sex offenders…very much taking a position of neutrality…trying to just normalise and understand their behaviour and I remember leaving and I just said to her this is really upsetting me…I think it's because I'm a parent…*
>
> *Jennie*

Clinical material, in particular, was associated with the experience of significant and often difficult to manage emotion due to personal resonance between their own children or family and distressed clients seen in CAMHS.

In the following account Brook demonstrates the difficulty of making a distinction between a clinical case and one's own children. By turning attention away from talking about the emotional experience of being a mother working with distressed children, she perhaps highlights the complexity and challenging nature of this experience. This account concludes by confirming how her 'biggest challenge' was associated with separation between the personal and professional.

> *...it is hard because when you're a parent and you just think of your child and look at the child. It's just too, too awful and I think that is harder, it's harder to separate and I think that, yeah that's the biggest challenge.*
>
> *Brook*

Ben also experienced personal resonance in his clinical work having a significant effect on him.

> *There was more personal emotions there kind of, that kind of rose up that might not have done if I hadn't met that family, or didn't have my own family...what had come up there, so kind of you know, getting watery eyed when you're, when I was talking to parents about their experience...*
>
> *Ben*

The following quote, however, demonstrates how such experiences were often unexpected and resulted from similarities between his own family and those seen in CAMHS.

> *...maybe unlocking feelings that might be quite personal...you weren't really thinking about until it's triggered by another family who might have similar things...*
>
> Ben

For Sophie, personal resonance resulted from working with a child with a mental health problem resulting from a condition suffered by her own child as a baby. This appeared to impact greatly on her perceived ability to work on this case without the support from her supervisor.

> *...that was really difficult to work with that case because [own child] had a really bad [condition] as a baby and it was really worrying...*
>
> *Sophie*

Holly also identified personal resonance as a potential issue, but considered herself to have been protected somewhat from its challenges due to incongruence in ages between her own child and clients seen by her in CAMHS. In the following quote she does, however, demonstrate how it may have been harder to separate the personal and the professional if working with children who were more similar in age to her own step-daughter.

*I think because she's been so young most of my clients have been older than her so it's been easy, easier to separate it out*

<div align="right">

*Holly*

</div>

Half of the interviewees identified feelings arising from clinical work being almost too difficult for them to tolerate. In Jennie's case, these feelings resulted from the resonance of the case to her own daughter.

*…a terrible childhood sexual abuse case…with a girl who was almost the same age as my daughter and I remember thinking there's no way I'm gonna be able to do this job…*

<div align="right">

*Jennie*

</div>

Jennie's accounts demonstrate her on-going challenge regarding this matter. In the following quote she refers to child abuse as a 'taboo topic'. This perhaps demonstrates her own position in relation to the subject and, in some way, this enables her to disconnect from the distress that the topic evokes in her. In order to manage this emotion, she concludes her account by making attempt to reassure herself of the rarity of child sexual abuse.

*Child sexual abuse…I think as a parent is always going to bring something up in, in a lot of parents because it deals with a very taboo topic [pause] about the vulnerability of children and it brings home the vulnerability of your own children as well. Childhood sexual abuse is incredibly rare really.*

<div align="right">

*Jennie*

</div>

However, child abuse was a particularly challenging area for all participants. Like Jennie, Elizabeth also highlighted a sense of needing to distance herself from the emotions raised by abuse cases.

*...when abuse cases came in we discussed them in case group discussion, I'd always feel very upset and very nervous and very anxious talking about it and we talk about that and it would always be the psychologists that didn't have children that wouldn't be as upset or and could kind of talk about it more openly and verbalise their, their thoughts a bit more...*

*Elizabeth*

Brook makes use of the words 'deeply' and 'gut wrenching' to indicate the strength of feeling associated with thinking about harm to a child.

*...when there's abuse cases you feel it even more deeply... it's very hard to let go of it. When I just thought of a child being harmed in any way absolutely is gut wrenching and although I would have been obviously distressed about it before I was a parent, now that I am a parent, I just can't bear it and that is much harder to let go of...*

*Brook*

Five participants expressed an innate drive to parent a child worked with in CAMHS. This experience seemed to be associated with the need to avoid or prevent any further distress being experience by the child and consequently to them self by not being able to stop the distress.

In the following quote Brook demonstrates the difficulty in not becoming emotionally involved in CAMHS training.

*...it felt quite hard not to get emotionally over-involved with that little boy. Because...you almost feel like you want to do is take them home and look after them, cos that's your sort of maternal thing coming out that you can say 'oh God, I can look after you...Or give you lots of love and, you know, so I suppose I did find that hard...*

*Brook*

For Elizabeth the experience of not being able to respond to her maternal instinct was extremely challenging. In the next account she demonstrates her need to distance herself from the case in order to avoid the distress it evoked for her.

> *I was worried cos I knew that, I would actually probably want to rescue them and want to make it ok for them and I know that I wouldn't be able to do that [...] knowing that we couldn't actually work with the abuse stuff was almost quite protective in a way, it's kind of like that's brilliant cos I don't want to go there... [...] I felt that I couldn't rescue and I couldn't do what a mum, a mother's kind of instincts are to rescue and make it ok, I couldn't do that so that I kind of almost rejected the client before I'd even been asked to work with them...*
>
> *Elizabeth*

Holly's experience of not being able to respond to her maternal instinct seems to have presented her with an internal conflict that is hard to overcome.

> *I did the right thing in not letting her hug me...cos that isn't our relationship, but as a parent, I think she really just needed a hug, like she really just needed a hug [...] Oh bless her and it kind of, it really hurt that I couldn't do that I couldn't give her a hug and [pause] yeah I think looking back I'd do the same thing because as a professional that's what you have to do.*
>
> *Holly*

However, for Brook her inability to protect required the use of an alternative strategy to manage the distress. The following account highlights her awareness of the reality that she is unable to protect, but her continued yearning to do so.

> *Just that maternal wish that you could protect them, thinking that they deserve different And I [...] just so wish you could change the lives of this children that are*

*having it this awful childhood.  I'd end up adopting God knows how many children [laughs]...*

*Brook*

Brook demonstrates the internal conflict this creates and her subsequent attempts to manage the difficult emotions her CAMHS work raised.

*I think you just have to have a talk with yourself don't you, think I'm doing everything professionally that I can and that's as far as I can go, I'll do every I can professionally...your powerless to stop the situation beyond what you can do professionally*

*Brook*

For the majority of the participants the familiar face in therapy was sometimes their own. They reported a changed appreciation for CAMHS parents due to an almost lived experience of the distress of these parents. This appears especially true for Sophie.

*Your patience with other parents is much greater…your care with other parents is much greater, you really understand that it's hard being a parent…what your saying to them isn't just theoretical anymore, it's something that much more closer, it's actually something that's very sort of emotional from you…you understand that it's really difficult.*

*Sophie*

This quote indicates Sophie's own feeling of connectedness with the parents that she works with in CAMHS, suggesting that she too lives the experience in some way. In the subsequent quote, Sophie makes use of the word 'rawness' indicating that there is something that needs to be tended, to be protected in order to prevent it from becoming infected in some way, perhaps suggesting a need for protection.

*Before being a parent you're kind of, I was sort of a bit further removed from the sort of human experience…after being a parent…You really understand the rawness of people's narrative really…*

*Sophie*

# Discussion

The above provides an overview of the experiences of parent-trainees during CAMHS training. The results will now be reviewed in the context of the research question, using existing literature and the selective introduction of alternative literature. Smith et al. (2009) discuss how this is often necessary in IPA studies given that the process of analysis may open up new considerations. Following such discussion, methodological considerations and clinical implications of the study will be discussed.

### *Identity and Power*

Supporting the view that roles are valued (Haywood, 2010), the results from this study demonstrate how parent-trainees identified their PDR as important in creating a valued identity. In particular, parent-trainees demonstrated how substantial changes occurred in how they saw themselves and felt they were perceived in CAMHS training as a result of being a parent. Such findings are in keeping with the idea that we are socially-dependent beings (Foulkes, 1948) and that identity is a fluid concept, that is both non-neutral and only truly meaningful in relation to others (e.g. Davidson and Patel, 2009; Shotter and Gergen, 1989; Harre, 1997 Frosh, 1991; 1999). This supports postmodern perspectives which regard to identity and the self as dependent upon the existence and co-operation of others (Burr, 1995).

Changes in self perception can be understood if people are thought of as being in the middle of their own stories, for which the plot is constantly being revised alongside the introduction of any new life event (Polkinghorne, 1988). Consequently, the findings from this study reinforce the view that the self is provisional and continuously open to revision (Frosh, 1991; 1999) and that reflexivity is central to the process of self identity (Giddens, 1990). Whilst not denying that changes in identity may occur in populations other than parent-trainees, this study highlights how the 'plot' of a parent-trainee's story, and hence the sense of self for these individuals, may be reconstructed during the period of CAMHS training, partly due to the experience of being a parent.

Postmodern views do not however view the self as a definitive or neatly defined concept. Not only is the self regarded as having multiple and fluid identities (e.g. Gergen, 1985; Burr, 1995; Anderson, 1997; Frosh, 1999), these identities are considered to be fed by multiple sources and subsequently able to take on multiple forms (Kumar, 1995). It is therefore considered how the PDR becomes truly meaningful to parent-trainees in the context of CAMHS training and how professional identity may shift for parent-trainees during this time. This may be particularly noticeable when moving from a cohort where parents are the minority, to a CAMHS placement where parental roles are common and often a central focus. Whilst all the participants demonstrated comfort with their parental role as a defining feature that set them apart from other trainees whilst on a CAMHS placement, for some this distinction appeared somewhat less comfortable in the presence of their training cohorts where they were often one of very few parents. This supports the idea that discomfort may be experienced resulting from awareness of one's differences in relation to others (McIntosh, 1998). However, the results also highlight the complexity of disparity and possible gender differences. Whilst most participants enjoyed the chance to provide a different perspective, they also made reference to the challenges associated with being the lone parent. Yet for Ben, unique parental status was an identity on which he thrived.

Findings also demonstrate that parent-trainees generally considered themselves to be more credible in their professional role due to the occupancy of their PDR. These feelings appeared strongly connected with how they felt they were perceived by others, and especially others who were also parents (i.e. those accessing CAMHS, colleagues, supervisors). Such findings may suggest that the altered sense of self generated within CAMHS training for the parent-trainee is, in part, due to the increased likelihood of 'identity comprehension' (i.e. alignment between how an individual values their identity and how they perceive it is valued by others; Thatcher and Greer, 2008) that results from a similar value being placed on parental identity by the self and others working in, or accessing CAMHS services. This may arise from the focus given towards the parental self within CAMHS settings or alternatively alignment of the role of parent

between the self and others in such contexts. This latter consideration initiates interesting discussion.

Davidson and Patel (2009) discuss how a process of 'othering' (i.e. making distinction between self and others who do not occupy a particular characteristic) allows a split to be established whilst simultaneously construing the other's position as of less value than one's own. It is therefore suggested that the distinction parent-trainees make between themselves and non-parents, as evidenced within this research, allows increased subjective credibility to be associated with their role in CAMHS. However, as is evident across the participants' accounts, this in turn may impact on the relationships that parent-trainees form with clinical families if either the self or the families perceive the parent-trainee to be an 'expert' or as someone that can empathise more readily (following disclosure of the parental self). Such positioning may have positive and/or negative implications for clinical practice and is therefore considered further.

Social Identity Theory (Tajfel and Turner, 1979) identifies how a process of social categorisation acts as a socially and historically determined template for making sense of society and organising perceptions of the self and other. Such process then accentuates inter-group differences and intra-group similarities in regard to a relevant dimension. Consequently, it is considered that parent-trainees, when in the process of CAMHS training, may have drawn a distinction between themselves and others based on their identity as a parent and/or parental experience. This in turn may have enabled the parent-trainee to achieve and retain a 'credible' position for as long as the measure of 'parent/non-parent' remained their marker. Wetherell (1996a) discusses how such action then initiates a process in which individuals cognitively push apart (perceptually and judgementally) those who 'are' and those who 'are not', whilst simultaneously pulling together the members of their own group (i.e. those with the recognised trait that is similar to the self). Such categorisation is then followed by a process of social identification in which the individual establishes a social identity that is connected to one's own definition of self as well as the creation of a valued system for the individual within the eyes of others. This plays an important role in defining the individual's

position within the wider social network. Again, linking such theory to the experience of the parent-trainee may suggest how it is those with parental status that are also those regarded as members of the parent-trainee's own 'credible' group. Furthermore, it could be argued that it is through membership of this group that valued identity becomes obtainable within the eyes of the individual, as well as the eyes of other parent colleagues and also parents accessing CAMHS.

These considerations are particularly interesting given that some parent-trainees perceived their parenting role as suppressed by newly qualified colleagues higher up the professional hierarchy. The recently qualified psychologists were perceived by some of the participants to view the trainees' parental self as a threat to their own position, resulting in a jostling of power. The relationship between self esteem and the value an individual places on the group of which they are a member (Tajfel and Turner, 1979) is crucial for understanding intergroup discrimination and hostility. It is therefore considered how recognition for the value of the other's credentials may be perceived by both parties (i.e. the parent-trainee and newly qualified) as a means by which their own power is relinquished.  Subsequently, both parent-trainees and newly qualified individuals may be, in a sense, lured into a process of group comparison in their own struggle to establish a positive self identity. In addition to this, it is important to consider how the emotion and value attached to the membership of a particular group in turn plays a vital role in determining the individual's own self evaluation and sense of self esteem. Foucault (1980) highlights how power enables language and meaning to be introduced, which in turn influences choice and action. It is therefore considered that parent-trainees and newly qualified psychologists in CAMHS can become casualties to others' fears about loss of power and visions of a less credible self.  This is strongly associated with the view that power is intrinsically linked and central to the development of one's personal and professional identity (Davidson and Patel, 2009; Foucault, 1980) and may relate to the distinct lack of power felt in a trainee position that shifts suddenly on qualification.

The process of 'othering' can also be drawn on to consider the value parent-trainees in this study placed on unique skills and knowledge they felt they brought into their clinical role as a direct result of being a parent. Here, it may be suggested that a distinction is made between the self (i.e. parent-trainee) and the non-parent based on the ability of each to bring 'valuable' (i.e. broader thinking, relational) skills into the professional role. Parent-trainees may align themselves with the view that 'there is no substitute for experience, non at all' (Maslow, 1966, p.45) and it is the experience of one's own parenting, as opposed to professional experience, that is of most value. This supports the increasingly recognised notion that experiential learning can provide a valuable teaching tool when thinking about one's clinical work (e.g. Sheik et al, 2007), but also that one's personal experience of being a parent may limit perceived credibility of other forms of knowledge or experience. This reinforces the notion that the relationship between power and identity may be explained if power is regarded as a possession of a particular social group, by virtue of group membership.

Wetherell (1996b) discusses how power is significantly linked to ideologies and collective social constructions which interact with the network of beliefs, assumptions and ideas that people have about their place in life. It is therefore important that the broader social context and in particular societal views on identities associated with parenting or non-parenting roles be considered.

***Societal Views on Parenting and Non-parenting Roles***
It may be suggested that Western culture exposes each of us to a 'pronatalist attitude' that not only praises parenthood, but assumes or encourages it for all. This is portrayed within the majority of Western society's institutions (e.g. religion, politics, education, law) and is reflected throughout a strong social discourse around the role of parenthood, and particularly motherhood (.e.g. Hey, 1989; Letherby, 1994, 1999; Earle and Letherby, 2007; Ashurst and Hall, 1989). Given that exposure to the strong social discourse around the role of parenthood is relevant for anyone involved within CAMHS (merely through existence within western culture), regardless of parental status, it is important to

consider the potential impact that such narratives may have had on the personal narratives of the parent-trainees and therefore research findings within this project.

Letherby (1999), a feminist writer and researcher, argues that in any discussion of difference and diversity between women, attention must be paid to the similarities and differences of mothers and non-mothers. Whilst femininity can be defined in the language of marriage, domesticity and childbirth, and motherhood may be regarded as a 'privilege', 'duty' and 'proof of adulthood' (Hey, 1989) Letherby (1999) considers that such ideals may have important implications for both those who do and those who do not assume these positions. Specifically, Letherby (1999) discusses how non-parents may find themselves feeling stigmatised and perceive that others view them as "less than whole, pitiful and desperate" (p. 359) and even childlike (Letherby, 1994) despite not feeling this way themselves.

Literature such as this highlights the potential powerful implications that societal discourses may have in the broad context and subsequently in the clinical context for both parent and non-parent clinicians. One author who discusses this matter is Leibowitz (1996). By drawing on her experiences of being a "childless analyst" (p. 71) Leibowitz (1996) is able to reflect on how the question of 'Do you have children?' can represent an attempt to enter territory laden with profound feelings for both therapist and client about gender identity, self-image or wishes for nurturance. She also considers how such question can contain various meanings for clients and stimulate incredibly varied feelings in the therapist, depending upon their personal feeling about his or her own identity as a parent, would-be parent or a non-parent. This may help provide explanation for the participants' references to perceiving non-parent colleagues as feeling threatened by their parental role and Holly's apparent dilemma regarding her own credibility as a step, rather than biological, parent. Although Bos, van Balen and van den Boom (2003) found similarities in the way in which gay and heterosexual parents ranked their parenthood and Herek (2006) found sexual orientation of a parent to be unrelated to her or his ability to provide a healthy and nurturing family environment, DiLapi (1989) considered that societal values around parenthood, and

specifically motherhood, have been reflected by the married heterosexual woman being regarded the most appropriate to parent. Although recent changes may suggest progress, this suggests a hierarchy of parenthood to exist in society and supports models of selfhood that privilege narrative and suggest that identity emerges 'cumulatively and intersubjectively', always mediated by others (Rainwater, 1996, p100). Austin (2007) discusses how current definitions of parenthood usually tell us little about the extent or justification of alleged rights and obligations of parents, do not specify what factors make a good parent or make reference to the role of a biological relationship to the child. These issues may however have important implications for the current societal views around the concept of parenting, identities occupied in relation to parenthood and therefore the views surrounding different parental status for clinicians and families involved in CAMHS settings.

Whilst power maybe imposed relationally, consequences of power can often be welcomed, accepted and even inseparable to one's own identity (Wetherell, 1996b). It is therefore considered how parent-trainees may draw on their parental identity in a CAMHS setting in order to establish a valued identity and hence a sense of power that is both imposed on a broad societal level and also locally within CAMHS work (i.e. through contact with other parents). Each of the participants appeared to promote their identity as a parent, as demonstrated through their willingness to participate in this study. However, adopting or occupying any position of power or knowledge in a clinical context may pose practice and/or ethical dilemmas. Mason (1993; 2005) discusses this issue at length and highlights the importance of adopting a position of 'authoritative doubt' in which one's own expertise and position is owned, but equally one's own limitations and uncertainty when working with clinical material are also acknowledged. Such action may help moderate the effects of any predetermined beliefs that those accessing or working in CAMHS, including parent-trainees, may have about a 'good' or 'effective' therapist in CAMHS needing to be a parent themselves.

### *Relational Matters*

The parent-trainees in this study considered their relationships in CAMHS training to be significantly affected by a PDR. Shared experience of a parental role with a CAMHS parent was often associated with more immediate connections being formed based on shared assumptions of implicit understanding; particularly regarding challenges and emotions associated with parenting. These findings are in keeping with Coar and Sim's (2006) discussion of how increased solidarity may be experienced when interviewed or 'interviewing one's peers'. However, findings also identify how conceptual blindness (Andersson et al, 1996) may occur between parent-trainees and CAMHS parents due to subjective interpretation.

These findings relate to the participant's perceived role of disclosure for the parental or non-parental self of the CAMHS therapist. Whilst Gutheil and Goddard (1993) note that crossing certain boundaries may at times "be salutary, at times neutral and at times harmful" (Gutheil and Goddard (1993, p. 189), parent-trainees perceived disclosure of their own parental status to be useful for those accessing CAMHS services, as a means by which to help alleviate anxiety and/or initiate a sense of shared understanding. Whilst this supports the view of Cooper (1998a, 1998b) and Ehrenberg (1995), such findings also demonstrate the importance of support for parent-trainees to develop and retain their awareness for potentially negative implications that disclosure of the parental self may present. These include the possibility of subtle manipulation of the client and/or the process of therapy being threatened by the interference of the client's fantasy elaborations, as highlighted by authors such as Abend (1982), DeWald (1990) and Lasky (1990).

The above discussions identify the importance of the dynamic social context of the therapeutic alliance and the view that formulation is not simply a process of fact-finding, but rather a subjective and interpersonal process that takes place in the context of an evolving therapeutic relationship (Dallos et al., 2006; Minuchin, 1974) between parent-trainee and CAMHS parent. Whilst such relationships may be innocuous and even helpful, alliances formed on assumed understandings may have significant

consequences for those occupying PDRs and therefore also those who are accessing CAMHS.  These findings identify with concerns raised for traditional dual roles (Kitchener, 1988). Reference to 'implicit understanding' and a sense of assumed connection may demonstrate how conflict of interest, loss of subjectivity and incompatibility in expectation may all be evident within the relationships formed by parent-trainees and their CAMHS clients.

Such findings strongly contest the view that self-insight is unnecessary during training (Minuchin and Fishman, 1981), but may highlight why it has previously been regarded as a 'hindrance' in training (Hayley, 1980). Fauth and Nutt Williams (2005) found self–awareness may lead trainee therapists to feel more interpersonally engaged and form better therapeutic alliances, but may also result in distraction during therapy. They subsequently concluded moderate self-awareness as most helpful.

### Aspects of Self and Support Processes

Parent-trainees indicated an apparent inability to make clear distinction between their parental and professional self whilst undertaking CAMHS training. This supports the view that it is 'nonsensical' to separate out the personal from the professional (Gillmer and Marckus, 2003) and Kottler and Parr's (2000) perceived difficultly establishing where the personal and the professional begin and end. Although perceiving themselves as able to outwardly maintain professional boundaries, parent-trainees reported that certain professional actions initiated significant discomfort to their parental self. This is demonstrated in Holly's account when she talks of not being able to give a hug to a CAMHS child that she felt 'really just needed a hug'.

Parent-trainees identified personal resonance often meant they found themselves experiencing the emotions of a parent when in their professional role and at times fusing experiences of CAMHS children with their own children, a concern highlighted by Francis (1988) and Doe and Savidge (2003). This was particularly relevant when working with highly vulnerable children which supports previous research findings (e.g. West, 1997). Parent-trainees perceived such experience to render them extremely

vulnerable to personal distress. These results are highly relevant given the established link between a psychologist's personal distress and competency in their professional work (e.g. Cherniss, 1995; Guy et al., 1998). This supports the views that personal aspects of the parent-trainee are significant to their clinical work and therefore need consideration and exploration during the training period (Aponte, 1994; Simmonds and Brummer, 1980; Francis, 1988; Steiner, 1985). Furthermore, these findings support the notion that dual relationships may carry risks (DCP, 1995). However, parent-trainees experienced the need at times to 'cut-off' from their emotions to some extent in order to allow the self to undertake emotionally challenging and complex work. This again may have important clinical implications that need to be considered.

The experience of personal distress in relation to clinical work is not however unique to CAMHS work, PDRs or any other aspect associated with parent-trainee's experience of CAMHS training. Personal distress resulting from clinical work is acknowledged back as far as Freud (1905; 1933) and is often referred to in discussion on practices of therapist self-care (Norcross, 2000). It is important that therapists recognise and share their experiences of difficult feelings, despite factors such as confidentiality, isolation, shame and feelings of incompetency all having the potential to hinder this process (Norcross, 2000; Mollon, 1989; Scaife, 2009). This has important implications for parent-trainees because they considered themselves to be particularly vulnerable to personal distress. The results therefore reinforce the importance of the reflexive–practitioner model (Schön, 1983; Habor, 2004; BPS, 2004) for parent-trainees in order to provoke thinking about the occupancy of the PDR and its potential impact on how they relate to clients and clinical material.

Similar findings are relevant to parent-trainees' own supporting networks. Whilst individuals highlighted variation in the factors significant to their experience of PDRs during CAMHS training, external consideration and validation of the individual experience was essential for all parent-trainees; particularly in the earlier stages of CAMHS training. Limited consideration of the experience of a PDR may subsequently limit opportunity to acknowledge, recognise and explore complex feelings associated

with such a position. Norcross (2000) identifies how acknowledgement that virtually all mental health professionals experience similar kinds of pressures can be highly beneficial for one's own experience and very relevant in the role of therapist self-care.

The results emphasise that all parent-trainees felt well considered clinical supervision with appropriate regard for the impact of a PDR was highly significant for gaining understanding and meaning of their experiences. These findings are also in keeping with research highlighting the significance of support from course staff and clinical supervisors for moderating trainee's work adjustment (e.g. Kuyken et al., 2003) and other findings identifying the significance of supervision during the training period (e.g. Russell and Petries, 1994; Romans et al., 1995; Holme and Perry, 2007).

Opportunity for parent-trainees to be open about and explore their experiences in supervision meant that they reflected a more positive overall experience of their PDR and in a number of cases personal growth resulted. This is identified when looking at distinctions between the experiences of Elizabeth when compared to those of Ben and Sophie. These findings reinforce the view that the quality of the supervisory relationship is central to supervisory outcomes (Ellis and Ladany, 1997) and demonstrate how greater access to appropriate support leads to trainees experiencing fewer problems psychologically adapting to their trainee role (Kuyken et al., 2003).

Expansion of these findings suggests that parent-trainees often strongly associated good supervision and consideration of the PDR with a supervisor who also occupied a PDR. Parent-trainees related parent supervisors with greater consideration of the PDR, greater opportunity to discuss and explore the experiences associated with its occupancy and increased opportunity for guidance on relevant matters (e.g. self-disclosure).

These findings do not contrast those identifying the sympathetic listener and agreed confidentiality as key to good therapeutic encounters (Finch, 1993), but highlight how commonality in supervisory relationships on CAMHS placements maybe significant for

parent-trainees. This is in alignment with studies (e.g. Griffith, 1998; O'Connor and Madge, 2001), which suggest that a sense of mutuality is co-created by recognition of a shared role and this creates a sense of "shared universe of meaning" (Smith, 1996b p.64). Linville's (1985) model of Self Complexity, which proposes self knowledge to play a significant role in one's own resilience to different life events, may highlight the parent supervisor as having some advantage in supporting a parent-trainee's development of self, specifically about the occupancy of a PDR. This may result from the parent supervisor's ability to draw on their own experience and knowledge of a PDR and use this knowledge to facilitate the parent-trainee's own self knowledge. This model may subsequently also suggest that the parent supervisor is able to increase a parent-trainee's overall level of emotional stability and ability to respond to stress. This in turn may render the parent-trainee's PDR experience, when supervised by a parent supervisor more satisfying, as supported by the findings of this study.

In addition, Scaife (2009) highlights how many of the difficulties that present in supervision may be attributed to lack of confidence in one or both parties. It is considered therefore that non-parent supervisors and/or parent-trainees may have either limited awareness of the influence of a PDR, or confidence to open up or follow through discussions regarding the PDR experience.  It may however be that one or both parties feel less willing to voice their opinions if they perceive the other to be an 'expert' (Miller, 1998).

As with parent-trainee and CAMHS parents, shared understandings are also assumed by parent-trainees between themselves and parent supervisors. Such outcomes are again potentially hazardous, but strongly support the idea of solidarity being initiated by commonality (i.e. a known shared characteristic) between two individuals (e.g. Platt, 1981; Coar and Sim, 2006). Some individuals also associated these experiences with a flattening of the professional power hierarchy in supervision.

### Working Influences

This study demonstrates similarities between parent-trainees and their peers in regard to the influential nature of factors such as supervision and feedback (Lucock et al., 2006). However, parent-trainees identified their own feelings and instinct (regarding parent matters) as a significant influence during CAMHS training. This differs from the general trainee population and supports Goldbart's (2004) view that one's own parenting can provide a critical lens by which to consider theoretical concepts. Subsequently, it is considered how during CAMHS training parent-trainees may be more aligned with those of a higher professional status, who viewed instinct to be influential for clinical practice (Lucock et al., 2006). A changed perception of identity (during a parent-trainee's CAMHS training) may therefore align itself with increased confidence regarding one's own instinct, when it comes to clinical practice. This again reinforces connections between power and personal and professional identity (Davidson and Patel, 2009).

### Placement Context

Parent-trainees also identified other factors as relevant for their experiences of a PDR. In some cases the team ethos of the CAMHS placement and in all cases the broader context of CAMHS settings were found to impact significantly on the consideration of the parent-trainee's PDR. These findings are perhaps somewhat surprising given emphasis on the reflexive-practitioner model during training (Youngson, 2009) and the growing recognition for the role of self in therapeutic encounters (e.g.Bennett-Levy, 2002; Gerson, 1996). Such results, however, emphasised parent-trainees' dependence upon the external context for determining what is 'normal' or 'legitimate' in terms of their own experience (e.g. use of self, role of disclosure, feelings evoked) and the extent to which a parental role is considered . Higher levels of identity comprehension (Thatcher and Greer, 2008) may also provide some explanation for why parent-trainees demonstrated greater satisfaction with placements giving specific consideration to the parental self of the trainee (i.e. specialist systemic placements). However, these findings also reinforce the view that the wider cultural context will inevitably frame the

activities of a therapist (in the context of self), as they are subject to laws and ethics of culture in which they work, whether they are agreed with or not (Dallos et al., 2006).

Theoretical orientations of parent-trainees' CAMHS placements were also shown to have an impact on their experiences of PDRs. These findings appear to be linked to the emphasis placed on self-reflexivity by different theoretical models, yet seem to contrast a study finding little difference among therapists' own self-change as a function of their theoretical orientation (Norcross and Aboyoun, 1994). This study therefore highlights how the role of self-awareness and understanding of the PDR experience was important for all parent-trainees but its consideration on a CAMHS placement was largely dependent upon the theoretical model utilised in that setting. This supports the view that focus on a single theoretical model may reduce opportunity for cognitive and experiential growth (Goldfried, 2001) and the importance of a general, integrative supervision model that serves psychologists of all theoretical orientations (Milne and James, 2005).

Parent-trainees were also found to place significant emphasis on time and experience for the management of the PDR during CAMHS training. If considered from an attachment perspective (Bowlby, 1988), it could be suggested that appropriate support provides parent-trainees with secure bases from which they feel safe enough to explore their experiences and gain understanding of the complex feelings which may be associated with PDRs. Overtime these individuals may develop understanding of the impact of their PDR and gain independence to take on management of this role. However, as with all attachment relationships, parent-trainees identified the need for on-going connection despite the presence of a more autonomous self.

### *Parental Change*
Parent-trainees also identified PDRs to be influential for themselves as parents. Several individuals felt that CAMHS training provided them with opportunities to gain new perspective on their own children, parenting or lives as suggested by Doe and Savidge (2003). In these cases clinical work and theoretical knowledge resulted in a re-viewing

of their own parenting practices, a need to incorporate new considerations into their own parenting and manage conflicting perspectives around parenting focused issues. These findings relate closely to the views that training and learning about difference can initiate re-evaluation of one's own position and experiences in training and can create unique opportunity to reflect on one's self (Tan and Campion, 2007). Such findings also complement those found by Nel (2006) who looked at the experiences of trainee family therapists. However, this particular study adds to the findings of Nel (2006) due to its specific focus on PDRs. It highlights how discomfort may be experienced in relation to anxiety about one's own action created by conflicting considerations introduced through the professional role and demonstrates how parent-trainees not only felt a desire to initiate a change to parental roles, but that actual changes were made to this role by parent-trainees in order to manage the conflict. This study also highlights how, at the time of interview, those who had received 'good' support appeared to have reached some form of resolution for some of their discomfort and regarded it as part of the experience of having a PDR. This supports the view of Basescu (1996) who identified conflict to be part and parcel of being a parent and a psychotherapist.

Overall, this study demonstrates how, despite some discomfort about their own parenting, all parent-trainees considered themselves to be 'better' parents as a result of their CAMHS training. This contrasts with the view of the child clinical psychologist, Dr Tanya Byron (O'Brian, 2005), but does not deny how parent-trainees engaged in much deliberation about their own parenting due to their professional role.  As a result, some parent-trainees considered themselves as privileged due to the impact of their exposure in CAMHS work indentifying how a PDR in CAMHS training provided opportunity for both professional and personal growth. This is in alignment with research undertaken by Radeke and Mahoney (2000) who concluded that psychotherapists considered their work to have made them wiser, more aware, accelerated their psychological development and increased their capacity to enjoy life. This supports the view that providing therapy can allow a therapist to heal their own wounds (Kottler and Parr, 2000).

So whilst the PDR was demonstrated to be a powerful experience for the sampled parent-trainees, it is important that further consideration be given to the foundations and origins of this narrative before discussion is undertaken regarding its potential implications within the clinical environment.

### *Further Deconstruction of the Narrative*

Emphasis on the postmodernist paradigm throughout this project has directed significant attention to the role and meaning of language in relation to the experience, and identity of the parent-trainee. It is appropriate therefore that consideration be given to the "dialogical-narrative self" (Anderson, 1997, p.220) that exists through the stories that parent-trainees tell about their lives, particularly in relation to CAMHS training, as a way of making sense of their experiences within this context (Lawler, 2000). As discussed, such 'stories' (told to the self and others) are considered to be fluid, influential in regard to one's social identity (Polkinghorne, 1988) and linked explicitly to broader social narratives (Somers and Gibson, 1994).

The narratives obtained from parent-trainees are, like those for any societal group, considered to be linked to the broader societal discourses and based on ideologies that exist in relation to parenthood. It is interesting therefore that Wetherell, (1996b) suggests that ideologies are discourses and traditions which justify practices and make them "reasonable, natural and unquestionable" (p.312). Similarly, McNay (2000) suggests that individuals act in certain ways as a feeling of violation to their sense of being may occur, if they were to do otherwise. Consequently, it can be argued that, although feminist research has opened the door for consideration around the role of maternal ambivalence (e.g. Phoenix, Woollett, and Lloyd, 1991), the parent-trainee narratives obtained within this research provide individual representations of the perceived ideological view of a parental role. Subsequently, such individuals are able to establish a valued identity within their social and private world, by preventing a violation of their sense of identity as a parent. This supports the idea that like any other personal identity, the parental identity of the parent-trainee is constructed within a contextual moral discourse (Grieve, 1989).

For the parent-trainee however, the contextual moral discourse is likely to be impacted by not only the broader societal discourse but also discourses evident within professional practice of working with parents and families in CAMHS settings. It is, for example, considered how eminent psychological concepts, such as attachment, containment and 'good enough', may be equally as influential in the parent-trainee's narrative when undertaking CAMHS training, as broader perhaps less theoretical, social discourse relating, for example, to nurturance and protection. Consequently, the context of CAMHS training itself may help to mould the acceptability of how experience is constructed and therefore what is communicated by a parent, a parent-trainee or a non-parent trainee undertaking training in this area. Such processes will however in turn impact on the services offered within CAMHS and subsequently reinforce recognised parental identities and broader societal discourse around parenthood, for both parents and non-parents working in or accessing CAMHS.

This can be discussed further in relation to the writings of Goffman (1959). Goffman (1959) discusses how the presentation of self in everyday life may be regarded as a social performance that is delivered as a means to an end. Goffman (1959) also considers how social performances will vary from individual to individual dependent upon the extent to which a person believes in the impression of reality they are attempting to engender in those around them. Again, such performance is considered to be influenced by the broader social context in conjunction with the individual's knowledge of their audience. As such, a symbolic projection is created through a process of monitoring and reflection (E.g. Giddens, 1990). It is therefore considered how the parent-trainee's awareness of the researcher's own position (e.g. as a female, parent, trainee clinical psychologist) in addition to their perceptions around expectations of parenthood are likely to have been significantly influential in regard to what was communicated during the research interviews. It is interesting therefore that Goffman (1959) also considers how one's self presentation may be shaped for not only the good of the individual, but potentially for the greater good of society. In other words, that parent-trainees were perhaps reflecting the view perceived 'good' or 'useful' for the

greater society in terms of nurturance, protection, strength of feeling etc. This supports the notion that people are agents within the social world and able to do or say things to affect the social relationships in which they are embedded (Haynes, 2008).

The above discussion reinforces the view that perceptions of self are socially derived, but also largely mediated through language, relationships and cultural and historical contexts (Bruner, 1990). Schafer (1992) discusses how at any time there are several possible narratives of ourselves that exist, none of which are necessarily true or real. Individuals seek to find stories that work for them and it is these that are important, rather than the story that resembles a "real life history" (Schafer, 1992, p.52). Therefore, whilst it is acknowledged that both parent and non-parent clinicians may undergo a process of reflexive ordering of self narrative when exposed to new experience, the parent-trainee may draw on their story or identity as a parent, rather than an alternative aspect of self, when in the process of CAMHS training as this 'works' best at this time. That is to say that the parental identity can act as a means by which the parent-trainee can make sense of their experience and gain a valued identity whilst undertaking CAMHS training. Such process is likely however to reinforce the strong societal discourse surrounding the parenting role which subsequently may reinforce the perspectives on parenting brought by the families accessing support from CAMHS services. The impact of which will be considered further under the section entitled 'Clinical Implications'.

**Methodological Considerations**

By interviewing parent-trainees about their experiences of CAMHS training and analysing their accounts using IPA methodology, this study has been able to answer the research question and provide a rich and detailed understanding of the experiences of parent-trainees during CAMHS training.

Although IPA methodology does not claim complete transferability, best practice guidelines for qualitative research (e.g. Elliot et al, 1999) and IPA methodology (e.g.

Smith et al., 2009), followed throughout the project, allow contribution to be made the developing knowledge base (e.g. Smith and Osborn, 2008). It is acknowledged however that the findings are relative and interpretative and the relatively small sample may have resulted in particular aspects of this phenomena being overlooked.

Whilst purposive homogeneous sampling used in IPA should not regard the members of its sample as an 'identikit' (Smith et al., 2009 p49), diversity within the sample may have influenced the findings presented within this project. For example, some participants had experienced a PDR prior to clinical training (i.e. as assistant psychologists) whilst other individuals had became parents during their training. The sample also included a step-parent, a single parent and parents to children of different ages. Consideration is therefore given to the relevance of these and many other potential mediating factors, including alternative roles and age, for the findings identified. While fairly representative of the trainee clinical psychology population, the sample contained only a single male participant. Consequently, the paternal perspective is under-represented in this study.

This project must acknowledge that actual lived experience can never fully be grasped and reflexivity is a hermeneutic reflection of the researcher's own position, as both subject and object. Therefore, by exploring the experiences of six individuals who occupied PDRs during CAMHS training, this study offers one possible construction of the research question. To provide the reader with opportunity to follow the specific analytic process adopted within this study an audit trail for one interview is included (Appendix 13a-13b).

Given that true objectivity is impossible (Doane, 2003), the primary investigator has attempted to own and monitor her personal position throughout the research process. The potential influence of this position is however acknowledged. Whilst peer status of a researcher may inhibit interviewees in their accounts, due to assumed understandings of one's own experience or a fear of professional or personal scrutiny (Coar and Sim (2006); Platt, 1981), commonality may also initiate freer discussion and/or provide a sense of validation for the participants' own experience (Mercer, 2007). It is also noted

that all participants had recently or were in the process of completing their own doctoral research project. Consequently, all appeared familiar and supportive of the project and mindful about the quality of their data. This may have influenced decisions about the participants' framing of their experience or information shared.

Finally, the participants' reasons for volunteering remain unknown and the sample may therefore represent individuals who have been more or less affected by their experiences of the PDR than other parent-trainees.

**Clinical Implications**

The data from this study raises a number of important clinical implications for individual parent-trainees, those facilitating clinical training and maintaining supporting roles for trainees (i.e. course teams, clinical supervisors) and also the broader context of clinical psychology. The following section will therefore consider some of these implications, although it does not claim to be exhaustive. In some cases it may be that the implications are already being considered, but they are discussed here due to their prevalence within the experiences of those partaking in this study.

The occupancy of the PDR is a complex and often challenging experience for individual parent-trainees, both in and outside of the professional context. This study highlights the need for general increased awareness and consideration for the significance of PDRs and their potential to impact CAMHS training across the various levels surrounding parent-trainees. If not acknowledged, parent-trainees, especially in their early stages of training, may feel isolated in their experiences. This may have detrimental consequences on both individual well-being and subsequently, that individual's clinical practice.

*Parent-trainees*
For the parent-trainees themselves, there needs to be a development of a personal understanding of their own experiences of the occupancy of a PDR within CAMHS

training, in relation to their clinical role, professional relationships and also themselves as a parent.  It is important they receive support to develop skills to monitor their own experiences and emotions in relation to clinical material and comprehend how such experience and subsequent personal well-being may compromise ethical practice. Specifically, parent-trainees should be encouraged to recognise their own limitations and understand the feelings and experiences evoked when limitations are reached. Resiliencies and strengths associated with the individual's occupancy of a PDR also need consideration. This supports the view that self-awareness is necessary for optimal functioning among psychologists (Swebel and Coster, 1998) and consideration that personal well-being is closely linked with ethical professional practice (e.g. Cherniss, 1995).

Parent-trainees therefore need to adopt responsibility for accessing appropriate professional support through use of supervision and contact with course tutors in relation to their PDR experience. Seeking of social support is relevant to PPD (Sheikh et al., 2007) and parent-trainees will benefit from recognising the role that informal (i.e. peer) support may play.  However PPD is an individualised process that will be approached differently by different individuals (Hughes and Youngson, 2009) and each trainee will also need to take on the responsibility to access alternative forms of support during training, (i.e. personal therapy) if experiencing additional need to explore the impact of the PDR experience.

Additionally, parent-trainees are in a position to initiate the use of reflexive-practice techniques (i.e. reflective diaries, learning logs and process notes) to aid reflection and 'critical reflection' (i.e. reflection on reflection; Newnes, Hagan, and Cox, 2000) about the implications of their own experience and position for clinical work. They may also complete audio recordings or participate in other forms of practice to aid self-reflexivity (e.g. genogram; Francis, 1988) to enhance understanding of the self and how their personal experience shape their encounters with the world (Sheikh et al., 2007). Although often occurring later in training, such processes may help parent-trainees with earlier stages of PDRs.

This study also highlights how assumptions made due to the experience of a shared role with clinical families needs consideration. Individual parent-trainees will need to be supported to adopt and retain, what Kelly (1955) described as, a 'credulous' approach in clinical work to prevent their own opinions and experiences creating a sense of 'conceptual blindness' (Andersson et al., 1996) when working with clinical families.

*Training Providers*

Training providers are deemed central to the awareness and consideration given to PDRs during CAMHS training. Through a more formalised understanding of the potential effects (personal and professional) of PDRs for parent-trainees in CAMHS training, training providers may develop their own position when thinking about parent-trainees. They may also become more concerned with the communication of the possible impact of PDRs with the trainees themselves, clinical supervisors and other tutors involved in the support of parent-trainees.

Specific techniques (i.e. exposure to diversity in CAMHS work; Norcross, 2000) may enable parent-trainees to manage complex and often difficult feelings they may experience during CAMHS placements. However courses may need to rely on numerous strategies to support parent-trainees to become openly aware and able to knowingly use their own reality as a 'fallible but valuable guide' (Rosenblatt, 1997).

*Academic Teaching*

Those who facilitate teaching sessions need to acknowledge potential feelings that may be raised in parent-trainees and demonstrate sensitivity around emotive issues for parents (e.g. abuse, sex-offending, attachment).  Academic teachers should also communicate that complex feelings are anticipated at such times and monitor teaching practices through formal and informal feedback measures. Teaching practice may be enhanced by drawing on the resources of parents (i.e. parental experiences) if appropriate to challenge theoretical concepts and traditional ideas.

Other considerations for teaching relate to PPD of parent-trainees during their CAMHS training.  Although a 'slippery concept' (Gillmer and Marckus, 2003, p.20), Sheikh et al (2007) identify how enhanced self-awareness, resilience building and heightened reflection skills (i.e. PPD) can be secured through a process of experiential learning. Clinical psychology training providers may, if not already doing so, consider the use of Problem-Based Learning (PBL) to support trainees to experience and deal with uncertainty and develop professional knowledge through consideration of personal experience (Nel et al, 2008) specifically in relation to personal roles.  Alternative methods of experiential learning may also be developed through teaching and supervisory practices (e.g. Sheik et al., 2007; Vasquez, 1992).

*Clinical Supervisors*
Experiences of the PDR in CAMHS training appear strongly connected to the position of the clinical supervisor (i.e. professional status, age, life experience etc.). It is therefore important that the training of clinical supervisors incorporates consideration for the implications of a supervisor's own position (parent or otherwise) and the interface between this and the trainee's own context for the supervisory relationship. For example, where a supervisor is not a parent, or practices are undertaken through particular theoretical orientation, consideration needs to be given to the effect this may have on a parent-trainee's opportunity to consider and explore their own experiences related to a PDR. Experimental models of supervision may be a powerful way in which to support such process (Falender et al., 2004; Milne, Scaife and Cliffe, 2009).

Consideration to the compatibility of parent-trainees with others in their immediate professional support network is important in facilitating the processes that enable trainees to feel secure to discuss their own limitations and concerns, without fear of assessment or personal judgment. This may imply, for example, that the experience and expertise of a tutor or CAMHS supervisor needs to be considered when placing a parent-trainee in a CAMHS placement (BPS, 2010). Where supervisors are known to have limited experience associated with parent-trainees or PDRs, a parent-trainee may require additional support (i.e. from an experienced personal tutor, advisor). Trainees

have been found to 'hide' aspects of their work from supervisors where poor supervisory alliances are established (Ladany et al., 1996). This may have significant implications for ethical practice.

*Alternative Support*

Trainees obtain support from many different sources and access to these should be encouraged (e.g. personal therapy). However, this study also identifies the value of parent-trainees being offered contact with peers who also have experience of a PDR. Parent-trainees may therefore be supported to access peer networks across cohorts or universities to help to normalise the experiences associated with the PDR, made more complex by the context of clinical training.

*Broader Context of Clinical Psychology*

Whilst this study has looked specifically at the experiences of parent-trainees during CAMHS training, issues identified may be relevant across other areas of clinical training where dual roles, diversity and minority status exist (e.g. disability, race or gender). It highlights the importance of support in these trainee populations.

Current professional guidelines remain vague and provide little guidance about the implications and management of dual roles in the broad sense and in relation to parenting and the training context. This highlights the need for clearer acknowledgement and guidance in these areas which may in turn lead to enhanced clinical practice.

Although social categorisation is likely to remain an inevitable and normal aspect of professional life, it is important that where possible CAMHS teams recognise and subsequently manage potential conflicts arising from differences in parental status of those who work or train within these areas. It is important that individual differences become valued in their own right and, where appropriate, through reflective sessions, team meetings etc. group/individual differences be explored in regard to the positive and negative implications that any position may have. Such processes may facilitate

increased respect for individuality and promote difference as a recognised strength of an individual and/or the team for the team itself and ultimately those accessing services.

Finally, it is considered how some of the participants had experiences of a PDR as an assistant. Given the emphasis on time and experience for negotiating and understanding the impact of the PDR this is especially relevant. This identifies need for consideration of those occupying PDRs across the profession, not just in the training context.

**Implications for Further Research**

Given the limited literature base looking specifically at the issues covered in this study there are many possibilities for future research. For example, minimal research currently considers the perspective of the trainee clinical psychologist, the experience of occupying other non-traditional dual roles in training (e.g. re: disability, clinical diagnosis) or indeed the experience of occupying a PDR or non-traditional dual role in the broader context of clinical psychology (i.e. qualified psychologists). Research would therefore allow further exploration into these areas and provide greater insight into the current practices and experiences associated with clinical training and dual roles. This in turn may be useful for improving policies and procedures relating to dual roles and also training practices.

Completion of comparative studies may allow further investigation into the experiences of those parent-trainees who are the 'minority within the minority' parent-trainee population. For example, it may be interesting to further consider the experiences of fathers or those in alternative carer roles during CAMHS training. This study may be considered in relation to alternative research looking at diversity in clinical psychology training to highlight broader themes relevant to minority issues. Additionally, it may be interesting to explore the experiences of non-parent trainees undertaking CAMHS training or the impact of becoming a parent for qualified CAMHS psychologists.

## *Conclusion*

Using IPA methodology this study is able to provide a useful account of six individuals' experience of the occupancy of a PDR during CAMHS training.  Overall, those occupying PDRs during clinical psychology training felt positive about their PDR and believed it brought many benefits to themselves as parents and CAMHS clinicians and therefore their practice in CAMHS settings.

The PDR is, however, also shown to be an extremely complex phenomenon that has significant potential to positively and negatively influence the well-being of the trainee, how they see themselves as parents, the way that clinical material is perceived and also the way in which others are related to.  PDRs therefore require significant consideration and respect by the individuals occupying them and those in supporting roles to enable meaning-making, limit potentially hazardous consequences for both the clinician and clinical families and help individuals achieve optimum outcomes for all.

Many of the implications identified in this study (i.e. self-reflexivity, good support and PPD of trainees), although not necessarily new to clinical psychology, demonstrate how issues of diversity continue to raise new considerations for individuals and the broader context of training and clinical psychology.

## *Final Reflections*

As I write my final reflections, I ask myself to once again stand back from my experience of completing the research process. I see vast development in the understanding of my own PDR experience and greater insight into the broader influences PDRs may have for individuals occupying them, the services and colleagues with whom they work and ultimately individuals seeking support of CAMHS professionals.

This project highlights the need to accept complex and difficult feelings as inevitable and a valued facet of the parent clinician. Yet, such feelings offer another tool to the 'therapeutic toolkit' only if respected, explored and understood. Consequently, I believe it possible for parent-trainees to propel their clinical thinking to new levels providing their PDRs accompany high levels of consideration, trusted relationships and opportunity for validation.

It is perhaps not surprising that completing this project as a participant researcher has made it an emotive journey, yet a journey in which a sense of personal validation has been found and for this I am grateful. Such experience should not however be ring-fenced for those who study the phenomena of the personal and professional. I question whether there are experienced clinical psychologists who have occupied a PDR for much of their career, yet have not been privileged enough to have had the opportunity to truly consider the complex implications of this role or reach a position of being able to maximise its potential. I will therefore endeavor throughout my career to encourage any individual occupying a PDR or any other dual role, or even the absence of a dual role, to consider the powerful impact their experience may have on him or her self as a person and therefore him or herself as a professional.

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## *Appendices*

## *Appendix 1a: East of England Ethical Approval Documentation*

(The researcher's home address has been blanked out for confidentiality purposes)

20 July 2009

Mrs Amanda George

███████████

Dear Mrs George

| | |
|---|---|
| **Study Title:** | **A Qualitative Study into Experiences of Parent Trainee\* Clinical Psychologists During Child and Adolescent Mental Health (CAMHS) Training(\*the term 'parent trainee' refers to a trainee clinical psychologist who is also a parent, and have been since before starting any CAMHS training. The study also includes newly qualified clinical psychologists (i.e. 0-2 years post qualification) who were parents during their CAMHS training).** |
| **REC reference number:** | 09/H0311/72 |
| **Protocol number:** | 2 |

Thank you for your letter of 11 July 2009, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

### Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

### Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

### Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk. *Where the only involvement of the NHS organisation is as a Participant Identification Centre, management permission for research is not required but the R&D office should be notified of the study. Guidance should be sought from the R&D office where necessary.*

*Sponsors are not required to notify the Committee of approvals from host organisations.*

**It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).**

**Approved documents**

The final list of documents reviewed and approved by the Committee is as follows:

| Document | Version | Date |
|---|---|---|
| UMAL Indemnity | | 01 August 2008 |
| Field Supervisor's CV | AH | |
| Educational Supervisor's CV | PWN | 07 May 2009 |
| Letter from Sponsor | | 04 June 2009 |
| Covering Letter | | 03 June 2009 |
| Investigator CV | AG | 03 June 2009 |
| Application | | 09 June 2009 |
| Participant Screening | 1 | 03 June 2009 |
| Pre-Interviewing Briefing Sheet | 1 | 03 June 2009 |
| Interview Schedules/Topic Guides | 1 | 03 June 2009 |
| Interview De-Briefing Schedule | 1 | 03 June 2009 |
| Research Information Letter to attach to initial email | 2 | 02 July 2009 |
| Initial Email to Clinical Programmes | 2 | 02 July 2009 |
| Response to Request for Further Information | Email | 11 July 2009 |
| Participant Consent Form | 2 | 02 July 2009 |
| Participant Information Sheet | 2 | 02 July 2009 |
| Protocol | 2 | 02 July 2009 |

**Statement of compliance**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

**After ethical review**

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

| 09/H0311/72 | Please quote this number on all correspondence |
|---|---|

Yours sincerely

PP Jenny A

**Dr Steve Eckersall**
**Chair**

Email: jenny.austin@eoe.nhs.uk

Enclosures:     "After ethical review – guidance for researchers" (SL- AR2)]

Copy to:     Dr Nick Wood
Research Tutor, Doctorate in Clinical Psychology
University of Hertfordshire
College Lane
Hatfield, Herts
AL10 9AB

Natercia Godinho
Cambridgeshire & Peterborough
Mental Health NHS Foundation Trust
Fulbourn Hospital
Fulbourn
Cambridge
CB21 5EF

This Research Ethics Committee is an advisory committee to East of England Strategic Health Authority
*The National Research Ethics Service (NRES) represents the NRES Directorate within*
*the National Patient Safety Agency and Research Ethics Committees in England*

**_Appendix 2a: Local Research and Development Approval Documentation 1_**

**Provider Services**

**Camden NHS**
**Primary Care Trust**

**North Central London Research Consortium**
3rd Floor, West Wing
Camden PCT, St Pancras Hospital
4 St Pancras Way, London, NW1 0PE

Telephone: 020 7530 5375

Facsimile: 020 7530 3235
www.camdenproviderservices.nhs.uk

10th September 2009

Ms Amanda George

Dear Ms George

**Title: Trainee Experience of CAMHS Training in Clinical Psychology for Parent trainees: A Qualitative Study**
**LREC Ref: 09/H0311/72**
**R&D Reference Number: 09MHP37**

I am pleased to confirm that the above study has now received R&D approval, and you may now start your research in Camden & Islington MH&SCT. May I take this opportunity to remind you that during the course of your research you will be expected to ensure the following:

- **Patient contact:** only trained or supervised researchers who hold the appropriate Trust/NHS contract (honorary or full) with each Trust are allowed contact with that Trust's patients. If any researcher on the study does not hold a contract please contact the R&D office as soon as possible.
- **Informed consent:** original signed consent forms must be kept on file. A copy of the consent form must also be placed in the patient's notes. Research projects are subject to random audit by a member of the R&D office who will ask to see all original signed consent forms.
- **Data protection:** measures must be taken to ensure that patient data is kept confidential in accordance with the Data Protection Act 1998.
- **Health & safety:** all local health & safety regulations where the research is being conducted must be adhered to.
- **Adverse events:** adverse events or suspected misconduct should be reported to the R&D office and the Ethics Committee.
- **Project update:** you will be sent a project update form at regular intervals. Please complete the form and return it to the R&D office.
- **Publications:** it is essential that you inform the R&D office about any publications which result from your research.
- **Ethics:** R&D approval is based on the conditions set out in the favourable opinion letter from the Ethics Committee. If during the lifetime of your research project, you wish to make a revision or amendment to your original submission, please contact both the Ethics Committee and R&D Office as soon as possible.

Please ensure that all members of the research team are aware of their responsibilities as researchers. For more details on these responsibilities, please check the R&D handbook or NoCLoR website:
http://www.noclor.nhs.uk

We would like to wish you every success with your project

Yours sincerely,

Angela Williams
Research & Development Manager

**_Appendix 2b: Local Research and Development Approval Documentation 2_**

# Cambridgeshire and Peterborough NHS

NHS Foundation Trust

*Understanding mental health, understanding people*

Please reply to:
Natercia Godinho
R&D Manager
R&D Office
Douglas House
18 Trumpington Rd
Cambridge CB2 8AH

R&D ref: M00361
Ethics ref: 09/H0311/72
Date:    09/09/2009

Tel:    01223 746145
Fax:    01223 746162
E-Mail:    natercia.godinho@cpft.nhs.uk
Website: www.cpft.nhs.uk

Amanda George

Dear Ms. George

Study title: A qualitative study into the experiences of parent trainee clinical psychologists during child and adolescent mental health (CAMHS) training.

Thank you for applying for NHS permission to Conduct Research for the above named project. This study has now been validated and reviewed according to the Research Governance Framework For Health and Social Care for research appraisal. The study therefore has been granted <u>full</u> approval on the basis described in the application form, protocol and supporting documentation.

Trust approval of the above research applies to the research sites listed on the application form. Any changes to the above research should be communicated to this Trust and to the relevant Ethics Committee, and protocols followed accordingly.

The University of Hertfordshire have agreed to act as Sponsors, according to the Research Governance Framework For Health and Social Care, of the above study and funding is also provided by the same University.

## Honorary Research Contracts (HRC)

All researchers with no contractual relationship with any NHS body, who are to interact with NHS patients in a way that directly affects the quality of their care, should hold honorary NHS contracts (Access Letter or Research Passport). For more information on whether you or any of your research team will require an HRC please liaise with the R&D office. **It is your responsibility to inform us if any of your team does not hold NHS contracts.**

## Risk and Incident Reporting

Much effort goes into designing and planning high quality research, which reduces risk; however untoward incidents or unexpected events (i.e. not noted in the protocol) may occur in any research project. Where these events take place on trust premises, or involve trust service users, carers or staff, you must report the incident within 48 hours via the Trust incident reporting system on www.cpft.nhs.uk.

HQ Elizabeth House, Fulbourn Hospital, Cambridge CB21 5EF.
T 01223 726789  F 01480 398501  www.cpft.nhs.uk

In partnership with the University of Cambridge

## Research Governance, Confidentiality and Information Governance

Whilst conducting this study, you must fully comply with the Research Governance Framework. This can be accessed at http://www.dh.gov.uk website then use the DH search facility. All personnel working on this project are bound by a duty of confidentiality. All material accessed in the trust must be treated in accordance with the Data Protection Act (1998).

All parties involved in this research to familiarise themselves and comply with the Trust's policies and procedures available on the Trust website:
http://www.cpft.nhs.uk/Publications/DocumentsthatGuidePractice/DtGP/tabid/486/language/en-US/Default.aspx

## Protocol / Substantial Amendments

You must ensure that the approved protocol is followed at all times. Should you need to amend the protocol, please follow the Research Ethics Committee procedures and inform all NHS organisations participating in your research.

## Monitoring / Participant Recruitment Details

You will be required to produce a short electronic progress report annually and at completion.
It is the responsibility of the Accrual Data Contact (ADC) to upload any and all accrual data (recruitment data) relating to this Trust to the appropriate site and to liaise with the local Principal Investigator and the R&D Office on such accrual.

## Final Reports

At the end of your research study, we will request a final summary report so that your findings are made available to local NHS staff. The details from this report may be published on the Trust intranet site to ensure findings are disseminated as widely as possible to stakeholders.

Failure to comply with any of the above may result in withdrawal of Trust approval.

On behalf of this Trust, may I wish you every success with your research.

Yours sincerely,
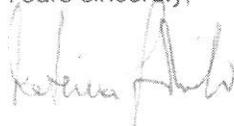
Natercia Godinho
R&D Manager

## *Appendix 3a: (Initial) Email to Directors of Clinical Psychology Training Courses*

Dear ….


I am a third year Trainee Clinical Psychologist at the University of Hertfordshire and I am about to embark on my final year doctoral research project. I am hoping to recruit trainees from [University name] for my project. Therefore, I am writing to you today to request your consent to approach trainees from your course.


Attached to this email is an information letter detailing my project that outlines what you can expect if you are happy for me to progress. Pending consent, I will forward the participant information pack, which provides greater detail in relation to the recruitment procedure (attached for your information), to your course administrator to send on to your trainees. Trainees who are interested in participating may then make contact either through your administrator or to myself directly.


I thank you for your time and I look forward to hearing from you in relation to your response.


Best wishes


Amanda George

Trainee Clinical Psychologist

University of Hertfordshire

## *Appendix 3b: Research Information letter (to course directors)*

**Contact:** ███████████████ **(Tel:** ██████████ **)**

**Study title:** Trainee Experiences of CAMHS Training in Clinical Psychology for Parent Trainee:  A Qualitative Study.

### Purpose of the study

My project will aim to develop some understanding of how individuals may process the experience of being a parent whilst undertaking CAMHS training (i.e. CAMHS placement and academic teaching relevant to CAMHS work). Using the information collected in this research, I hope that it may be possible to help those who provide training courses, clinical supervisors and other psychologists to make sense of, and understand the experience of the parent trainee in more depth. This has potential to facilitate the development of improved support structures.

### Sample

For my project I am looking to recruit 4 to 6 individuals who are parents who have recently finished or are currently undertaking their CAMHS placement as part of their clinical training programme. I initially intend to make contact with just current trainees, however if I fail to obtain a suitable number of current trainees, the study may extend to individuals who have qualified within the past two years. I am therefore requesting your permission to initiate contact with the trainees on your doctorate course to see if they a) are interested in participating in the study and b) meet the inclusion criteria. This will involve me sending an introductory email to all potential participants which will outline the project (see participant information attachment) and then making subsequent contact with those individual who express interest in the project.

You will not be responsible for providing me with any personal details of the trainees connected to your course as I will only obtain such details following contact initiated by trainees themselves. All participant information that I obtain following a show of interest from an individual will be kept confidential, unless there is concern regarding risk, as per the BPS guidelines.

All participants will be given opportunity to ask questions about the study before consenting to participation and will be asked for written consent before taking part.

If you require any additional information regarding the project or wish to discuss the matter with me further, I will be happy for you to initiate contact using the above contact details.

Yours sincerely, Amanda George (Trainee Clinical Psychologist, University of Hertfordshire)

## *Appendix 4: (Initial) Email to Potential Participants*

Dear Trainee

My name is Amanda George and I am a second year Clinical Psychologist in training at the University of Hertfordshire. I beginning to recruit for my major research project and I am writing to you today to invite you to participate in this project.

I am currently investigating the experiences of CAMHS training (i.e. CAMHS placements and academic teaching relevant to this area of work) for trainee psychologists who are also parents to children under the age of 16. This may also include newly qualified clinical psychologists, who previously completed their CAMHS training as a parent.  For my project I am looking to recruit 4 to 6 people who are either a parent or step-parent to at least one child.

My project will aim to develop some understanding of how the CAMHS training experience is interpreted from an individual perspective for the parent trainee. Following this I am hoping my research may help those who provide training courses, clinical supervisors and other trainees themselves to make sense of, and understand this experience in more depth.

To participate, you would be asked to take part in one tape-recorded meeting lasting around 1 - 1½ hours in a comfortable setting, which could be your own home, a clinical setting or at your university. The meeting will involve you talking to me about your experience of your CAMHS training.  It is fully acknowledged that telling your story may highlight some complex issues and that some questions I may ask you might feel sensitive. If any of the questions are found to be particularly upsetting you do not have to answer them.

It is wholly your choice as to whether you decide to participate or not. You are welcome to ask any further questions before this decision is made. If you do decide to consider participation you will be provided with the study information sheet to help your decision further.  If you do decide to take part you are still free to withdraw at any time and without giving a reason.

All information collected about you throughout the course of research will be kept strictly confidential. Your name and other identifying information will be kept securely and separately from your tape-recording and the subsequent data-analysis and all interview recordings will be deleted following transcription. People involved in your course will not have access to any raw research data which may be able to identify you at any time. Confidentiality may only be breached in accordance with the British Psychological Societies code of conduct e.g. if any information is disclosed during the interview which leads to sufficient concern about the person's safety or the safety of others. In these cases my project supervisor will be contacted to discuss any possible concerns, unless the delay would involve a significant risk to life or health.

If you are willing to consider participation, please feel free to contact me on the email address below or telephone me on 01707 286322. For further discussion and information about this project.

Thank you for your time, it is very much appreciated.


Kind Regards,


Mrs Amanda George                     Supervisor: Dr Pieter Nel

Trainee Clinical Psychologist          Consultant Clinical Psychologist & Academic Tutor

University of Hertfordshire.            University of Hertfordshire

███████████████                        ███████████████

                                       Tel: ███████████

## Appendix 5: Participant Information Pack

**Study title**

*Parent Trainee Experiences of CAMHS Training in Clinical Psychology: A Qualitative Study.*

Dear Trainee,

I would like to invite you to take part in a research study, but before you decide you need to understand why the research is being done and what it would involve for you.

Please do ask us if there is anything which is not clear, or if you would like more information, and take time to decide whether you would like to participate or not.

### What is the purpose of the study?

My name is Amanda George and I am a second year Clinical Psychologist in training at the University of Hertfordshire. I am conducting this research for my 3rd year Doctoral research project.

I am currently investigating the experience of CAMHS Training (i.e. CAMHS placement and teaching) for trainee clinical psychologists who are also parents.

For my project I am looking to recruit 4 to 6 individuals who are parents who have finished or are currently undertaking their CAMHS placement as part of their clinical training programme. My project will aim to develop some understanding of how individuals may process this experience.

I hope this research may help those who provide training courses, clinical supervisors and other psychologists to make sense of, and understand this experience in more depth, potentially facilitating the development of improved support structures.

### Why have I been invited?

Your Clinical Psychology Training course has consented to their current trainees and recently qualified psychologists being involved with this project should you so wish to do so.

And

You have expressed an interest in my project via contact by email or by telephone.

### Do I have to take part?

It is completely your choice as to whether you decide to participate or not. If you do decide to participate you will be given a copy of this information sheet to keep and you will be asked to sign a form recording your consent.

If you do decide to take part you are still free to withdraw at any time and without giving a reason.

### What will happen if I take part?

To participate, you would be asked to take part in one tape-recorded interview lasting around 1 - 1½ hours in a comfortable setting, which could be your own home, at your university or a clinical setting in which you work. The meeting will involve talking to the researcher about your experience of CAMHS training.

If you consent, you may be contacted at a later date to ask if you wish to comment on our research findings. You are able to decline this offer without giving a reason.

### What are the possible disadvantages of taking part?

It is fully acknowledged that telling your story has potential to raise various different emotions. Some questions I may ask you might feel sensitive. However, if any of the questions are found to be particularly upsetting you do not have to answer them.

### What are the possible benefits of taking part?

We can not promise that the study will help you. However, the research project will allow you to have time and space to reflect on your often unheard experience. Potentially this research may help those who provide training courses, clinical supervisors and other clinical psychologists to make sense of, and understand the experiences of those who are undertaking training as a parent.

### What if there is a problem?

If you have any concern about any aspect of this study you should ask to speak to the researcher who will do her best to answer your questions (Telephone number: ▮▮▮▮ ▮▮▮▮▮ ). If you remain unhappy and wish to complain formally you can do so by

contacting the projects Research Supervisor, Dr Pieter Nel (Telephone number: ███████ ).

### *Will my taking part in the study be kept confidential?*

All information collected about you throughout the course of research will be kept strictly confidential. Your name and other identifying information will be kept securely and separately from your tape-recording and the subsequent data-analysis and tape recordings will be deleted following their transcription. All data storage (i.e. on a data memory stick or PC) will be protected through encryption and password protection. At no point will data be either accessible or heard by unauthorised persons (e.g. within the home environment). People involved in your course will not have access to any raw research data which may be able to identify you at any time.

Due to the time constraints on this project an approved transcription service may be used to transcribe your interview. In this case your recording will be labelled A, B, C etc. to protect identity. The service will sign a non-disclosure, confidentiality agreement.

Some parts of the data collected by this research will be looked at by authorised persons from the University of Hertfordshire (Sponsoring organisation). Anonymised sections of the data collected may also be looked at by representatives from academic and professional assessment bodies in order to assess the quality of this doctoral research project and additionally, anonymised sections of data may be shared in a peer research group (set up at the university) to check for data themes. All will have a duty of confidentiality to you as a research participant.

Your recordings and any identifiable data relating to your participation will be kept for 5 years post research project submission (June 2015) according to the University of Hertfordshire's 'Good practice in research' guidelines. All identifiable data will be destroyed by the chief researcher after this time in accordance with university guidelines.

### *Are their any reasons where confidentiality may be breached?*

As all participants will be regulated by the British Psychological Society due to your professional status the following code of conduct will be followed with regards confidentiality:

British Psychological Society: Code of Conduct.

1. If you disclose information during the interview which leads to sufficient concern about your safety or the safety of others it may be judged necessary to inform an appropriate third party without formal consent.

2. Prior to this occurrence the researcher's project supervisor will be contacted to discuss any possible concerns, unless the delay would involve a significant risk to life or health.

### *What will happen to the results of this research study?*

The results will be written up in the form of a thesis for the purposes of gaining a Doctoral qualification in Clinical Psychology.

I will ask you if you would like to comment on the analysis of your interview to help with the accuracy of the results. You can decline your involvement.

The findings may be shared via academic publication and/or presentations. Participants will not be identified in any report or publication. Any quotes used will be fully anonymised. You have the right to decline the use of your interview quotes.

### *Who has reviewed the study?*

All research in the NHS is looked at by an independent group of people called a Research Ethics Committee to protect your safety, rights, dignity and well-being. This study has been reviewed and given a favourable opinion by the Hertfordshire Research Ethics Committee who have raised no objections on ethical grounds.

Due to the academic nature of the research this project has also been subjected to both a formal and a peer review by the University of Hertfordshire's Doctoral Programme in Clinical Psychology.

### *Further information and contact details*

Should you have any further questions or any concerns during the study please do not hesitate to contact the researcher or her research supervisor using the contact details provided below.

If you are interested in potentially participating in this study please fill in the reply slip included with this information sheet and return to Amanda George (Chief Investigator) via email.

Should you wish to complain about this study the Independent Complaints Advocacy Service (ICAS) supports individuals wishing to pursue a complaint about the NHS. (See http://www.dh.gov.uk)

The contact details for the areas covered by this study are as follows:

- ICAS Bedfordshire & Hertfordshire  Tel:  0845 456 1082
- ICAS North Central London Tel: 0845 120 3784
- ICAS North East London Tel: 0845 337 3059
- ICAS North West London Tel: 0845 337 3065
- ICAS South East London Tel: 0845 337 3061
- ICAS South West London Tel: 0845 337 3063
- ICAS Cambridgeshire, Norfolk, Suffolk Tel:  0845 456 1084

Thank you for taking time to read this information.

Kind Regards,

**Mrs Amanda George**                    **Dr Pieter Nel**

**Chief Investigator**                    **Research/Academic supervisor**

**Trainee Clinical Psychologist**         **Consultant Clinical Psychologist**

**University of Hertfordshire.**              **University of Hertfordshire**

                                          **Tel:** ▮▮▮▮▮▮▮▮

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***Reply Slip.***

***(Please tick the appropriate boxes and return by email to the researcher:*** ▮▮▮▮▮▮▮▮▮▮▮***).***

1.    *I am not interested in participating in this project.*                    [ ]
2.    *I may be interested in participating in this project*                    [ ]
      *but would like further information.*
      *I consent to you contacting me on the telephone number*
      *Below/email address at the specified suitable times and days of week\*\*.*
3.    *I am interested in participating in this project.*                        [ ]
      *I consent to you contacting me on the telephone number*
      *Below/ email address at the specified suitable times and days of week\*\*.*

*My Details (Please Supply if you tick statement 2, or 3):*

*Name:*

*\*\* Please Supply if Statement 2 or 3 have been ticked\*\*:*

*Telephone number:*

*Email address:*

*Suitable days for contact (Delete as appropriate):*

*Mon / Tues / Weds / Thurs / Fri / Sat / Sunday.*

*Suitable times for contact (E.G. Mondays 12-2pm):*

*Day:*                    *Times:*

*Day:*                    *Times:*

*Day:*                    *Times:*

## *Appendix 6: Client Consent (Written)*

**Title of Project:** *Parent Trainee Experiences of CAMHS Training in Clinical Psychology: A Qualitative Study.*

**Name of researcher**: *Amanda George, Trainee Clinical Psychologist.*

To be completed by participant (Please initial each box):

| | |
|---|---|
| 1. I confirm that I have read and understand the information sheet dated ….2009 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. | |
| 2. I understand that I am free to decline entry into the study and I am able to leave the study at any time without reason? | |
| 3. I consent to the tape recording of my interview | |
| 4. I understand that my interview <u>may</u> be transcribed by a University of Hertfordshire recommended transcription service, who will sign a non-disclosure / confidentiality agreement. | |
| 5. I understand that relevant sections of the data collected by this research will be looked at by authorised persons from the University of Hertfordshire (Sponsoring organisation). Anonymised sections of the data collected may also be looked at by representatives from academic and professional assessment bodies in order to assess the quality of this doctoral research project and possibly a peer research group to check for data themes. All will have a duty of confidentiality to you as a research participant | |
| 6. I agree to take part in the above study. | |
| 7. I agree to be contacted for my comments on the findings of the study. I am aware I can decline my involvement at any time. | |
| 8. I agree that anonymised quotes from my interview may be used in any publications. | |

**Signature:**                    **Date:**                    **Name:**

**Participant**

**Signature:**                    **Date:**                    **Name:**

**Person taking consent**

## *Appendix 7: Participant Screening Measure*

All participants will be asked the following questions to screen for inclusion and exclusion criteria of the study.

Was verbal consent obtained from the potential participant before asking the questions below?

Yes/No

1. Is the participant a current trainee clinical psychologist/ or recently qualified?

…………………………………………………...………………………………………………

2.  Is the participant a parent / or step-parent?

…………………………………………………...…………………………………………………

3. Has the participant completed / or is currently completing a CAMHS placement?

…………………………………………………………………………………………………

4. Has the participant received academic teaching relevant to CAMHS work?

……………………………………………………………………………………………………………

5. Was the participant a parent / step parent before they started their CAMHS training?

…………………………………………………………………………………………………

6. Did the participant have a child/ children under the age of 16 at the time they completed their CAMHS training?

…………………………………………………………………………………………………

7. Do they feel comfortable discussing their personal experience?

…………………………………………………………………………………………………

Age:

Gender:

Ethnicity:

Age of children currently / at start of CAMHS training:

Relationship status (if relevant)

Does the participant wish to be contacted to check the themes of their interview:

## *Appendix 8: Pre-Interview Briefing Sheet*

Pre-interviewing Briefing Sheet

Thank you for agreeing to take part in the study. As you know I am interested in finding out about the experiences of CAMHS training (i.e. CAMHS placements and academic teaching relevant to the CAMHS working) for trainee clinical psychologists who are also parents.

This will involve me asking you some questions about your experiences and recording your responses as we discussed prior to you agreeing to take part. It may be that we stick very closely to the proposed interview questions, but it is also possible that I will ask you questions that relate directly to the experiences that you choose to share with me.

I would just like to remind you again about confidentiality. All information that you share will remain confidential unless there is concern regarding risk to either yourself or another person. This is in concordance with the BPS code of practice guidelines (that I am sure you are familiar with). In the write up of the project all information will be anonymised.

The interview is expected to be between 1-1 ½  hours long, however if there is anything that you do not wish to answer, please feel free to tell me and we can move on to the next question. If you wish to stop the interview at any time, it is your right to do so without any adverse consequences.

There will be opportunity for you to ask me any questions you have about the research at the end of the interview if you choose to do so.

Do you have any questions you would like to ask me before we start?

## *Appendix 9: Interview schedule*

**Becoming a parent / starting clinical training**

1. **When you initially heard about this research, what were your first thoughts?**

Prompts:

- Thoughts?
- Feelings?
- Expectations?

2. **When did you become a parent?**

Prompts:

- Before/after starting course?
- Was it a conscious decision?
- If yes, why did you decide to have a child at this point in your life?

3. **a. What was it like starting training as a parent?**

   **b. How did it feel returning to training as a parent? (I.e. How was training different as a parent trainee to the time before you were a parent?)**

Prompts:

- Where there any other parents in your cohort?
- What emotions did you experience (in relation to parenting / other trainees/supervisors/ course staff)
- Any practical changes?

*__Experience specific to CAMHS training / placement__*

   4. **Given that you are a parent yourself, what were your expectations about your CAMHS placement before you started it?**

Prompts:

- Thoughts? Feelings?
- Any anticipated challenges / things to look forward to?
- How might these differ from a non-parent trainee?

   5. **How did your expectations compare with your actual experience of CAMHS training?**

Prompt:

- Similarities in expectation? Example?
- Difference in expectation? Example?

   6. **What strengths do you think you brought to CAMHS training due to being a parent?**

Prompt:

- Can you describe a situation where being a parent yourself has been 'helpful' in any way? How was it helpful?

   7. **What challenges did you face working in your CAMHS training?**

Prompt:

- Describe a situation. Why challenging?

   8. **How might your CAMHS placement /teaching experience be different have been different from trainees who are not parents?**

Prompts :

- Influenced on clinical practice?

- Experience of CAMHS Teaching?

- Attitude

- Relationships (with supervisors / MDT's / service users)

**9. Has your CAMHS training had any implications for your personal life in the context of parenting?**

Prompt:

- E.g. parenting methods/issues, relationships, friendships

- How you see your self as a parent

**10. Can you describe a situation particularly poignant about your CAMHS placement / teaching?**

Prompt:

- Tell me about something that really sticks in you mind about your CAMHS placement

**11. How have you feelings about your overall CAMHS placement / teaching experience changed over time?**

***Clinical Implications***

**12. Have you made use of any strategies / techniques to help you process the experience of your CAMHS training?**

Prompts:

- Supervision

- Therapy

**13. Do you think there is anything particular the course team / supervisors / did that you found supportive in the context of what we have discussed?**

Prompt:

How could training programmes be improved to support parent trainees like yourself more?

### *Ending*

14. **Is there anything else you feel you would like to say about your experience as a parent undertaking clinical training or a parent undertaking CAMHS training/placement?**

15. **As we are coming to the end of our interview, is there anything you would like to say, (before we finish)?**

General prompts throughout interview

- What images come to mind?
- Can you tell me a little more about that?
- Can you give me an example of that?

# Appendix 10: Interviewing De-briefing Schedule

**Participant** ..................................................................................................................................

**Date**..............................................................................................................................................

**INTERVIEW DE-BRIEFING SCHEDULE.**

### 1. Recap on purpose of study

- To investigate the individual experience of trainee clinical psychologists, who are also parents of CAMHS training (i.e. CAMHS placements and academic teaching associated to this area of work).
- To ensure personal experience is heard.
- Long term goal: to disseminate information about CAMHS experience for trainees who are also parents, other psychologists, clinical supervisors and educational institutions.

### 2. Review of interview

How you found the interview

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......................................................................................................................................

Is there anything you would have preferred or would have liked to be done differently?

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..................................................................................................................................................

......................................................................................................................................

Do you have any recommendations to aid my improvement of the investigation?

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..................................................................................................................................................

......................................................................................................................................

**3. Unresolved issues**

Are there any issues raised during the interview that have concerned you?

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.................................................................................................................................................................
.......................................................................................................................................

Do you have any questions which you feel still need answering?

.................................................................................................................................................................
.................................................................................................................................................................
.......................................................................................................................................

**4. Professional Services**

If you require information about further support services in different localities this can be arranged.

**5. Future concerns and contact with researcher.**

- If you have any concerns or further questions about this research please do not hesitate to contact the researcher or the project supervisor.
- The researcher and supervisor will be available for contact up to 6 months after participation.
- Do you wish to be contacted to check themes?

.................................................................................................................................................................
.................................................................................................................................................................
.......................................................................................................................................

Any other notes

.................................................................................................................................................................
.................................................................................................................................................................
.......................................................................................................................................

## Appendix 11: Interview Reflection Sheet for Researcher

Participant Ref:

Date of Interview:

**Content:**

What were the main points of discussion?

Any notable conflicts experienced?

Any unexpected themes identified during the interview?

**Process:**

Interpersonal factors (e.g. rapport)

Participant engagement (talkative / anxious / relaxed)

Factors that may have influenced the process of interview? E.g. interruptions

Use of open/ closed questions

Appropriate Topics covered?

Any confusion noted from the participant?

**Other reflections:**

## Appendix 12: Transcription Confidentiality Agreement

### Transcription confidentiality/ non-disclosure agreement

This non-disclosure agreement is in reference to the following parties:

Amanda George ('the discloser')

And

PERKINS

Maria ~~Hoyte~~ ('the recipient') *MP*.

The recipient agrees to not divulge any information to a third party with regards to the transcription of audio recordings, as recorded by the discloser. The information shared will therefore remain confidential.

The recipient also agrees to destroy the transcripts as soon as they have been provided to the discloser.

The recipient agrees to return and or destroy any copies of the recordings they were able to access provided by the discloser.

Signed:... *M Perkins* .............

Name:.... *MARIA PERKINS* ...

Date:.. 29 October 2009 ...

## Appendix 13a: Audit Trail (1) - Interview Six: Emergent Themes

1. Parental role changing perspective in professional role
2. Others consideration of PDR seeming dependent upon their own level of experience
3. Parenting role increasing sensitivity and empathy
4. Others not demonstrating understanding for value and significance placed on PDR by self
5. Own parenting experience making self more vulnerable to distress
6. Parenting experience increasing awareness in professional work
7. Self providing new contribution to clinical work by being a parent to clinical work by being a parent
8. Impact of PDR on self considered more by clinicians that are parents
9. Maternal instincts hard to contain in professional work
10. Supervision helpful for processing dilemmas in PDR
11. Importance of space to reflect on effects of PDR
12. Importance of external consideration for helping self explore impact of PDR
13. PDR threatening expected hierarchy for non-parent superiors
14. Needing to be a parent to understand other parents
15. PDR significant for clinical practice
16. Significance of supervisor position for allowing PDR to be considered on placement
17. Importance of external input (for Validation)
18. Self more competent due to parental role
19. Working for children rewarding for self
20. Managing Conflicting perspectives of parenting
21. Potential for own parenting to negatively impact clinical perspective
22. Expectation that PDR would be considered in CAMHS not met making experience more difficult
23. Theoretical orientation making difference to level of consideration for PDR
24. External validation coming from like minded others
25. Silencing of parental perspective hard to negotiate
26. Parental experience complementing professional insight
27. Importance of external factors to allow parenting self to contribute
28. External (informal) support significant
29. Others experience of PDR validating own perspective of PDR
30. Potential for own parenting to skew professional opinion
31. Significance of external validation re: own experience of PDR
32. Clinical work increasing anxiety re: own child
33. Self as better parent due to professional insight
34. Professional knowledge changing perspective on parenting issues
35. (Professional role initiating) evaluation of past parenting practice making self feel like bad parent
36. Importance of time for negotiating complex feelings associated with PDR
37. Professional role providing reassurance re: own parenting
38. Significance of external support for negotiating PDR
39. PDR increases credibility in professional role
40. Managing conflicting perspectives about value of Parental experience
41. Lack of external validation for value and significance of PDR upsetting for self

# Appendix 13b: Audit Trail (2): Interview Six - Clustering of Themes in Superordinate themes

<u>Please note:</u>

➔ Numbers 1-4 (bold / underlined) highlight the interview's four superordinate themes.
➔ Bullet points in bold text (not underlined) highlight the interview's subordinate themes. (These are emergent themes collapsed together or original non-collapsible emergent themes).
➔ Smaller font text, under each subordinate theme, highlights original collapsible emergent themes.

1. **<u>Parental self enhancing status and self value in professional role</u>**
   - **Parental role giving new insight into clinical issues presenting in CAMHS**
     Parental role changing perspective in professional role
     Parenting experience increasing awareness in professional work
     Self providing new contribution to clinical work by being a parent
     Needing to be a parent to understand other parents

   - **Professional self more credible due to own parenting experience**
     Self more competent due to parental role
     PDR increases credibility in professional role
     Parental experience complementing professional insight
     Parenting role increasing sensitivity and empathy in professional role

2. **<u>Maternal Instincts hard to contain in professional work</u>**
   - **Maternal instincts hard to contain in professional work**
     Maternal instincts hard to contain in professional work
     Own parenting experience making self more vulnerable to distress
     Potential for own parenting to negatively impact clinical perspective
     Potential for own parenting to skew professional opinion
     Managing conflicting perspectives of parenting

3. **<u>Professional Experience Changing perceptions about parenting</u>**
   - **Professional role increasing one's own anxiety re: parenting**
     Clinical work increasing anxiety re: own child
     (Professional role initiating) evaluation of past parenting practice making self feel like bad parent

   - **Self perceived as 'better' parent due to professional role**
     Self as better parent due to professional insight
     Professional role providing reassurance re: own parenting

   - **Professional knowledge changing perspective on parenting issues**

**4.** <u>**Need for external support and validation complicated by external context in which individual operates**</u>

- **Provision of own support seeming dependent upon position of other**
  Others consideration of PDR seeming dependent upon their own level of experience
  Impact of PDR on self considered more by clinicians that are parents
  Others experience of PDR validating own perspective of PDR
  External validation coming from like minded others

- **PDR threatening expected hierarchy for non-parent superiors**
  PDR threatening expected hierarchy for non-parent superiors
  Others not demonstrating understanding for value and significance placed on PDR by self

- **Theoretical orientation changing others perceived value and need to consider PDR**
  Theoretical orientation making difference to level of consideration for PDR
  Managing conflicting perspectives about value of Parental experience

- **Needing space, support and validation of PDR experience to negotiate associated dilemmas**

  Supervision helpful for processing dilemmas in PDR
  Importance of space to reflect on effects of PDR
  Importance of external consideration for helping self explore impact of PDR Significance of external support for negotiating PDR
  Importance of time for negotiating complex feelings associated with PDR
  Importance of external input (for Validation)
  Significance of external validation re: own experience of PDR
  Lack of external validation for value and significance of PDR upsetting for self
  Expectation that PDR would be considered in CAMHS not met making experience more difficult
  External (informal) support significant
  Significance of supervisor position for allowing PDR to be considered on placement
  Importance of external factors to allow parenting self to contribute
  Silencing of parental perspective hard to negotiate

<u>Emergent Theme dropped</u>

Working for children rewarding for self → Dropped as not directly associated with PDR

## <u>Appendix 14: Audit Trail (3) - Superordinate Themes Drawn form Individual Interviews</u>

<u>Interview one</u>

- Professional experience influencing emotions and confidence in own parenting
- Value of external input for experience of PDR
- Parenting self evoking emotion within professional role
- Parenting self positively influencing professional practice
- Parenting role influencing trainee identity

<u>Interview two</u>

- PDR introducing dichotomy in own parenting
- External consideration of PDR important for own feelings around PDR experience
- Greater connection perceived due to shared parental role
- Parenting experience as additional tool for professional work
- PDR influencing growth and development during training

<u>Interview three</u>

- Seeking understanding and acceptance of PDR
- Value of professional experience for parental self under question
- Value of parenting self in professional role under question
- Increased confidence v increased vulnerability with risk of emotional over involvement

<u>Interview four</u>

- Parental experience as resource to clinical practice
- Being a step-parent preventing one from feeling truly credible when with other parents v parenting role enhancing credibility in professional role
- Own parenting initiating increased resonance with professional work
- Increased insight resulting from professional role impacting on parenting self
- Needing external support and time to understand PDR experience
- Own parenting experience providing invisible link with other parents

<u>Interview five</u>

- Perception and expectation of self altered due to PDR
- PDR providing opportunity to learn about parenting v PDR initiating confusion in parenting self
- Parenting self providing greater awareness of professional limitations
- Important of external support in understanding complexities of PDR, enhanced further with own experience of PDR

<u>Interview Six</u>

- Parental self enhancing status and self value in professional role
- Maternal instincts hard to contain in professional work
- Professional experience changing perceptions about parenting
- Need for external support and validation complicated by external context in which individual operates

# Appendix 15: Reflective Diary Extracts

## Diary Extract 1: Reflections on Pilot Interview

*Interview piloting highlighted some potential overlap in questions and how little prompt was needed for the participant to begin to discuss their experiences of the overlap between the professional and personal role on each other. However, the process also raised consideration for additional (specific) prompts / probes that may be referred to encourage participants to give fuller, deeper disclosure of experiences relating to the question area.*

*The qualified participant reflected a sense of disloyalty, as the interview had drawn out the challenges faced within the family and not the 'positives' / achievements / successes of the family and following the interview were able to reflect whether this mirrored the emotion attached to the parenting role / clinical work undertaken with parents / children and also whether this represented the negative skew that CAMHS psychologists are exposed to in relation to parenting (i.e. only seeing the 'worse case scenarios').*

*The clinician also reflected how they had felt that they might have been less willing to share so much detail / information due to an established trust / relationship that they and I had formed through a previous supervisory relationship – this led to thought / discussion re: the importance of making participants feel relaxed enough to share their experiences in this way. We also explored the benefits of me (the researcher) providing participants with the opportunity to hear about my own position following the interview.*

*I was also aware how it was possible to divert away from the interview schedule due to my own personal interest in the subject area, but needing to balance this with the need to gain information (i.e. data) relevant to my research question. In addition, I noted the difficulty I experienced in refraining from reflecting back to the interviewee my own understanding of what they were saying to me during the interview and this raised need for me to think about the transition from a therapist role to a researcher role.*

## Diary Extract 2: Entry completed following initial contact with potential participants

*I had contact via phone with my first participants today and I was surprised how I felt connected to them in some way...perhaps in a way that I haven't been able to with my own cohort. I was taken aback when I was asked why I had an interest in the subject of parent trainees. I had not realised that up to this point I had not told the participants about me also being a parent...and what difference this may make. On reflection, I thought this would be assumed...Would I be asking these questions if not for my own experience? Once (B) found out that I was a parent I sensed that she was 'enthused' in some way. She was immediately curious and began to ask me questions about how old my child was...aware of a need to hold back I was also aware of a tug in me. I wanted to share ... and was pleased that an interest in the project outside of my own existed...*

## Diary Extract 3: Diary entry following completion of all participant interviews

*The process of interviewing generated a renewed confidence within the project and its aims to communicate the experiences of parent dual role during training. Listening to the words of others highlighted the importance of occupying a parent dual role and the implications that such position may have for the individual and their family life and also the professional role and the families with whom we work. In reflection, I am perhaps surprised by the element of uncertainty that accompanied the significance of the parent dual role which now appears strongly associated in my own mind; and the sense of surprise that the phenomena has not been considered to my knowledge at an earlier date in the context of clinical training or indeed in any other forum. Opportunity to verbalise one's own experiences appeared not only to offer validation of the self (i.e. the participant), especially those in minority groups, but also the listener as I became aware of my own feelings as I listened. Whilst each individual presented a unique stance, a unique story of how they got to where they are today I became increasingly aware of subtle and often less than subtle differences that lay within the individual experience, how each interview had their own individualised theme running through. I was however , perhaps more surprised at some of the similarities in experience that people presented. Themes that were so close to the stories of others that even the same words were used to describe the feelings...something I'd not anticipated.*

## Diary Extract 4: Diary entry following the process of analysis

*Completing the analysis has highlighted the significance that the participants placed on the value of their own lived experience for their work in CAMHS. They discuss the value of lived experience, a validation of the parenting role in relation to the clients they see, the colleagues with whom they work and also the supervisors who support them. They highlight a sense of 'unwritten' (Sophie) understanding that can not be learnt from a text book or brought into the room by one's professional knowledge, but gained only through one's own personal lived experience of the phenomena. I re-experienced a sense of confirmation for some my own preconceptions about the parent dual role; only I now realise that I have become aware of what these preconceptions were as I journeyed through this process. Being a parent does feel like a valuable contribution to the work undertaken in CAMHS but I am now very consciously aware of the fine line that must be trodden between the professional self and the role of parent. Such a fine balance but one that must be appreciated and respected by all to prevent the action of unethical practice in the work of those who are parents working in CAMHS. I am also aware that whilst the experiences captured in this research relate specifically to those in the clinical training context, they are very relevant to the wider forum of CAMHS practice and quite possibly the profession of clinical psychology.  Therefore, what I came to think somewhat puzzling and raised questions in me during the process of this project was actually relevant for the general role of the clinical psychologist. The sense that everything seemed to be pointing to the value of lived experience, that without this experience it was not possible to work or support others to a level where they feel truly validated. What does this imply about the value we have for all those who enter our clinics with whom we do not share life experience? Is it possible that we are unable, or they feel that we are unable to truly validate them unless we have travelled a similar journey? Are we kidding ourselves that we validate feelings when perhaps unknowingly there remains a sense of 'unless you've been there, you can't possibly truly understand'?*

*This led me to draw on my own experience of my parent dual role and those who I feel really have validated me, and yes two of these were psychologists who also had a parental role. However, the person who has perhaps validated me the most is a fellow trainee who is not a parent, but is someone who has continually shown me her desire to understand, her curiosity and her respect for the experiences I shared.*

# Appendix 16 – Interview (Elizabeth)

(Removed following assessment to retain participant confidentiality)