MAJOR RESEARCH PROJECT

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A GROUNDED THEORY STUDY OF PSYCHOLOGISTS' CONSIDERATION OF THEIR CLIENTS' PARENTHOOD

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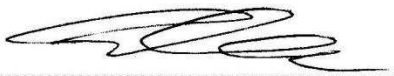
Signed  ..... (candidate)

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STATEMENT 1

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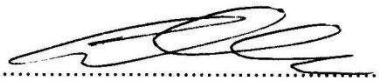
Signed  ..... (candidate)

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I hereby give consent for my thesis, if accepted, to be made available to external users through the CCCU institutional repository and the British Library EThOS service, and for the title and abstract to be made available to outside organisations.

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SUMMARY OF PORTFOLIO

Section A provides an overview of the impact of parental mental health difficulties on the person's family. The current health policies and clinical guidelines in relation to family-inclusive care are discussed, along with research exploring service users' families views and experiences of adult mental health services. Studies investigating mental health professionals' family-inclusive care practices are critically reviewed, followed by a consideration of how psychological theories conceptualise parenthood. The paper concludes by identifying areas for future research in this field.

Section B is an empirical paper and provides the findings of a grounded theory study investigating psychologists' consideration of their clients' parenthood in therapy. Semi-structured interviews were conducted with thirteen participants, and the model that was generated describes the number of tensions that psychologists manage in clinical work with active parents. Clinical implications, future research, and limitations of the study are discussed.

Section C provides a critical reflection of the research project by addressing four pre-determined broad questions: the development of my own research skills in the course of the project, how the project could have been improved, how conducting this research has impacted on my own clinical work with clients, and areas for future research.

CONTENTS

SECTION A: LITERATURE REVIEW PAPER

SECTION B: EMPIRICAL PAPER

SECTION C: CRITICAL APPRAISAL

SECTION D: APPENDICES

LIST OF TABLES AND FIGURES

Section A: Active Parents, Families, and Adult Mental Health Services: a Review of the Literature

Word count: 5474 (plus 65 additional words)

Abstract

Parental mental illness has long been liked with various negative outcomes for the affected person's children. Despite this, very little research has explored how parental mental health and service users' children are considered in adult mental health services. This review provides an overview of the impact of mental illness on a person's parenthood and their children, discusses current clinical guidelines and policies in relation to family-inclusive care, and considers views of and barriers to family involvement in adult mental health services. Additionally, research investigating professionals' consideration of their clients' parenthood in such services is critiqued. There is a dearth of literature in this area, and the review findings suggest that whilst professionals in adult services discuss their clients' children with the clients, they often do not consider parenting support to be part of their role. Despite interest in family-inclusive practices, limited time, high caseloads, and perceived limitation in skills to involve families were identified as some of the key barriers. None of the studies investigating how professionals consider their clients' parenthood employed a theoretical framework, and many were limited by methodological weaknesses. Theoretical conceptualisations of parenthood are briefly discussed, and the review concludes by identifying areas for future research.

Introduction

It has been estimated that one in four adults living in Britain experience some form of mental health difficulty in one year, and one in six have a diagnosable mental illness at any given time (Office for National Statistics, 2001). These estimates only include individuals living in private households, thus potentially underestimating the true figures by excluding those from more socially disadvantaged backgrounds. Mental health difficulties do not only affect the person suffering from the illness, but also those around them, including children. A significant proportion of adult mental health service users are active parents, with approximated prevalence of children living with at least one parent affected by a mental illness ranging from 21 to 23 percent (Maybery, Reupert, Patrick, Goodyear, & Crase, 2009).

The current review provides an overview of the impact of parenthood on the person with mental health difficulties and their children, followed by a description of the current health policies and clinical guidelines relating to family-inclusive care. The review then discusses the views of families where a parent uses adult mental health services, followed by a critique of research investigating mental health professionals' perspectives on the use of family-focused care. Given the lack of theoretical understanding of how parenthood is conceptualised in adult mental health services, the review briefly discusses how some commonly used psychological theories may consider parenthood in therapy. The review concludes by identifying future directions for research in this field.

Parenthood and Mental Health

Adults suffering from mental health difficulties are at least as likely to be parents as those without psychiatric diagnoses (Nicholson, Biebel, Williams, & Katz-Leavy, 2004).

Although parenting may be stressful at best, caring for a child can provide a valued role for an adult who is otherwise struggling to meet demands in life. For example, parenthood can bring structure and organisation into a life that is otherwise experienced as chaotic, and enhance treatment adherence, motivation, and recovery in those suffering from mental illnesses (Nicholson, Sweeney, & Geller, 1998; Mowbray, Oyserman, Bybee, MacFarlane, & Rueda-Riedle, 2001). Motherhood, in particular, can be crucial in severely mentally ill women's self-perception and identity (Mowbray et al., 2001). Children can be a valuable source of social support and help maintain abstinence in mothers with substance misuse problems who are also likely to have mental health difficulties (Tracy & Martin, 2007). Tracey and Martin (2007) observed the positive role of motherhood regardless of whether children were in care or living with parents.

Conversely, there is evidence to suggest that parenthood can also increase anxiety and stigma, particularly in relation to being a good enough mother (Blegen, Hummelvoll, & Severinsson, 2010) and a disrupted relationship with a child as a result of a "mental breakdown" can perpetuate and maintain the downward spiral of worsening mental health (Montgomery, Mossey, Bailey, & Forchuk, 2011). Another study noted that mothers with mental health difficulties strived to maintain meaningful relationships with their children, which often included strategies to hide their mental illness in an attempt to protect the children from its impact (Montgomery, Tompkins, Forchuk, & French, 2006). Paradoxically, most mothers, when they found themselves unable to manage without support and subsequently sought treatment, expressed a wish to learn to be more authentic with their children. It seems, therefore, that parenthood can potentially be both an invaluable resource and a possible stressor when coping with a mental illness; it may be that maintaining a balance between the two can be extremely challenging, and losing this

balance may perpetuate the mental health difficulties experienced by the parent, which can, in turn, impact on the child's coping and development.

Parental Mental Illness and Child Development

Parental mental health has long been linked with various psychosocial outcomes for children, and a recent World Health Organisation survey identified parental mental illness as one of the most common factors predicting an often lifelong course of adversities that start in childhood (Kessler et al., 2010). An earlier literature review estimated that children growing up in a family with a depressed parent have a forty percent chance of receiving a mental health diagnosis by the age of twenty, and by 25 this risk increases to sixty percent (Beardslee, Versage, & Gladstone, 1998). Similar findings have also been reported by other authors (e.g. Black, Gaffney, Schlosser, & Gabel, 2003; Park, Senior, & Stein, 2003). Furthermore, many studies have consistently highlighted a risk for various behavioural, interpersonal, and academic difficulties (e.g. Rutter & Quinton, 1984; Farahati, Marcotte, & Wilcox-Gök, 2003; Maughan, Cicchetti, Toth, & Rogosch, 2007; Reupert & Maybery, 2007).

The parent-child attachment style is one of the most commonly observed mediators of these negative effects. For example, maternal depression has been associated with insecure attachment styles in the child (Frankel & Harmon, 1996) and irritability towards and disengagement from the child (Lovejoy, Graczyk, O'Hare, & Neuman, 2000). Several theorists have also argued that considering attachment relationships when conceptualising parenthood is of particular relevance given its focus on both intrapsychic and interpersonal dimensions, as well as its natural overlaps with systemic theories that emphasise identifying resources and competencies within dyadic relationships, thus providing scope for improving

the outcomes for both the parent and the child (e.g. Sydow, 2002, Miculincer & Florian, 1999).

Although depression is the most widely researched diagnostic category in studies investigating how mental health affects parenting and child well-being, it appears that diagnostic labels are not associated with specific difficulties in parenting or child-related problems. Instead, the degree of the impact that the mental health difficulty has on parenting, parent-child relationships, and home environment are more important predictors of the children's outcomes (Smith, 2004). Additionally, a secure attachment with one parental figure has been found to buffer against psychosocial and behavioural difficulties (Cunningham, Harris, Vostanis, Oyebode, & Blissnett, 2004; Edwards, Eiden, & Leonard, 2006). It is noteworthy, however, that parental mental illness does not necessarily directly lead to emotional or behavioural difficulties in the child, but is often compounded by various health and social inequalities associated with having a mental health diagnosis (Solantaus & Puras, 2010).

Current Guidelines and Policies

The move towards family-centred and resilience-focused care has recently received increasing attention in many European countries. Solantaus and Puras (2010) reported current practices varying from clear violations of human rights to advanced preventative initiatives: in some Eastern European countries de-institutionalisation is ongoing whilst community mental health services are being developed, and the removal of civil rights when a person is admitted to inpatient services is still enforced. This includes the person's custody of their children. The Nordic countries have taken progressive steps by legislating family-focused care planning, including mental health promotion and prevention, with

parents who have mental health problems. However, building an infrastructure has required changes in all levels of the society and, even after a decade of high profile investments, is still ongoing.

The rest of this section will focus on UK guidelines and policies relevant to parental mental health, and concludes with a brief discussion on the clinical application of these recommendations.

Health Policies and Guidance

Historically, UK policies focused on the most severe forms of mental illness, such as schizophrenia and bipolar disorder, with more common psychological distresses receiving relatively little attention. In 1999, the National Service Framework for Mental Health recognised the needs of children of mentally ill parents, recommending parenting skills training for "at risk" parents and increasing clinicians' awareness of safeguarding practices (Department of Health, 1999). More recently, No Health without Mental Health guidance (HM Government, 2011) highlighted the benefits of early identification and prevention of parental mental health difficulties, and ensuring opportunities for children's social and emotional development. However, the suggested changes enforce the practice of supporting adults and children/young people in separate services, which can lead to disjointed service provisions. An effort was made by the Social Care Institute for Excellence (2009) to offer more flexible services to parents with mental health difficulties to overcome this issue. Recommendations included improving multi-agency working, reviewing the access criteria to adult mental health services for active parents, encouraging open discussions about parental mental health to enhance all family members' understanding of the difficulties, and considering the combined effect of parental and child difficulties on the

family's functioning. Additionally, recommendations have been made to improve children's access to mental health services, to ensure appropriate competency in staff undertaking assessments, and adherence to evidence-based treatments (Layard, 2008).

National bodies have also addressed the issue of parental mental health. For example, a recent report by the Royal College of Psychiatrists (2011) highlighted the need to consider service users' children in all public sector mental health provisions, and recommended that the impact of the parental difficulties on the child/ren should be routinely assessed and monitored.

NICE Guidelines for Adult Mental Health

Some positive changes towards family-inclusive practice have been endorsed since the introduction of National Institute for Health and Clinical Excellence (NICE) guidelines for various mental health conditions. For example, the current NICE guidelines for schizophrenia (National Collaborating Centre for Mental Health (NCCMH), 2009), depression (NCCMH, 2009), bipolar disorder (NCCMH, 2006), and obsessive-compulsive disorder (NCCMH, 2005) include recommendations for interventions involving family members. However, although evidence indicates that including family members in the treatment of panic disorders improves treatment outcomes (Byrne, Carr & Clark, 2004), NICE does not recommend systemically-informed interventions in such cases (NCCMH, 2011).

Despite the recognition that families are important in the recovery process, NICE has paid very little attention to children living with a parent with one of these diagnoses. The only exceptions include guidelines for ante-natal and post-natal mental health (NCCMH, 2007) and alcohol dependence (NCCMH, 2011), which encourage clinicians to be mindful of

the potential impact on the parent-child relationship and the child's health and development.

Applying the Guidelines in Adult Mental Health Services

Although the above suggests that UK mental health services are "family-aware" and welcoming of systemic conceptualisation of mental health difficulties, the services for children and working age adults are delivered separately with little flexibility for integration. In addition to making it harder to keep the whole family in mind when working with parents with mental health difficulties, such dividedness can reinforce professionals' beliefs that the impact of parental mental health on the children is not a part of their role. For example, in a qualitative study Göpfert and Mahoney (2000) found that adult mental health services in the UK were not only unwelcoming for children in term of their facilities, but also in terms of staff attitudes. Many parents expressed a wish that staff would be more willing to involve the whole family, but felt ambivalent about talking to staff about the effects their mental illness had on the family. Largely, parenting was not conceptualised as a central aspect in service users' lives, and the exclusion of children from services was seen as a reinforcer of the negative feelings they experienced as a result of worrying about their parents' health.

It has been suggested that every parent using mental health services should be asked questions about their relationship with their children, including the value of parenthood to the client, how their current difficulties have impacted upon their relationships with their children, and ability to (emotionally) care for the children (Mason, Subedi, & Davis, 2007).

Involving Families in Adult Mental Health Services

What Do Families Want?

Research investigating parents' views on involving families in their mental health care indicates some ambivalence: on one hand parents have reported valuing a holistic conceptualisation of their situations and finding that the inclusion of family members in treatment planning can benefit the whole system, including parent-child relationships (Glynn, Cohen, Dixon, & Niv, 2006). Furthermore, involving children can, amongst other benefits, enhance family functioning, improve the child's understanding of the parent's condition, and reduce the child's internalising symptoms (Beardslee, Wright, Gladstone, & Forbes, 2008).

On the other hand, however, many parents are concerned about how the disclosure of parenting difficulties may be viewed by professionals, and some worry about losing custody of their children (Park, Solomon, & Mandell, 2006). Additionally, some parents may struggle to focus on their children's needs when their own difficulties are experienced as all-consuming (Stallard, Norman, Huline-Dickens, Salter, & Cribb, 2004). Furthermore, parents can sometimes struggle to see the impact their mental health difficulties may have on their children (Maybery & Reupert, 2006), or fail to acknowledge that their underage child has actually become their carer (Cooklin, 2010). Therefore, it is crucial to offer parents who access mental health services opportunities to safely discuss the impact their difficulties have on their children (Lippet & Nolte, 2007).

It has also been suggested that family members can have mixed feelings about becoming involved in their loved one's mental health care. However, some of this reported ambivalence may be explained by the indirect sources used to gain this information: mental

health professionals report difficulties engaging families, either due to families' unwillingness to engage, young age of children, or practical hindrances such as distances and transport costs (e.g. Maybery & Reupert, 2006; Bibou-Nakou, 2003). Conversely, when families are asked directly, they frequently report wanting to be more involved and being eager to understand their relative's difficulties better (Hultsjö, Berterö, & Hjelm, 2007).

Interventions Involving Children

Published interventions involving children in adult mental health services tend to focus on enabling appropriate communication about the parental difficulties. Such family interventions are not designed to be therapeutic as such, but to prevent further deterioration in parental mental health and to promote children's resilience.

The family talk intervention (Beardslee, Gladstone, Wright, & Cooper, 2003) is a widely researched programme designed for this purpose, and involves five meetings with a clinician or sessions in a lecture format. It is based on eclectic theoretical underpinnings, including narrative, cognitive, and psychoeducational elements. Similar programmes have also been reported by other authors (e.g. Place, Reynolds, Cousins, & O'Neill, 2002; Solantaus & Toikka, 2006; Solantaus, Toikka, Alasuutari, Beardslee, & Paavonen, 2009), and have generally been found to improve family functioning and confidence to talk about the parent's mental health difficulties, increase trust in professionals, and improve children's understanding while decreasing their internalising symptoms (Pitman & Matthey, 2004; Beardslee, Gladsone, Wrigth, & Forbes, 2007; Pihkala, Sandlund, & Cederström, 2011).

However, despite these promising indicators, such interventions remain sparsely available in adult mental health services in the UK. Moreover, an Australian study highlighted that programmes to support the parenting role of service users delivered in

adult services lacked theoretical underpinnings and were rarely comprehensively evaluated (Reupert & Maybery, 2011). Such findings suggest that theoretically-based programmes are mainly delivered with the involvement of academic departments, are often not evaluated to enhance the evidence-base, and are not part of routine clinical practice.

Utilisation of Family-focused Care

Adult mental health services in the UK have to keep a record of the children living with their clients, which may include their parenthood status. However, how this information is utilised is likely to vary depending on the service and the individual professional working with a client who is a parent. This section will critically evaluate the extant literature on how service users' parenthood and their children are considered by professionals in adult mental health services. After a review of professionals' reported practices, factors relating to the wider contexts of the workforce are briefly discussed.

Critique of Studies Investigating Mental Health Professionals' Consideration of Their Patients' Parenthood

Qualitative studies. Rose, Mallinson and Walton-Moss (2004) carried out focus group interviews with families, patients, and mental health professionals to identify barriers to family-focused care in community and inpatient psychiatric settings in the US. Mental health professionals (n=25) reported lack of service support, limited time, lack of coordination between inpatient and outpatient services, not perceiving family interventions as being within the scope of their role, lack of skills and experience, and families' resistance to be involved as the key barriers. These findings suggest that professionals may lack confidence to efficiently utilise family-based interventions and feel that the service

structures are unsupportive of such approaches. Analysis of service users' and family members' interviews suggested that patients, families, and health professionals can have very different views on the types of interventions needed in psychiatric settings. Although this study included adolescent children of service users, the focus was not on parental mental health per se. Most of the respondents were nurses, limiting the generalisability to other professional groups. Furthermore, the authors used a mixture of qualitative analyses, including content and thematic analyses without adhering to one specified methodology, thus compromising the overall rigour of the study. Given the varied pools of participants, a systematic application of grounded theory or Delphi methodologies would have been advantageous.

Maddocks, Johnson, Wright and Stickley (2010) explored qualitatively how UK mental health nurses experienced caring for patients who were parents. They identified needing to provide support and remain impartial as important aspects of their work with these clients. Addressing the specific needs of a client who is a parent was also seen as crucial, including potential risk and resilience factors that parenthood can bring to the life of someone who is suffering from mental health difficulties. Many described favouring person-centred approaches over family-centred ones, although reported believing that rehabilitative services should adopt a more family-focused stance and address the patients' parenting role. The importance of liaising with other agencies and the difficulties associated with multiagency work were highlighted as concerns for the nurses. Whilst the findings provide an interesting insight into the challenges experiences by mental health nurses when working with active patients, the researcher was not independent to the setting where the interviews were conducted, thus potentially limiting the participants' willingness to share their experiences openly. The broad phenomenological approach to methodology was also

potentially biased for the same reason, although Maddocks et al. (2010) demonstrated improved methodological rigour compared to the earlier publication by Rose et al. (2004).

Surveys. In a survey of 91 mental health professionals in the UK, Slack and Webber (2008) found that 81 percent of care-coordinators reported always assessing whether or not the involvement of child services was needed in their patients' children's care, and almost 79 percent reported directly supporting the children themselves. These figures seem high in contrast to professionals who did not carry care co-ordinator responsibilities: 47.8 percent and 44.7 percent, respectively. As many as a quarter of the respondents reported believing that their clients' children's difficulties would not reach the threshold for child mental health services, and only 15.4 percent reported not having sufficient time to address the children's concerns. However, there were significant differences in the professional backgrounds of the respondents, with social workers reporting feeling least concerned about the limited time they could allocate per patient and his/her family.

The survey highlighted that whilst adult mental health workers generally emphasised the value of supporting the service users' children, role constraints prevented them from effectively applying this in practice. For example, while professionals in inpatient settings more often agreed that children should be routinely supported, when given a scenario of a hypothetical case, they were less likely to report intentions to assess the child's need for input or support the child themselves compared to those working in community mental health services. Interestingly, length of time in profession was unrelated to the pattern of responses. The limitations of this survey are discussed jointly with the next study.

A larger-scale survey of 311 Finnish nurses' levels of considering the families and support networks of their patients who were active parents reported that most nurses discussed the age-appropriateness of the children's responsibilities (76-81%, depending on

level of training), the opportunities for the children to meet their developmental needs (62-71%), the children's social and leisure activities (61-62%), and the availability of appropriate support from other adults than parents (77%; Korhonen, Vehviläinen-Julkunen, & Pietilä, 2008a). Generally, the higher level of training the nurses had, the more likely they were to report practicing in a family-centred way. Staff characteristics that were strongly associated with openly discussing the children's situation with patients included being female, older, a parent themselves, married, and having further training in family work. In contrast to the Slack and Webber's (2008) survey, more experience in the profession was also associated with the nurses' likelihood of addressing parenting and family issues with their clients.

Although these surveys highlight a number of personal and professional characteristics potentially relating to the likelihood of considering the children of mentally ill parents, the findings are somewhat contradictory. There may be differences across countries and professional groups regarding the degree to which parental mental health is considered in relation to the patients' children. Furthermore, the cross-sectional survey designs and the use of non-standardised measures limit the reliability and validity of the findings of both studies. They also limit the inferences that can be made about the causality and the directness of associations between the measured variables.

Impact of training. A recent Australian pilot evaluation of a staff training programme for working with families where a parent has mental health problems reported positive early outcomes (Reupert, Foster, Maybery, Eddy, & Fudge, 2011). After completing this six-module (total time-involvement one working day) web-based resource, professionals rated gaining significant improvements in knowledge, skills, and confidence to work with the wider family system. Furthermore, participants from adult services reported that, after training, they had come to view family-work as part of their professional role,

which is encouraging given the perceived role-constraints suggested by Slack and Webber (2008) and Maddocks et al. (2010). However, the pilot only consisted of a small number of a mixed group of professionals (37), and the degree to which the new skills are put into practice and sustained in the longer-term remains unclear.

Summary of the critique and concluding thoughts. In sum, research investigating how parenthood is considered by professionals working in adult mental health services is sparse and the results indicate a somewhat mixed picture of the variables associated with the likelihood of involving patients' families, including their children. Studies have either only included nurses, or relatively small sample sizes have included participants from so varied professional backgrounds that it has not been possible to gain a general consensus of how much service users' parenthood is considered by different professional groups in adult services. However, it seems that, without additional training, professionals report low levels of confidence in engaging families, including children, and do not feel supported by their services to do so. Whilst having a care-coordinating responsibility seems to increase the likelihood of actively addressing the needs of clients' children, results suggest mixed evidence for the relevance of the professional's experience in their jobs.

However, despite the identification of these potential barriers, surveys and qualitative studies have indicated that professionals working in adult mental health settings do consider their patients' children, and many report supporting the children themselves despite perceived role conflicts and time-constraints. Even a short one-day training course seems to have beneficial effects on professional's confidence to address their clients' parenthood and assess their children's needs.

None of the studies reviewed employed a theoretical framework in explaining the results. Furthermore, the dynamics involved in deciding to either directly support the

parenting role of the client or perceiving this to be somebody else's duty were not considered. Furthermore, professionals were rarely enquired about their preferred theoretical approaches to their work roles, through which tentative inferences about such decisions could be made. In order to gain a better sense of how adult mental health services consider their patients' parenthood, it is crucial to understand how their evidence-based practices conceptualise this phenomenon.

One professional group that has an advanced understanding of theories relating to both intra- and inter-psychic dynamics is therapists. Such theories include the considerations of individual, relational, and systemic aspects of an individual's functioning, and are distinct from many of the theoretical models applied by other multidisciplinary professionals, who may prefer more task-focused or medical models. Whilst some of the reviewed studies included therapists, none were conducted exclusively with them, nor were participants asked about their preferred theoretical orientations in their clinical work with active parents. How theoretical orientations impact on the consideration of parenthood in therapy can offer a springboard to start exploring factors that influence the degree to which the service users' parenthood, parent-child relationships, and children's needs are thought about in adult mental health settings. To explore this issue further, different therapeutic models' perspectives on parenthood will be briefly discussed later in this review, but first, a brief reflection on how wider factors may impact on research in this area is provided.

The Impact of Wider Factors

In addition to individual characteristics, wider service and political factors can also impact on the degree to which parenthood and family issues are considered in adult mental health settings. For example, large caseloads (Byrne et al., 2000), time-limited involvement

(Maybery & Reupert, 2006; Korhonen, Vehviläinen-Julkunen, & Pietilä, 2008b), focus on short-term financial costs (Darlington, Feeney, & Rixon, 2005), and limited access to appropriate supervision (Thompson & Fudge, 2004) have been reported to limit family-focused practice amongst professionals working in adult mental health services. The ever-increasing focus on cost-cutting and throughput, sometimes at the expense of effectiveness, can also reinforce the focus on individualistic approaches (Jones & Scannell, 2002).

Interagency liaison is important when parents access mental health services, particularly if multiple family members are known to different services. However, collaboration between agencies can be difficult due to some common challenges faced by many teams, including high staff turnovers, frequent staff shortages, and high workloads (Alakus, Conwell, Gilbert, Buist, & Castle, 2007).

Considering these service-related pressures, difficulties with multiagency work, and various political drives, it is perhaps not surprising that professionals in the reviewed studies reported struggling to maintain a family-focused frame. It seems, therefore, that services and policies need to support professionals more to help them keep families in mind.

When critiquing the literature, it is also important to consider the context from which it arises. It is interesting to note that the literature in this area is currently dominated by a small group of voices from Australia and Scandinavia, and to some degree from the US. It is tempting to speculate that some of the current research may be driven by the political contexts in these countries. For example, in Finland, active consideration of service users' children has been highly promoted for more than a decade (Väisänen & Niemelä, 2005), and has recently been reinforced by stricter and clearer legislation (Sosiaali- ja tereysministeriö, 2010). Results from initiatives carried out in such countries, whilst clearly crucially

important, may not be directly generalisable to the practices in other countries across the world where the support for family-inclusive practices may not yet be as high profile.

Theoretical Frameworks in Therapies Provided in Adult Mental Health Services and Their Perspectives on Parenthood

The above review highlights that consideration of service users' parenthood in adult mental health services has not utilised a guiding theoretical framework. Nor has the literature explored how professionals consider the parenting role of their clients asked about the respondents' own theoretical preferences. This is of particular relevance, as the degree to which children and families are considered can vary depending on the underlying theoretical framework of the intervention. Although all services provided by public sector organisations are expected to be evidence-based, interventions that are theory-driven *and* consider relational aspects are likely to be delivered in some format of psychotherapy. This section will discuss how some of the predominant psychotherapies conceptualise parenthood.

Individual Therapies

Cognitive-behavioural therapy (CBT) and more recent third wave approaches tend to focus on the individual's current ways of coping in relation to their cognitive and emotional processes, with formulations based on individualistic conceptualisations of difficulties and maintaining factors. Important relationships can be considered, typically when identifying the client's protective factors, but are not the focus of the intervention. Unlike in some adapted CBT-interventions for children, CBT-protocols for adult mental health difficulties rarely routinely recommend incorporating other family members into the treatment. One

exception is the treatment of obsessive-compulsive disorder, where family members are often seen as accommodating the problem behaviours (Salkovskis & Kirk, 2004). Thus, parenthood may be considered if the patient actively raises the issue or sets specific goals around relationships with children, but the model does not place any particular importance on supporting this role.

Psychodynamic theories explore the person's unconscious desires and styles of interpersonal relating, and how they might affect their current difficulties. Early relationships are thought to form a basis for how the individual relates to others throughout his/her life. Thus, becoming a parent is an important transition, and is seen as requiring the ability to form and maintain a unique and interdependent bond. The view of "parenthood as a developmental phase" (Benedek , 1959) suggests that as the child develops and starts to separate from the parent, the parent is forced to face his/her own past psychic conflicts and renegotiate his/her current relationships (Etchegoyen, 2000). Erikson (1995) expanded on this by arguing that parenthood offers satisfaction to the desire to be needed and the wish to pass on knowledge, which are inherent to human nature and a necessary part of maturation. Although psychodynamic theories recognise that parents will have to come to terms with the parenting they themselves had, as well as the internal conflicts that may arise as a result of rearing children, therapies based on psychodynamic principles are unlikely to directly support the current parenting role of the patient.

Cognitive-analytic therapy (CAT) is concerned with procedural sequences. That is, how events are interrelated, and how thoughts, feelings, and motivations influence the current difficulties. CAT pays close attention to reciprocal roles, thus it is predominantly concerned with relationships with others and less so with internal conflicts. Like psychodynamic theory, CAT proposes that reciprocal roles are formed early in life and

replayed in adulthood (Ryle & Kerr, 2002). Parenthood is viewed as an extremely important relationship, and therapy may explore how the patient's relationship with his/her children is influenced by their own experiences of being parented. However, it does not necessarily involve supporting the patient's current parenting.

In sum, despite the implicit focus on the individual, individual therapies do not necessarily exclude family relationships and parenthood. In fact, some approaches consider relational aspects as a matter of course. However, the extent to which these are acted upon varies greatly between models, and this variation is possibly even greater amongst individual therapists.

Systemic Therapies

Systemic theories were originally derived to describe interactions and their effects in families attending therapy. They postulate that a mental health problem, albeit distressing, serves a function for everyone in the family. For this reason, family members can unintentionally and unconsciously reinforce illness-related behaviours and beliefs.

Systemic ideas are not only relevant in traditional family therapy, but can also be used in individual therapy (Hedges, 2005). For example, family relationships, interactions, and the meanings of actions and language can be explored in individual work. Parenthood and relationships with children are, therefore, seen as important factors in the both the maintenance of difficulties and the recovery process. Therefore, the person's parenting role is crucial when this framework is utilised.

Future Directions and Conclusions

This review has outlined the impact that mental health difficulties can have on service users as well as their children. Given the suggested role children play in the parent's recovery from a mental illness, the vast-ranging possible negative outcomes for the children, and the current evidence-based guidelines and policies, it is surprising that there is a dearth of literature exploring mental health professionals' consideration of parenthood in their work.

Efforts have been made to design psychoeducational programmes for service users who are parents and their families, with the aim to promote understanding of parental mental health difficulties and to prevent future relapses. Whilst such interventions have been valued by the families (Pihkala et al., 2011), a recent European survey found that only two percent of families with a member diagnosed with a severe mental illness received any form of psychoeducation (Rummel-Kluge, Pitschel-Walz, Bäuml, & Kisslin, 2006).

Furthermore, professionals working in adult mental health services have reported a lack of confidence in engaging children or addressing parenting-related issues, despite often discussing children with their clients. Professionals have also highlighted limited support from their service to routinely include families. Moreover, Slack and Webber (2008, p.72) argued that whilst "the impact of parental mental health is well known . . . children's very existence may fail to be recognized by adult mental health services". Given that the impact of disturbed or interrupted attachment in childhood is associated with later mental health difficulties, clinicians working with parents should be considered as having a potential role in fostering resilience and protective factors in children. Therefore, by addressing the parenthood of clients with common mental health problems, professionals could have a positive impact on their children's psychosocial development and future mental health.

This review indicates that the following future research avenues would contribute to a better understanding of the barriers and facilitators for the consideration of parenthood in adult mental health services:

- The differences and similarities between different professionals' considerations of parenthood in adult mental health services.
- The theoretical frameworks utilised in adult mental health services, and their impact on how parenthood is considered.
- Therapists' conceptualisation/consideration of their clients' parenthood.
- Research aimed to impact policy and service development, specifically exploring the interfaces between adult and child mental health services.

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Section B: A Grounded Theory Study of Psychologists' Consideration of Their Clients' Parenthood

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Abstract

Background. Potential negative outcomes for children who grow up with a parent suffering from mental illness are well-documented, including attachment difficulties and later mental health problems. However, research to date has not investigated how therapists conceptualise their clients' parenthood, with the aim to protect the future mental health of the clients' children.

Aims. To explore how parenthood is considered in therapies provided by psychologists in adult mental health services.

Method. In-depth interviews were carried out with psychologists working in adult mental health services in the UK. Thirteen psychologists were interviewed, and the data were analysed using grounded theory.

Results. A preliminary model was generated, which comprised of five categories: drivers, therapist factors, psychological theorising, client variables, and risks. The inter-relations between these categories are complex, and the degree of psychologists' consideration of their clients' parenthood is based on the nature of such overlaps.

Conclusions. Psychologists are skilled at formulating the role of their clients' parenthood, but do not necessarily address and support this role directly. The reasons for this are multifaceted, but any lasting change in practice is likely to require changes in services' infrastructures and policies that support family-inclusive practices.

Declaration of interest. None.

A Grounded Theory Study of Psychologists' Consideration of Their Clients' Parenthood

Epidemiological studies suggest that up to 23 percent of all families have at least one parent suffering from a mental illness (Maybery, Reupert, Patrick, Goodyear, & Crase, 2009). The outcomes for children growing up with a mentally ill parent have been well-documented in the literature, and include difficulties ranging from insecure attachment patterns to behavioural, social, and academic problems (e.g. Rutter & Quinton, 1984; Frankel & Harmon, 1996; Maughan, Cicchetti, Toth, & Rogosch, 2007). Furthermore, forty percent of children who grow up with a depressed parent are likely to have a diagnosis of a mental illness by the time they reach 20 years of age, and this risk increases to 60 percent by the age of 25 (Beardslee, Versage, & Gladstone, 1998).

Whilst parenting can be particularly difficult when struggling with mental health difficulties, children can be an invaluable resource for the parent and a motivator to seek help (Mowbray, Oyserman, Bybee, MacFarlane, & Rueda-Riedle, 2001; Blegen, Hummelvoll, & Severinsson, 2010). Given the above and the impact that parental mental health difficulties can have on the child, it seems that adult services may be ideally placed for supporting service users' children when the parent is experiencing difficulties. That is, whilst specialist children's services are a necessary part of mental health provision, adult services have a role in supporting families when children are not presenting with difficulties but are at risk due to parental mental health problems. Although the need to support service users' parenting has long been recognised (Mowbray, Oyserman, & Ross, 1995), many families fail to receive such support from adult mental health services (Solantaus & Puras, 2010).

Involving Families in Mental Health Services

Programmes designed to include service users' children have typically consisted of psycho-educational components and strategies for improving communication about mental health within families (Solantaus, Toikka, Alasuutari, Beardslee, & Paavonen, 2009). Such programmes, although reportedly useful, have not tended to be based on any particular theoretical framework, limiting the understanding of the processes involved in supporting families where a parent suffers from a mental illness (Reupert & Maybery, 2011).

In order to address children's needs when a parent is experiencing mental health difficulties, professionals need to consider a range of factors. One framework that considers significant others and contextual factors is systemic theory. In mental health settings, systemic frameworks are most frequently applied in therapy work, including both individual and family therapies (Hedges, 2005).

Professionals' use of systemic conceptualisation in adult mental health services has received little attention in the literature. In an Irish survey that included some clinical psychologists practicing in England, Carr (1995) found that less than a tenth of UK respondents utilised systemic principles in their interventions. Staff in this survey identified further training in systemic consultation as a priority for continuing professional development. Although this survey was conducted more than a decade ago, systemic consultation remains sparsely available in many adult mental health services. Furthermore, research has identified some barriers to family-focused care relating to individual characteristics, such as professionals' attitudes and beliefs about involving family members and lacking expertise to work with systems (Kaas, Lee, & Peitzman, 2003). In addition, professionals' preference for person-centred ways of working may hinder systemic

conceptualisation even when the importance of children to the service users is acknowledged (Maddocks, Johnson, Wright, & Stickley, 2010).

Individual professionals are unlikely to change their practices unless they feel supported by the system within which they work, and family-focused care is embedded in the organisation's ethos (Maybery & Reupert, 2009). Indeed, lack of support, time, and coordination between services have been reported to hinder family-focused practice (Rose, Mallinson, & Walton-Moss, 2004). However, care-coordination responsibilities (Slack & Webber, 2008) and higher level of professional training (Korhonen, Vehviläinen-Julkunen, & Pietilä, 2008a) may be associated with increased involvement with service users' families. Findings from a recent pilot suggested that even a short course in family-centred care can increase professionals' knowledge, skills, and confidence to work with families (Reupert, Foster, Maybery, Eddy, & Fudge, 2011).

The lack of family-focus is not only an issue in clinical practice, but has, until recently, also been evident in the dominant discourse in adult mental health literature. According to Montgomery (2005), research to date has viewed mothers with severe mental illness as pathological, resulting in professionals having a distorted picture of clients, focusing on the symptomatology rather than on the wider context in which they live.

A recent review concluded that systemic interventions can be effective, either alone or as part of multimodal programmes, in the treatment of a variety of common mental health difficulties, ranging from domestic violence to sexual problems and psychotic illness (Carr, 2009). Family-inclusive practices are increasingly recommended by many policies and National Institute for Clinical and Health Excellence (NICE) guidelines. However, many of these recommendations do not specifically consider the parenting role of service users, nor the impact that parental mental health difficulties can have on family functioning.

Mental Health Service Structures

The separation of mental health services for adults and children in the National Health Service (NHS) has received some critique in the literature. Slack and Webber (2008) claimed that whilst "the impact of parental mental health is well known . . . children's very existence may fail to be recognized by adult mental health services" (p. 72). Furthermore, Göpfert and Mahoney (2000) reported that families experienced adult mental health services in the UK as unwelcoming for children both in term of facilities and staff attitudes. Although many parents expressed wanting to involve their families, they felt ambivalent about talking about the effects their difficulties had on significant others. Service users felt that their parenthood was not seen as a central aspect of their identity, and children experienced their exclusion as exacerbating their worries about their parent's difficulties. To avoid such effects, parents who use adult mental health services should be provided with opportunities to safely discuss the impact their difficulties have on their children (Lippett & Nolte, 2007).

Given that the impact of disturbed or interrupted attachment in childhood has long been associated with later mental health difficulties, clinicians working with parents should be considered as having a potential role in fostering resilience and protective factors in children. Therefore, by addressing the parenting approach of service users, professionals could have a positive impact on their children's psychosocial development and future mental health. Mason, Subedi and Davis (2007) recommended asking every parent who accesses mental health services about the value of their parenthood to the client, how their difficulties have affected their relationships with their children, and their parenting ability.

Rationale and Aims of the Current Study

Many parents with mental health problems demonstrate good parenting and derive meaning from this important role. However, a significant minority struggles to cope with its demands, and in such cases parental mental health difficulties can have a detrimental impact on children's psychosocial development. Supporting the parenting of those who access adult mental health services may, therefore, have important preventative implications. No previous research has evaluated how frequently and to what extent therapists working with adults with mental health difficulties consider parenthood. This is a particularly timely issue, given recent government drives to increase emphasis on family-centred care in all services, many of which include psychological therapies. Examples of these include No Health without Mental Health (HM Government, 2011), Think Child, Think Parent, Think Family (Social Care Institute for Excellence, 2009), and NICE guidelines for ante-/post-natal mental health and alcohol dependence (National Collaborating Centre for Mental Health, 2007 and 2011, respectively).

Due to the identified gaps in the evidence-base, the current study aimed to explore how parenthood is conceptualised in therapies provided in adult mental health services. In this study, conceptualisation of parenthood was based on the systemic attachment theory (Sydow, 2002), and, as such, therapists' considerations of the dynamics between internal and interpersonal processes within parent-child relationships were of a particular interest. That is, whilst active parents' ways of relating to others, including their children, was considered important, the study was also interested in exploring the ways in which clinicians considered the potential impact that parental mental health difficulties may have on the current attachments of the service users' children. Moreover, whilst attachment theory was a key construct in this definition, the overarching theoretical framework was systemic:

clinicians' ways of formulating clients' internal working models *in conjunction with* the complex dynamics within a parent-child relationship was considered an important aspect of the consideration of parenthood in therapy work, as was the degree to which resources and competencies were highlighted when working with active parents (not just deficits). Conceptualising parenthood from a systemic perspective also enabled the consideration of wider factors that may modify an individual's parenting behaviours (Farnfield, 2008). In other words, considering both the internal factors that are intrinsic to parenthood and external factors that may alter the degree to which a parent is able to care for his/her children moves beyond a "surface-static model of parenting", enabling the interactions with the child, family, and the environment to become a part of the formulation (Woodcock, 2003).

NHS-based clinical and counselling psychologists were interviewed about their practices with clients who are active parents in order to explore how the parental role is considered in therapeutic work, and to identify what factors facilitate and hinder systemic conceptualisation when working with active parents.

In-depth interviews were carried out to gain an understanding of and to generate a model of issues relating to the following broad questions:

- Are patients who are active parents thought about differently compared to those clients who do not have active parental responsibilities? If so, what are the differences?
- How might a client's parental status impact on the formulation/goals/aims/clinician's conceptualisation of therapy?
- What key factors might influence therapist's use of systemic conceptualisation when working with clients who are active parents?

- In what ways, if at all, does clinical work with clients who are active parents include addressing and supporting their parenting role?

Method

Participants

The study was advertised on a professional website. Interested participants were encouraged to contact me to discuss their suitability.

The participants included thirteen psychologists working in the NHS. Ten were clinical psychologists by training, and the remaining three were counselling psychologists. The ages of participants ranged from 27 to 54, and ten were female. Number of years since qualification ranged from one to 25, averaging 7.8 years (median = 7, modes = 1 and 7). All participants worked in adult mental health settings, although many had roles across different specialities and services. The settings where participants provided psychological therapies included secondary mental health, primary care, inpatient, complex needs, crisis team, health, substance misuse, and psychological therapies services.

Participants' preferred therapeutic modalities were varied, with all describing their work as integrative. However, five named cognitive-behavioural therapy (CBT) as their most common orientating theoretical model, and all but one reported utilising CBT techniques to some degree in their therapy practice. Three participants reported predominantly underpinning their work on the cognitive-analytic therapy (CAT) model and two described their therapy style as systemic. All those who named CAT as their preferred therapy model had completed full training in this approach, but only two of the twelve who reported utilising CBT were accredited CBT-therapists. One participant had completed a postgraduate

level training in systemic therapy, one was half-way through this training, and one had completed foundation level training with an intention to complete postgraduate training in systemic therapy in the future. Although six described drawing on psychodynamic ideas particularly in their formulations, only one participant had had additional training in this approach (currently training in dynamic interpersonal therapy).

Seven of the participants were parents themselves, and one was expecting their first child. Only one parent-participant had a grown-up child and no longer described themselves as an active parent.

Ethics

The study adhered to the Health Professions Council (HPC; 2009) and the British Psychological Society's (BPS; 2006) code of conduct and ethics, and ethical approval was obtained from Canterbury Christ Church University.

Design and Data Analysis

Grounded theory (GT) was deemed an appropriate method of analysis due to its specific aim to facilitate a discovery of a theory or a model of the chosen area of investigation that is grounded in the participants' accounts (Glaser & Strauss, 1967). This study explored how psychologists working in the NHS conceptualise their clients' parenthood, thus involving considerations of the processes involved in therapeutic work with active parents. GT seemed ideally suited for exploring this area of enquiry. Although the original Galser and Strauss' (1967) GT was based on a positivist epistemology, later developments of the methodology have moved towards and encouraged social constructionist ways of understanding research data (Willig, 2001). GT that is epistemologically social constructionist is interpretative, thus requiring the researcher to

acknowledge the influence of their own beliefs when co-constructing the data with participants (Charmaz, 2006). My epistemology is grounded in social constructionist ways of thinking, therefore, I approached the data collection and analysis using GT as described by Charmaz (2006).

Peers using GT and my supervisors were regularly consulted regarding methodology, coding, and the emerging model. Additionally, parts of interview transcripts were independently coded by another researcher competent in using GT, and similar codes were found. Any disagreements were discussed until an agreement was reached and alterations were made accordingly. The coding process involved the following actions as a non-linear process:

- Interviews were transcribed.
- First three interviews were coded using line-by-line coding, and the codes that emerged were examined for the possibility of including them as focused codes. One further interview was coded line-by-line, whilst simultaneously comparing the codes to the preliminary focused codes. The remaining interviews were coded using focused coding, although any statements that appeared to be of particular interest were examined line-by-line or, at times, word-by word.
- Constant comparison was used throughout the above stages to examine the codes that were generated across and within interviews.
- Memos were written whenever the data provoked thoughts or hypotheses about potential categories or further issues to explore.

- Axial coding was used to generate a more analytical understanding of the data, particularly when exploring relationships between the codes and emerging categories.
- Interview transcripts were reviewed to examine their relations to the emerging categories.
- Memos and the emerging categories were examined and re-examined, and formed the basis of the developing model.

No new themes seemed to emerge after the 11th interview. Although it was felt that saturation was reached, two further interviews were carried out to ensure that this was not due purely by chance.

Measures

A semi-structured interview schedule was developed jointly with my supervisors (Appendix 3). Minor amendments to the schedule were made following a practice interview with one of the supervisors and two pilot interviews. The supervisor and the pilot interviewees were asked to give feedback on the content and process of the interviews to ensure acceptability and validity. In addition to the interview schedule questions, participants were enquired about their demographic details and asked to describe their therapy work and the service/s they worked in.

Procedure

Participants were given written information about the study, and encouraged to ask any questions before consenting to participate (Appendices 4 and 5). Participants were given a choice of telephone or face-to-face interviews. Although telephone interviews limit

the opportunities for observing non-verbal cues and can make rapport-building with the participant more difficult (Opdenakker, 2006), it has been suggested that telephone interviews can reduce social desirability bias and increase participants' willingness to share sensitive information (Carr & Worth, 2001). Additionally, research specifically investigating the benefits and disadvantages of interview modes in relation to qualitative methodologies has indicated no notable differences when transcripts of face-to-face and telephone interviews have been compared (Sturges & Hanrahan, 2004). Furthermore, the option of telephone interviews was deemed appropriate due to the large geographical area from which the participants were recruited (UK-wide). Most participants reported preferring this option because of the flexibility it allowed in terms of interview time and location.

Ten telephone interviews were conducted for the convenience of participants, and the rest were carried out face-to-face. All interviews were audio recorded and transcribed verbatim. The length of the interviews varied from 33 minutes to 65 minutes. After each interview, participants were asked if they had any questions or comments about the interview or the research, and were reminded of my contact details should they want to get in touch with me at a later stage. They were also reminded of the complaints procedure, should they wish to discuss their participation with a person who was not directly associated with the project.

Results

General Findings

All clinicians reported being aware of their clients' parenthood statuses, and the estimated parent cases in caseloads ranged from 25-70%. It was relatively common for psychologists to see clients with other family members during the initial assessment, and

most typically the accompanying person was the client's partner. Other examples of family members attending sessions included times when clients wanted support in discussing their diagnosis or formulation with their loved ones. Unfortunately, few clinicians described feeling able to justify using a whole session for such purposes in today's time-pressured services. Generally, psychologists reported knowing where clients' children were during therapy sessions, either because they had arranged appointments around childcare and school times or because clients talked about this informally. Although two clinicians described having directly supported clients' childcare arrangements to facilitate attendance, most reported explicitly considering children's whereabouts only if childcare became an issue (e.g. during half-terms and home visits).

It became evident in the interviews that clinicians tended to think about mothers when asked about their parent cases. When asked about this, all participants stated that the majority of their clients were female and that this was particularly the case with active parents. However, some also acknowledged a possible bias, especially in terms of cultural expectations of mothers being more nurturing and taking a more active parenting role compared to fathers.

Summary of the Model

Altogether 225 focused codes were generated. These were condensed to 59 axial codes, which in turn generated seventeen theoretical codes. The theoretical codes formed the final five categories: drivers, therapist factors, psychological theorising, client variables, and risks. These categories had altogether eleven subcategories. (For details of the coding process, please see Appendices 6 – 8.)

The final categories and their subcategories are summarised in Table 1. The number of participants describing issues relating to specific subcategories is detailed in the far right column[1].

Table 1

Categories and Subcategories

Category	**Subcategory**	**Number of Participants**
Drivers	External powers	13
	Service structures and culture	13
Therapist factors	Personal style and preferences	6
	Managing models	11
	Learning and training	5
Psychological theorising	Positioning of parenthood in formulation	12
	Formulation versus therapy	7
Client variables	Presenting problem	8
	Family involvement	11
Risks	Safeguarding and child development	13
	Child's own needs	6

The preliminary model that emerged illustrates the multiple tensions that psychologists manage in their clinical work with active parents (see Figure 1 on page 62). It shows how the five main categories overlap, and how the complex dynamics between various categories lead to different levels of consideration of a client's parenthood in therapy. If all categories are present, it is highly likely that the therapist has an obligation to address the client's parenthood: from the participants' descriptions, this usually involved examples where there was a known or suspected safeguarding risk to the child (although *risks* is a category in its own right, for illustrative purposes it is embedded in the model in the

[1] Due to stylistic reasons, numbers of participants have not been detailed in the main text. Given the small sample size of 13, "most" will be used to refer to 7 or more participants, whereas "some" will indicate responses from 6 or fewer participants.

part where all the categories overlap). When all categories apart from *drivers* are present, it is likely that parenthood needs to be addressed, for example to consider the child's needs in their own right. However, the other possible combinations of overlaps with the *client variables* category only results in direct consideration and/or addressing the client's parenthood if the nature of the variables suggests that this is advantageous. The remaining potential overlaps (computations of *therapist factors, psychological theorising,* and *drivers*) influence the likelihood of considering client's parenthood in therapy. In the cases of the latter overlaps, the attention to parenthood is more likely to be at a conceptual level rather than directly addressing it.

To illustrate the rich data that informed the development of the model, the five main categories and associated sub-categories are discussed in more detail next, including quotations from the interviews.

Drivers

External powers. A strong theme of external drivers guiding clinical practice emerged. Clinicians reported having to manage tensions between current political influences, clinical guidelines, team dynamics, and their own assessment of the client's needs. Many suggested that the current political climate can limit the scope for systemic conceptualisation, and instead encourages clinicians to have a very specific and individualistic focus in their work.

> That's certainly on the horizon where I work, and there's a lot of talk about service users being paid for the needs care clusters, so depending on their presentation... you follow a flow-chart to see what they get. If someone presents with an anxiety problem at this level, they get 12 sessions of CBT. And that's what they get. I mean,

> that would make it much harder to think more broadly and creatively about systemic factors. Just being told what to do… I think there's less room for clinical judgement. Hopefully it won't come to that, but it feels a bit like there's movement towards having a neat formula for everyone's needs, rather than an individual formulation where you are able to do what's best for the person. I think that payment by results follows quite a medical model to psychological approaches, where you get a particular dose depending on your problem, rather than individualised formulation-driven approach, which could be much more focused on wider factors. But we'll see how it develops. (Participant two)

Some participants highlighted that the way adult mental health services are set up can hinder systemic conceptualisation in therapy work with active parents: "It's just not given enough prominence, really. Because adult mental health services are so geared towards the individual patient, but there's not enough thought given to the children and the families." (Participant thirteen)

Service structures and culture. Most participants also commented on their workplace culture playing an important part in the level of systemic conceptualisation in their own work. If colleagues, especially supervisors, were experienced as supportive of systemic conceptualisation, therapists reported being more likely to consider their client's parenthood and the impact that the mental health difficulties may have on the family: "Having systemically-minded colleagues, psychology colleagues, makes a difference. Makes it much easier. And supervision." (Participant thirteen)

Conversely, not having a systemically-minded team around made it difficult for some participants to maintain a broad view with their clients: "It can be a very lonely place to be." [being the only systemic person in the team] (Participant seven)

Therapist Factors

Personal style and preferences. Many therapists described their approach as non-directive, and in ordinary circumstances "going with what the client brings": "It's up to the parent to decide what they want to work on, and if that's [children] something that doesn't come up, then I don't think I'll necessarily push it unless that person decides to bring it up". (Participant three)

Managing models. Therapists varied in terms of their use of therapeutic models and the degree to which they integrated them. Some described it as important to choose an underpinning model early on, and carefully consider what aspects of other models could be integrated and how. This led some clinicians to be less likely to consider systemic issues when working with clients who are active parents.

> Within the CBT model, you can have the formulation of the presenting problem. So for example the panic cycle, which doesn't actually take into account the person's relational context, it's just about the catastrophic interpretations and physiological symptoms. That's the formulation, and if you're limiting yourself to that kind of formulation, obviously you don't really take into account the wider context. (Participant nine)

However, others described preferring to adjust the models and their focus depending on how the client presented.

> Typically I would start by using a CBT-framework if I was meeting someone for the first time, and then based on some information that I get and thinking with that individual, I might then start to explore ideas using other frameworks. (Participant one)

Even therapists who had had further training in systemic work described slipping into individual work mode. Partly, this was felt to be due to the above-mentioned service and wider political issues, but also because it can be easier to focus on the individual unless the client frequently talks about their families.

> I probably don't do it as much as I think that I do. Because I move very easily into the one-to-one weekly therapy mode, where I'm working with this one person and holding that person in their different contexts becomes more and more difficult. (Participant four)

However, some participants described incorporating systemic conceptualisation in their work even when engaging the family might be difficult for whatever reason: "We don't have to be that creative to be able to bring a system into the room, for example, you can use a genogram or just asking 'what would your daughter think of this?'" (Participant seven)

Learning and training. Many participants commented on their lack of training in systemic work limiting their confidence to incorporate such ideas in therapy with clients who are active parents.

> It would be great to be able to receive systemic supervision, or actually have a bit more experience of working particularly in that way, because then I think you become more confident in it and you might be able to bring it to your own practice. (Participant ten)

Three of the participants had been qualified for less than two years, and reflected that this may also impact on how much they apply systemic thinking in their practice despite expressing an interest to develop skills in this modality.

> If I'd been here longer and because I'm on a locum post. I also have to be flexible myself. And it could be to do with the point of qualification I'm at as well, maybe I

feel a bit less able to have strong opinions about how things should be done. (Participant twelve)

Psychological Theorising

Positioning of parenthood in formulation. Almost all participants talked about the importance of clients' experiences of being parented, whether in relation to their own current parenting or their presenting difficulties. It was evident that for most clinicians this was a core part of formulation when the client was an active parent.

> Parenting is interesting, because it's often about the role of being a parent but also the role of being parented, and I suppose a lot of the work that I do even within CBT and schema approaches looks back to the early history and the early parenting for themselves. I suppose the interesting thing is that people will often make links from their own histories to who they are and where they are now, and then make links from where they are now to their role as parents. I think that's very interesting, because all sorts of things happen then, people often recognise things for themselves, they recognise their own parents, but often if they've had a difficult early history they absolutely stay away from that stuff, and almost try to compensate for their own histories ... The interesting part of formulation is the way they work in that and how their current role as parent is in the very present, but actually the being parented is in the past and the connections between the two. (Participant five)

Formulation versus therapy. Whether or not the above formulation process was directly acted upon in therapy seemed to depend on the model that was used and the therapist's style. Some participants who used predominantly CBT-based approaches described rarely bringing this thinking into therapy work, whereas those basing their work

mostly on CAT, systemic, and psychodynamic approaches considered it crucial to discuss it with the client. Interestingly, when participants described integrating models, they outlined the same process: although they sometimes considered clients' experiences of being parented in therapy, they were less likely to do so when the dominant framework was CBT.

> If I'm working with my CBT hat on, I tend to not focus on that so much. Even though I'd still be thinking about their early experiences and how they've come to form particular beliefs about themselves and others, and expectations of themselves and others, and how that might influence how they are with their own children. But I don't tend to focus on that so much in the room with them. (Participant eleven)

Nevertheless, most clinicians saw children as a resource for the client and a powerful motivator for change regardless of the therapeutic framework, and as such it often featured in conversations indirectly.

> It's a very defined relationship that you automatically just know that it was there beforehand. And so it's likely, I guess, to be important in terms of therapy. Parents want to get better for their kids, it can be the reason why they've come to see me. Or it can be the reason they've not acted on suicidal thoughts. So yeah, I'd keep that in mind, maybe ask about it every now and again. (Participant eight)

In terms of the goals and format of therapy, clinicians reported rarely considering active parents any differently compared to their other clients. Exceptions included when the client specifically wanted to improve their relationship with their child or the client's children were the main motivator to seek help. However, most reported offering flexibility regarding appointment times when working with active parents as a practical way of supporting their parenting role: "I suppose, if they wanted to get on with their children better. Or if they wanted to be able to do things with them that other parents do, like just going to the park

after school." (Participant six) "No, not really, once the goals are set I work with them like I work with any other client. I might be a bit more flexible sometimes around changing the time." (Participant ten)

Client Variables

Presenting problem. The degree to which parenthood and systemic factors were considered by clinicians also depended on the presentation of the client's difficulties. Some psychologists reported exploring systemic factors further when clients seemed to locate their difficulties in their children rather than in themselves: "If you can see that there's a child that's getting the blame for everything and all the family charging around, and then you think that this is like a 'symptom bearer'." (Participant ten)

Other examples of times when the client's variables prompted the clinician to consider systemic factors included cases when the difficulties seemed relational in nature: "I would consider it when the issues seem to be more about relationships within the family and how everybody relates to each other, and if there are lots of difficulties within that." (Participant five)

Some therapists acknowledged that they may be prompted to consider systemic factors or involve other family members if the client's family seems "stuck", perpetuate the difficulties, or feel confused about the changes in the client who is in therapy.

> I'm very conscious of thinking about the support network that people have around them, but also the fact that people can be held back, the very same people who support them moving forward. It can really shake things up if someone is changing and progressing in therapy. (Participant twelve)

Although some clinicians described supporting their clients' parenting indirectly, for example by the use of Socratic questioning to enhance their self-efficacy, many reported only directly addressing and supporting parenting if it was raised by the client and directly related to the presenting problem.

> It depends on what the client brings to the sessions and how important it is in the whole conceptualisation and the goals for therapy, but it has happened. For example, practising being assertive with the children and school, and that's been part of CBT. (Participant eight)

Family involvement. Some participants noted that the degree of family involvement often depended on the family's beliefs about mental health services, and what they thought might be going on in therapy: "The family won't set a foot on the hospital grounds." (Participant six)

Risks

Safeguarding and child development. When asked about circumstances when clinicians might consider systemic issues in their work with active parents, the first factor that all participants named was risk. Risks included clear safeguarding concerns, such as abuse and neglect, but also more subtle risks to the child's normal development. Managing emotional risk factors was experienced as difficult by most participants, and viewed as an issue that needed to be approached very sensitively.

> What I would retain an awareness of is that they are responsible for children, and the children are in a home with parent who is struggling psychologically. So there's an awareness that the children are potentially at risk, not necessarily actual physical harm, but possibly emotionally. Also, how it affects the children if the parent is very

> socially avoidant, for example. A few concerns ... I feel that probably we don't do enough to protect the children from that situation. I think it can be overlooked a bit, and it can be hard to get support from Social Services if it's emotional rather than actual physical harm. (Participant two)

Although risk was brought up by all participants, those who had their own children often elaborated on how their perspectives on the impact of parental mental health on children had changed since becoming a parent.

> Since I've had my own children ... I can empathise with the parent, but also with the child, I'm more mindful of the child. If I'm seeing someone, I'm just thinking 'what do they need?' and is this parent able to provide that. It's just different now. (Participant ten)

Child's own needs. Some participants reported paying attention to their clients' children's mental health needs, and suggesting referral to child services if they considered that specialist support was appropriate.

> A number of my clients have had children either with behavioural difficulties or Asperger's or those sort of challenges... parenting children who have substantial difficulties that require extra support. We don't really have a specialist expertise, so we can raise the question and we can then maybe suggest that the GP refers them to CAMHS or somewhere. (Participant nine)

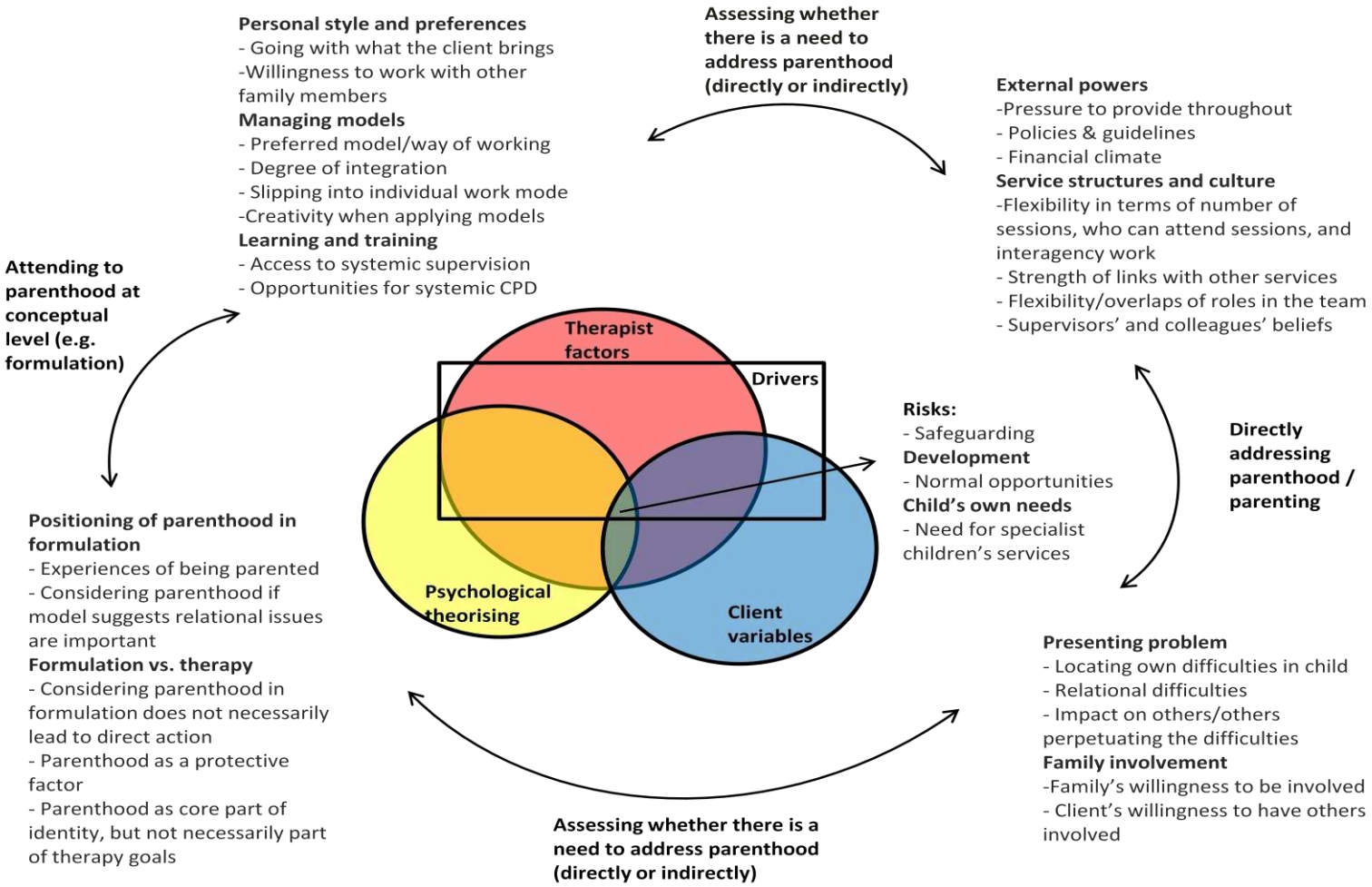

Figure 1. Model illustrating how different variables influence the consideration of clients' parenthood by therapists working in adult mental health services.

Discussion

This study proposes a preliminary theoretical model to aid the understanding of therapists' consideration of their clients' parenthood in adult mental health services. Psychologists manage a variety of tensions in their clinical work with active parents, including their own preferences for therapy models, service expectations, and wider social and political movements. In addition, the degree to which parenthood is directly considered in therapy depends on various client-specific factors and whether or not there are any known risks to the child's well-being and/or development.

The psychologists who took part in this study demonstrated regularly considering their clients' parenthood, particularly when working with mothers. They were skilled at theorising and considering the impact of parental mental health on children. This was the case regardless of the therapeutic model that underpinned the work, suggesting that these NHS-based psychologists formulated broadly and flexibly when the client's situation indicated that this may be appropriate. However, formulations were more likely to include aspects of parenthood if the model considered relational aspects than when it was more concerned with intra-personal factors.

A thorough psychological formulation of a client's parenthood did not necessarily lead to directly addressing and supporting the parenting role of the client. Mistry, Stevens, Sareen, De Vogil, and Halfon (2007) found that low emotional and functional support were independently associated with poor maternal mental health. In the current study, some clinicians described sometimes offering emotional support, for example by enhancing the client's self-efficacy and assertiveness, including in his or her role as a parent. However, this

was usually only offered if it was specifically requested by the parent-client, and functional support was rarely available, if at all.

The notion of "going with what the client brings" as clinicians' default way of approaching clinical work is of particular interest from the perspective of children's wellbeing. For example, one study found that children who were perceived by others as calm reported feeling drained and distressed by their parents' mental health difficulties, but attempted to mask such feelings in order to protect the rest of the family from further difficulties (Mordoch & Hall, 2008). Therefore, in addition to working with what is present in the room, further exploration about the children's coping may be necessary not only to assess potential impact of parental mental health on children, but to elicit parents' awareness of how their difficulties may be dealt with by others in the family.

The psychologists in this study reported that, in addition to personal interest in systemic ways of working, factors relating to service structures and wider political drives influenced their degree of implementing this framework in therapy with active parents. This finding is in line with studies involving multidisciplinary samples that have investigated barriers to family-inclusive work in adult mental health services (Biebel, Nicholson, Geller, & Fischer, 2006; Maybery & Reupert, 2006; Korhonen, Vehviläinen-Julkunen, & Pietilä, 2008b). In addition to targets that reinforce individualistic approaches, dynamics in the team may also influence the level of clinicians' consideration of their clients' children. For example, studies involving mental health nurses have found that nurses frequently report wishing to remain impartial to family difficulties and not seeing the consideration of children's wellbeing as their role (Maddocks et al., 2010). Furthermore, service factors such as high staff turnovers and high workloads can hinder professionals' capacity to hold families in mind (Alakus, Conwell, Gilbert, Buist, & Castle, 2009). It seems, therefore, that successful

attempts to increase family-inclusive care need to be supported by the organisations offering services to active parents in order to maintain clinicians' agency and autonomy in clinical decision-making.

Health-economics, family policy, and health policy perspectives all trumpet the importance of broad conceptualisation rather than purely considering individual family members in isolation (Kavanagh & Knapp, 1996), which is seemingly in contrast to both the reported findings in the literature and the service pressures described by the participants in the current study. However, resource distribution in the NHS, particularly in the current economic climate, is likely to be discouraging for family-inclusive initiatives, especially given the pressures to demonstrate quick benefits and outcomes. Some participants in the current study reported feeling pressured to provide a strictly time-limited service and draw on therapy models that are focused on specific presenting issues, and not having time, resources (e.g. supervision), or facilities to broaden their conceptualisations beyond the individual who accessed their service.

A UK-based service that has attempted to overcome the barriers to family-inclusive work was described by Pollet, Bamforth, and Collins (2000). In this service, adult psychotherapists and children's mental health workers work jointly, and strong links with health visitors are maintained. It offers various interventions with a focus on rapid assessments and brief interventions based on families' own prioritisation of difficulties. More intense support is offered to those who have more entrenched relational difficulties and are motivated to engage. Importantly, Pollet et al. (2000) also demonstrated that such approaches have financial incentives in the long-term.

Cognitive dissonance theory (Festinger, Riecken, & Schachter, 1956) can help describe some of the processes in the model proposed in this study. This theory, although

originally concerned with belief formation and attitude change, has also been applied to organisational behaviour research (Mullins, 2010). It proposes that when individuals hold conflicting ideas simultaneously, they strive to reduce this dissonance by changing their attitudes, beliefs, and/or behaviours, or by finding ways of justifying their beliefs and actions despite the conflict. Inevitably, dissonance occurs more strongly in those who are committed to their attitude-inconsistent situations (Cooper, 2007), which in the current study was demonstrated by the systemically trained participants by expressing a wish to apply this theoretical framework in their clinical practice whilst continuing to meet the expectations of their services.

In the current study, participants' beliefs about the most effective ways of working were sometimes conflicted with the expectations of the service and the wider political context. That is, training and clinical experiences, amongst other individual factors, had led many to believe that it is important to consider broader factors when working with active parents, but limited support from the service and pressures to provide throughput had forced them to re-evaluate the practicality of applying systemic theory in day-to-day clinical work. In an attempt to manage this dissonance, many participants described finding other ways of applying such thinking, for example by considering the parent-child relationship in the formulation. In addition, liaising with other team members regarding the client's children and/or parent-child relationships was sometimes described as a way of conceptualising parenthood. Many justified these actions by theorising that improvements in the parent's mental health were likely to have a positive impact on the child's wellbeing, thus giving them a sense that they were able to apply some aspects of systemic theory even when it was not possible to base their work completely on this model.

Although detailed exploration of team dynamics is beyond the scope of this paper, it is worth noting that many participants alluded to the importance of working within a multidisciplinary team when considering service users' parenthood. For example, whilst discussing the limitation of individualistic approaches, particularly in terms of their longer-term sustainability of benefits for active parents, participants also recognised the roles of their colleagues and often viewed "family issues" to be the responsibility of the service user's care coordinator. Being able to rely on others to consider broader contextual factors seemed to enable psychologists to achieve a level of safe uncertainty (Mason, 1993) regarding their clients' parenthood-related issues, whilst legal frameworks and policies provided a degree of safe certainty when service users' parenting was associated with potential risks.

Clinical Implications

Given that in a multidisciplinary team the psychologists' role focuses on the intra-psychic and relational processes of service users, they are ideally placed to formulate parenthood from different theoretical perspectives and to understand the dynamics between parental and child mental health. It is crucial that this knowledge is shared with the multidisciplinary team in order to safeguard children's development *preventatively*, and that appropriate measures are in place to ensure that professionals agree on how this can be achieved at service-level. Clinicians in this study described how easily they can become focused on the individual when external pressures dictate their pace of work, which, in turn, can reinforce and increase the risk of *reactive* safeguarding practices.

The dividedness of adult and child services can reinforce the diffusion of responsibility for supporting parenting. In this study, participants' level of direct

involvement depended on the service's parameters, with some participants seeing it as their role whereas others viewed it as another professional's responsibility. Additionally, previous research has highlighted that achieving agreement in this matter can be further compounded if children are receiving support from children's services for their own needs (Fredman & Fuggle, 2000). Longer-term preventative approaches could address this by explicitly considering the parenting role of service users who access adult mental health services, supporting their parenting when appropriate, and ensuring good communication with relevant children's services. Such practices may include involving families, including children, in routine clinical practice in adult mental health services.

Although trained family therapists and specialist family therapy services have an important and necessary role in adult mental health services, increasing the availability of such provisions in the current climate seems unlikely to be feasible. Rather, adult mental health services users are likely to benefit if professionals in the NHS are encouraged to use family therapy *thinking*. Psychologists have the relevant skills that are necessary to apply and model such practices to other professionals.

Limitations

This study had several limitations. First, although it was felt that theoretical saturation was achieved, the sample size of 13 is relatively small. Second, despite applying a theoretical sampling process, the sample was biased by self-selection. That is, participants were likely to be motivated to take part because of their interest in parental mental health and/or systemic ways of working, which limits the generalisability of the model to the overall population of NHS psychologists. Third, the study only included clinical and counselling psychologists, thus excluding the voices of other professionals providing

psychological therapies in the NHS. Although this was done on the basis of theoretical sampling (all participants were expected to have some knowledge of systemic theories and ways of applying them), the results cannot be generalised beyond these specific professional groups. Lastly, as with any qualitative methodology, GT is affected by the researcher's own biases. However, attempts were made to address this by inter-rater reliability checks and use of supervision.

Future Research

Future research should examine how some of the barriers identified in this research could be creatively overcome so that clinicians working with active parents would feel better able to directly address and support service users' parenting, when appropriate. Both qualitative and quantitative methodologies would be advantageous in exploring whether or not this is currently commonly done, and if so, how.

In addition, future research should explore active parents' experiences and perspectives of individual therapy and its impact on their parenting and parenthood identity. Such research would enlighten helpful ways to support service users' parenthood and, ultimately, foster their children's emotional well-being and development.

To enable clinicians working in adult mental health services to feel more able to dedicate time to consider relational aspects in therapy and act upon their formulations about parenting, when indicated, future research should aim to influence service development. Furthermore, policy development in the area of parental and family mental health needs to be clearer. In particular, professionals working in adult mental health services must be aware of the family-focused policies that are aimed at *all* services. Services have a role in fostering good family-inclusive practice and in enabling and encouraging such

research. Examples of how these issues are overcome in services across the UK are currently sparse.

In sum, future research needs to consider the service users' children when investigating adults with mental health difficulties who are parents. Furthermore, future studies should consider adult mental health services' role in shaping the children and their future mental health.

Conclusions

Psychologists working in adult mental health services consider their clients' parenthood when appropriate, and are skilled at formulating the relational and generational aspects of such difficulties. However, due to factors to do with personal style, therapy models, service and wider political drives, and client variables, these issues are not routinely addressed in therapy work.

The findings of the current study suggest that changes are required at an individual, service, and wider political levels. Policies that encourage broader conceptualisation in adult mental health services are powerful drivers and affect the practices of individual professionals, but for psychologists to implement lasting changes to their clinical practice, services need to have the required infrastructures and maintain a supportive attitude to foster a shift to a more family-inclusive practice. Only if these factors are in place can psychologists find opportunities to routinely utilise their broad theoretical knowledge to benefit both the client in front of them and also their developing children. Such changes would also likely increase psychologists' opportunities to further develop their confidence in addressing and supporting parenthood in their clinical work with active parents.

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Section C: Critical Appraisal

Word count: 1987

Research Skills

My journey with this project has tested my skills in many ways, and, overall, it has been an enriching experience. I am pleased that I conducted a qualitative project instead of a survey, which is what I initially proposed. I have come to view qualitative methodologies as highly meaningful ways of investigating clinically relevant material, and, in my opinion, they are as valid approaches to research as quantitative methods. This was my first attempt at grounded theory (GT), and I feel I learned new skills as well as built on my existing ones, particularly those that I gained in my MSc using interpretative phenomenological analysis (IPA). After MSc, I felt confident in designing another qualitative study; I was looking forward to learning a new methodology and identifying the differences between the approaches. I feel that, in addition to learning about GT, my understanding of qualitative methodologies in general has improved, and this is evident not only in completing my MRP, but also in how I now evaluate qualitative papers as a result of undertaking two of them myself.

I chose GT as it seemed the most appropriate method to answer the research questions that I posed, in the timeframe that I had. However, I was forced to re-consider my own epistemological viewpoint, and after reading about the method I was glad I could settle with a social constructionist approach –this is how I make sense of the world anyway, so it was fitting and felt more genuine than trying to deny my own beliefs. Having the "permission" to co-construct meaning with my participants also made the process enjoyable, and I believe this was reflected in my enthusiasm during interviews.

Identifying my own biases was not always easy. However, coming from a different culture than most of my participants, not being a parent myself, and doing a placement

closely relating to parenthood highlighted some obvious differences that encouraged me evaluate my participants' accounts from a position where I was able to maintain an awareness of my own assumptions. I have noted with interest that after moving from neonatology to older people's setting, my clients still regularly talk about their parenthood, and seem to place no less emphasis on this role even when their children are adults. As a non-parent, this made me consider my assumptions about parenthood as well as my own possible future parenthood, and how these might have impacted on my data analysis. In the process of reflecting on these issues, I found reading about the continuum of research paradigms from positivist to critical/post-structural theorising (e.g. Ponterotto, 2005) both intellectually stimulating and helpful in my approach to data analysis. I also noted changes in my attempts to use bracketing, and gradually coming to an acceptance that "perspectives can never be ruled out" (Fischer, 2009, p. 584). Returning to earlier memos, writing new ones, and keeping a reflective diary also helped me indentify biases in my own reasoning and maintain an awareness of my developing thinking.

I encountered ethical issues when recruiting participants. Given the method of recruitment, many potential participants expressed interest in my research. However, after ensuring that they were suitable, I lost contact with a few. I had to judge how many reminder emails I should send them; a decision that was not always easy when employing theoretical sampling and having to face the possibility of losing a potentially highly desired participant. As often with such dilemmas, I do not think that there was a definite answer, but having to evaluate these issues taught me about considering participants' perspectives.

Despite my increased confidence in undertaking qualitative research, I also realised the importance of support and supervision when using such methodologies. It is very easy to become so immersed in your data that it becomes difficult to see the wider picture, and if

I were to undertake another qualitative project in the future, I would ensure that appropriate supervision was in place to avoid such issues. In addition to supervision, I found peer support invaluable during the process of conducting my research. I imagine that it can be difficult to allocate time for research once qualified and working in a time-constrained NHS, and I think that regular contact with like-minded researchers and peers can be a priceless resource and motivator. These are important factors that I will keep in mind in any future research that I may conduct.

Although I learned a great deal about GT, there are still many areas that need developing. In particular, I would like to have more experience of triangulation and NHS ethics procedures. I hope I will have opportunities to hone these skills as part of my future jobs.

What Would I Do Differently and Why

Considering the timeframe and other practical limitations for doctoral research, it would have been difficult to conduct this study very differently. However, some of the limitations of the MRP could have been improved by a better recruitment strategy. To attract a larger sample, I could have considered other recruitment sources, which may have improved the theoretical sampling. For example, if I had obtained NHS ethical approval, I might have attracted a more varied pool of potential participants, and the self-selection bias may have been reduced.

Although GT was deemed as the most appropriate method for data analysis for this study, alternative methodologies could also have been applied. GT was originally based on social sciences, not on psychology, hence any model that is generated from the data using this method will be descriptive rather than a psychological one that readily illustrates

complex processes (Willig, 2001). However, this is a general shortcoming of GT in psychological research, and not specific to my study.

Although it was felt that theoretical saturation was achieved, the sample size was relatively small. It is widely acknowledged that it may not be possible to reach redundancy when working with rich data, and achieving theoretical saturation, therefore, serves as a hallmark for meeting the validity criteria (or trustworthiness) for qualitative studies (Williams & Morrow, 2009; Corbin & Strauss, 2008). That is, ensuring that saturation is achieved within categories when they are developed is perhaps a more meaningful measure of trustworthiness than carrying out numerous interviews in an attempt to reach a point where new participants do not provide any new information. In my research, some of the subcategories were not reported by the majority of the participants, and further investigation of these areas would be advantageous in ensuring the integrity of the data. Within the timeframe that was available, supervision, peer-reviews, memos, research diary, and constant comparison were used to overcome this dilemma.

Triangulation with the participants was not done in this study. However, Charmaz (2006) views constant comparison as a form of triangulation. Although the susceptibility to bias remains, comparing data not only between interviews but also within them helped maintain a degree of objectivity in the process. However, if I could do this study again and had sufficient time to meaningfully gather feedback from participants, I would employ participant-triangulation.

In addition to participant-triangulation to strengthen the methodology, it may have been helpful to apply the Delphi method, which involves summarising the results of the interviews and asking a different set of “experts” to comment on them (Keeny, Hasson, &

McKenna, 2011). In my study, it might have been useful to take the preliminary model to service leads or policy developers.

Had I had a longer timeframe, I may have considered involving service users more. They were only consulted in the initial proposal phase, but it may have been useful to include them in a triangulation process.

Impact on my clinical practice

In my sample, psychologists working with active parents considered their clients' parenthood a great deal in their clinical work, and viewed it as a fundamental part of one's identity. Literature suggests that other professionals do this too. However, finding time, space, and other resources to keep parenthood in mind and to address it as a routine part of practice seem limited. This had led me consider my own clinical practice in two ways: how I develop formulations with my clients, and how I might find ways of addressing/supporting my clients' parenthood.

In terms of formulations, I have come to realise that "working with what the clients brings" does not necessarily equate to working with what is present in the room. When I work with future clients who are active parents, I will keep this in mind and perhaps be more directive if they do not mention their children. My preferred theoretical stance allows this, and I cannot see any harm in asking about children. However, after reviewing the literature, I have come to a greater realisation of the extent of potential harm if children are ignored by professionals in adult mental health services, and it is not only good practice but also my duty to consider the impact that my client's difficulties may have on the children's development and mental health. After conducting this study, I think I will only consider my formulations sufficient if I have considered my clients' relationships with their children. I

feel that my research has helped me in learning to approach this issue very sensitively but assertively.

I may have to be a little bit more creative in finding ways to address and support my clients' parenthood, particularly if I end up working in a very time-limited and highly structured service like some of the ones described by my participants. However, I do believe that it is possible to support this important role in therapy, even if only by considering its meaning with the client or by identifying the client's specific needs in this area. I have realised the power of good formulations, and I will make every effort to share my formulations with my multidisciplinary team colleagues and other agencies involved, confidentiality permitting.

I have been inspired by some of my participants' relentless attempts to incorporate systemic ways of working and thinking in adult mental health services. As a relatively senior member of a multidisciplinary team, I will have supervision responsibilities and will be expected to provide consultation to staff. These tasks provide ideal opportunities to support systemically minded practices and to learn from other professionals' approaches to parenthood. In addition to reinforcing the practice of routinely considering the service users' children, I will need to model creative ways of applying a holistic approach to active parents' mental health care. I believe that systemic conceptualisation is a holistic approach that can be done creatively even in individual therapy, and it is not limited to just family therapy work.

My research has also highlighted how important it is to maintain good links with other services where my clients' family members are known. I will aim to continue such practice in my future work in order to ensure that families receive the most appropriate support that is available to them.

Further Research in This Area

I would be interested to involve service users about their experiences of different types of therapies that have/have not considered their parenthood. IPA may be an appropriate approach to this area of research.

Additionally, I feel passionate about research on how the links between adult and child services can be improved. This is closely related to service and policy development, and as such lends itself to a number of potential ways of investigation –both qualitatively and quantitatively. For example, families' and professionals' experiences of integrated pilot services may be helpful to explore (these do exist, but details are often not readily available, as such pilots are rarely published). I am particularly interested in exploring this by closely examining the dynamics between the categories that overlap in my preliminary model. In addition, developing meaningful ways of measuring progress and outcome in therapies provided to active parents needs further research, and it is likely that mixed methods designs will be most appropriate in identifying relevant variables and their interactions.

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Section D: Appendices

Appendix 1: Literature Search Strategy for Section A

In line with grounded theory, the process of reviewing literature was done very broadly and was perhaps not, at the early stages, as focused on specific research questions as it might have been if a quantitative or another type of qualitative methodology had been employed. Therefore, the summary below in a simplified report of the actual process, which was non-linear and the final inclusion and exclusion criteria for the critiqued papers were decided alongside the progress made with Section B of this portfolio. Many papers outside of the inclusion criteria were thoroughly read in the view of the possibility that they might support or disconfirm the model once it had been generated.

Inclusion Criteria
Studies investigating the consideration of parenthood in adult mental health settings were included. In particular, the perspectives of staff and services were of interest, although research exploring service users' experiences were also considered highly relevant. Service user related studies and conceptual papers were, therefore, cited in other parts of the Section A and formed an important part of how parenthood in service contexts was conceptualised.

Exclusion Criteria
Studies investigating parenthood and/or parental mental health in general were excluded. In addition, studies investigating the effectiveness of family-based interventions were excluded, although they were relevant to the topic and, therefore, cited outside of the critique section of the review.

Search Strategy
The following databases were searched for relevant publications: CINAHL, EBSCO, MEDLINE, PsychINFO, SAGE, ScienceDirect, and Wiley online library. The Cochrane database was also searched for relevant publications despite the expected unlikelihood of randomised controlled trials in this area of research.

Various computations of the key words "parent*", "parenthood", "parenting", "adult mental health", "mental health" "adult", "psychiatric", "psychiatric illness", "staff", "professional", "service", and "policy" were used when searching for relevant publications. In addition, searches were conducted using combinations of the terms "child*", "welfare", "outcome", "safeguarding" and "risk" to ensure that relevant publications from the perspectives of child mental health services were not omitted (this strategy did not identify any included papers).

353 potentially relevant articles were identified. The abstracts of these were screened, as were the reference lists of those publications that addressed the area of investigation. In addition, those papers that were indirectly related to the research questions were investigated if the contents indicated high relevance, thus warranting further exploration. Altogether 226 papers were read for the purposes of this portfolio, some in more detail than others, and only five were included in the final critique in Section A. These were the only empirical studies that investigated the consideration of service users' parenthood by staff working in adult mental health services.

Appendix 2: Ethics Compliance Letter

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Appendix 3: Semi-structured Interview Schedule

Following introductions and discussion on any issues that may arise from the participant information sheet, and after consent has been obtained, the following areas will be covered in the semi-structured interviews:

Demographic information:

- Age
- Gender
- Parenthood status
- Relationship status
- Profession
- Number of years since qualification
- Service the participant works in
- Preferred therapeutic modality/way of working
- Additional training before/since qualifying
- Specialist interests

General questions about working with parents:

- On average, what proportion of your caseload are parents of children and/or adolescents? [explain that the term "active parents" will be used to describe parents who have dependent children, i.e. not children who have moved out at an appropriate stage of the family cycle, etc].
- How often do you see clients who are active parents with other family members? Who do they bring with them? Who usually decides who attends sessions? Where are the children when their parent attends sessions with you? [school, nursery, crèche, etc]

Areas relating to specific research questions:

1) Are patients who are active parents thought about differently compared to those clients who do not have active parental responsibilities? If so, what are the differences?
    - When working with clients who are active parents, do you think about them differently compared to those who do not have dependent children?
    - If so, how/when do you think about them differently?

- What benefits, if any, do you see in considering the parent role when thinking about your clients who are active parents?

2) How a might client's parental status impact on the formulation/goals/aims/clinician's conceptualisation of therapy?

   - Are there any specific considerations you might make when working with clients who are active parents?
   - What kinds of factors do you consider / not consider?
   - How does it impact on the work you do with that client?

3) What key factors might influence therapists' use of systemic conceptualisation when working with clients who are active parents?

   - What circumstances might lead you to consider systemic factors, such as family context and parenthood, in your clinical work with clients who are active parents?
   - What do you believe would be the reasons for doing so?
   - Is there anything that makes it easier for you to consider these factors in your clinical work with active parents? If so, what are they?
   - Is there anything that makes it harder for you to consider these factors in your clinical work with active parents? If so, what are they?

4) In what ways, if at all, does clinical work with service users who are active parents include addressing and supporting their parenting role (whatever model is used in the work)?

   - Generally speaking, how often do clients who are active parents spontaneously talk about their children in sessions? Are there times when this happens more [e.g. during assessment, particular stages of treatment]? (although this is a general question rather than specific to the 4th research question, this seems a more natural place for it as the subsequent questions share a similar content)
   - Are there ever times when you directly address parenting issues in your work with clients who are active parents? If so, when/how would you do this?
   - Are there ever times when you offer support with the parenting role to clients who are active parents? If so, when/how would you do this?
   - Can you think of any other reasons why you do / don't directly address and support parenting when working with clients who are active parents?

Prompts to be used to elicit more / more detailed information:

- Could you say a bit more about that?
- Could you explain that a bit more?
- Can you expand on that?
- Was there anything else?

This semi-structured interview schedule is a guide only, and every interview may vary slightly depending on the participants' responses. For example, if a participant spontaneously answers questions scheduled to be asked later, they will not be asked to answer them again. Similarly, if participants spontaneously raise issues that were not included in the interview schedule, the interviewer may explore these issues in more detail if they seem relevant to the topic under investigation. As the nature of grounded theory is organic and evolving, new items may be added to the interview schedule and some may be removed depending on the emerging theory. If this is the case, any new items will be carefully worded and care will be taken to ensure that they do not imply that systemic conceptualisation is the most desired outcome.

Areas to explore if participant hasn't spontaneously talked about these (added after pilot interviews):

Gender differences (mothers vs. fathers)
Supervisor's model of work/theoretical preferences

Appendix 4: Participant Information Sheet

Title of the study:
A grounded theory study of therapists' conceptualisation of their clients' parenthood.

Information for participants
You are invited to participate in a doctoral research study from Salomons, Canterbury Christ Church University. Please read the following information carefully before you decide whether you want to take part.

My name is Leena Mylläri and I am a trainee clinical psychologist. My research is supervised by Professor Margie Callanan (Practice Consultancy Director, Canterbury Christ Church University) and Margaret Henning (Clinical Psychologist in Sussex Partnership Foundation NHS Trust). The study has been reviewed by the Department of Applied Psychology, Canterbury Christ Church University and has received formal ethical approval from the university.

Why have I been contacted and what is the purpose of the study?
Clinicians providing psychological therapy to adult clients in the UK are asked to take part in this research. This study investigates clinicians' views about considering parenthood when working with clients who are also active parents. The study aims to gain an understanding of clinicians' ways of conceptualising such issues in adult focused therapy, and what factors hinder and facilitate the consideration of parenthood in therapy work.

The interview will involve asking demographic information about you and questions about your clinical practice. There are no right or wrong answers to any of these questions.

What will it involve?
There are a set of questions which will be asked, but there is also an opportunity to explore issues that are not covered in the interview schedule, if you feel it is important to do so. The interview will take approximately 20–45 minutes to complete. If you would like to take part please contact me before the end of February 2011. Once you have participated in an interview, you may be contacted to comment on the themes that emerge from yours and other participants' accounts. You will only be contacted if you indicate that you would be willing to do so.

Do I have to take part?
No, there is no obligation to take part.

Confidentiality
All information will be treated confidentially. All information will be kept securely and all identifying information will be removed. Any extracts used in the final report and published papers will be anonymised.

Can I withdraw from the study after I have started the interview?
You can withdraw from the study at anytime. If you choose not to complete the interview after you have started it, all your data will be deleted and will not be used in this study.

What will happen to the results?
The results may be written up for publication, and they will be shared with relevant organisations and other researchers.

Will I be able to see the results of the study?
If you would like feedback on the overall results, the results will be available from September 2011. You can contact Leena Mylläri (lmm40@canterbury.ac.uk) for this.

Who should I contact if I need any further information or want to make comments or complaints about the study?
If you have any questions before you take part in an interview, if there is anything you feel I should know about your experience of the interview, or if you want to talk about the study, then please do not hesitate to contact the lead researcher (Leena Mylläri). Alternatively, you can contact Professor Margie Callanan (margie.callanan@canterbury.ac.uk) or Margaret Henning (Margaret.Henning@sussexpartnership.nhs.uk). If you wish to make a complaint, you can contact the department's research team (01892 507666), who are not directly involved in this research.

Thank you for considering taking part in the research study and for taking time to read this information sheet.

Appendix 5: Consent Form

Canterbury Christ Church University

CONSENT FORM

Title of Project: A grounded theory study of therapists' conceptualisation of their clients' parenthood.

Name of Researcher: Leena Mylläri

Contact details:

Address:

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Please initial box

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.	
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.	
3. I understand that any personal information that I provide to the researchers will be kept strictly confidential	
4. I understand that anonymous quotations from my interview may be used on published reports of study findings.	
5. I agree to take part in the above study.	

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Researcher	Date	Signature

Copies: 1 for participant
1 for researcher

Appendix 6: Axial and Focused Codes

Complete List of Axial (bold) and Focused Codes (normal font)

Addressing parenting
- Addressing parenting directly
- Addressing parenting indirectly
- Considering client's ability to parent
- Giving client positive feedback regarding their parenting

Adjusting to service expectations
- Changing practice as a result of service changes
- Learning ways to elicit most relevant information quickly
- Uncertainty about job security affecting decisions re CPD/therapy training

Assuming childcare taken care of
- Assuming client has arranged childcare
- Not aware of children whereabouts
- Not considering childcare unless it becomes an issue
- Team knows where children are

Being a good enough parent
- Appearing strong in front of children
- Doubting own parenting
- Proving oneself as a parent

Being directive
- Missing information unless directly asking
- Referral pointing out systemic issues

Being non-directive
- Going with what the client brings
- Not asking about children unless client brings it up
- Relying on client to bring systemic issues if they are relevant

Being parented
- Being parented impacting on how one is today regardless of parenthood status
- Correcting the parenting s/he had
- Considering parenthood in relation to family history and experiences of being parented
- Parenthood unearthing past issues
- Taking a parenting role with a client

Child-friendliness
- Lacking facilities for children
- Children interfering with therapy

Children as strength
- Viewing children as a resource for the client
- Children motivating client to seek help

Children as part of therapy
- Enabling parent to focus on child rather than on their own difficulties
- Involving child in therapy
- Setting goals to help client manage everyday tasks with children

Client initiating family involvement
- Client or family requesting family therapy
- Client asking if ok to bring family members
- Client asking to bring family members when they become aware of own relational patterns

Client's reluctance
- Client not wanting family to be involved
- Client seeing therapy as something where family isn't talked about
- Therapeutic alliance affecting whether family involved

Competing demands
- Childcare issues impacting on client's motivation and engagement
- Children's needs hindering therapeutic work with parent
- Competing demands of being a parent
- Finding space for therapy difficult for parents
- Prioritising family's needs

Considering parent-child relationship
- Considering child's characteristics in therapy
- Considering relationship with child in therapy
- Exploring parenthood and relationship with child therapeutically
- Focusing on relationship with child helpful in identifying patterns in all relationships
- Formulating client's relationship with child

Co-therapist
- Family members as co-therapists
- Sharing formulation with family members

Deviating from the model

Broadening formulation from individual to contextual
Considering issues more broadly than model allows
Missing information in purely individual models
Starting with an individualistic framework, but broadening if it doesn't fit
Using supervision to think more broadly

Dividing work to individual and systemic

Working systemically only in family therapy service
Separate formulations for individual and children/family
Only formulating systemically in family therapy
Thinking systemically easier in family therapy setting compared to when working with individuals

Family's beliefs

Family's attitude towards mental health services
Family members not wanting to get involved
Worrying about family sessions

Feeling pressured as a therapist

Service expecting throughput
Short-term intervention unlikely to work
Working within contracted limits regardless of needs

Feeling unsupported by service

Feeling isolated as a systemic practitioner
Feeling unsupported by service to include family members
Service unfamiliar with systemic ways of working
Service requiring therapists to be specifically trained to work in a certain way
Service discouraging systemic conceptualisation

Finding opportunities to learn about systemic work

Feeling inspired by systemic CPD
Increasing systemic considerations following therapy training
Learning about systemic conceptualisation case-by-case
Roles of exposure and experience in developing specialist interests and ways of working
Curiosity about systemic work

Finding opportunities to practice systemically

Increasing own use of systemic techniques
Blurring boundaries in order to address family's needs
Applying systemic principles in adult services hard but possible
Combining individual and family work
Incorporating systemic ideas into individual work

Finding parenting services

- Accessing parenting services elsewhere
- Finding out about services for parents
- Finding out what support is available to families not easy
- Talking to colleagues to find out about other services

Finding time for new learning

- Finding time for CPD
- Finding time to think differently (put new learning into practice)

Focusing on the individual

- Not inviting client to bring somebody along
- Providing space to focus on oneself, not other family members
- Seeing other family members rarely
- Encouraging parents to focus on themselves, not their children

Formulating parenthood context

- Client's loss of parenting role
- Client not seeing parenthood as an option
- Considering parenthood context
- Parenting as a class or cultural issue
- Regretting not having children
- Working with parents whose children have care orders

Informing assessment

- Family members bringing new insight into client's difficulties

Integrating models to address client's needs

- Following client's needs
- Integrating models
- Applying models one is less confident in if presenting problem relational

Lacking power to challenge the culture

- Feeling unable to express wishes as a less experienced/locum professional
- Having to make compromises between ideal work and reality of current job market

Maintaining a broad view

- Considering systemic factors routinely
- Client group characteristics require systemic conceptualisation
- Considering client's support network outside of therapy/team
- Routinely inviting clients to bring someone if they like

Meaning-making of parenthood
- Cultural beliefs about motherhood
- Society's ideas about parenting narrow-minded
- Therapist's gender and talking about parenthood
- Therapist's own ideas about parenthood and family-life

Model limiting scope of work
- Model prevents involving family members
- Model restricts broader conceptualisation

Needing more training
- Lacking confidence or training to use systemic conceptualisation
- Needing to be a systemic family therapist to work with families
- Professional training favoured individualistic approaches

Noticing children's needs
- Identifying client's children's needs as requiring specialist input
- Involving children's services
- Liaising with children's services/schools/etc
- Preventing children from developing difficulties
- Team finding services for children

Parenthood as core part of identity
- Being aware of client's parenthood necessary for formulation
- Considering impact of being a parent on client
- Considering parenting in formulation
- Parenthood, identity and roles

Parents as any other clients
- Not considering parents differently
- Offering flexibility to all clients regardless of parenthood status
- Parent-child relationship not considered especially
- Thinking about everybody differently

Parents as different
- Considering parents differently
- Implicitly formulating parents differently
- Model considers relationships

Political context
- Social and political factors hindering systemic conceptualisation
- Guidelines favour individualistic and narrow approaches

Safeguarding
- Considering impact on children
- Considering risks to and needs of child
- Thinking about children in specific circumstances

Sensitive issue
- Needing to approach parenting very sensitively
- Approaching risk issues sensitively
- Avoiding talking about parenting to protect therapeutic alliance

Difficulty engaging clients when parenting is an issue
Client wondering if therapist will understand their parenthood

Service expecting psychologists to offer individual therapy
Providing individual therapy only
Providing focused therapy
Service requires a specific focus
Service supports individualistic approaches

Service supporting systemic ways of working
Service acknowledging that client group requires flexibility
No pressure to offer limited service
Service offering flexibility, if appropriate to involve families
Accessing systemic supervision as required

Slipping to individual mode
Difficulty remaining systemically-minded all the time
Slipping to individual work mode

Someone else's role
Someone else is keeping an eye on parenting
Not my role
Not addressing parenting directly
Parenting support needs to be ongoing

Specific circumstances
Family attending meetings
Seeing families for specific reasons
Seeing families during home visits
Seeing families only in family therapy
Working with a family member/carer

Sticking to single therapy model in room with client
Choosing therapeutic model based on presenting problem
Choosing therapy model early and sticking to it
Sticking to the model

Supporting assessment
Bringing carers to assessment
Bringing children rare
Bringing partners
Seeing families during assessment

Supporting parenting
Supporting parenting directly
Supporting parenting if it's part of presenting problem
Talking to families about parental mental health

System stuck
Conceptualising systemically if aware of relational issues
Conceptualising systemically if client raises family as an issue

Family perpetuating problem
Therapist suggesting family to come
Suggesting family members to come if sees them as perpetuating client's problems

Systemic conceptualisation not always applicable
Applying systemic techniques not always appropriate
Client group characteristics hindering systemic conceptualisation
Client using parenthood to gain status
Conceptualising systemically less relevant in some cases
Only considering parenthood when it's very prominent issue

Systemic model fitting with own worldview
Systemic conceptualisation less blaming
Not possible to consider individuals in isolation
Systemic theory giving framework for existing ways of thinking
Therapist's duty in own thinking
Viewing systemic factors as more powerful than individual factors
Viewing the whole family as the client

Systemically-minded culture
Encouraging colleagues to be more family-aware
Modelling style of work of senior staff
Supervisor's and colleagues impact on systemic conceptualisation

Team sharing contextual information
Team engaging with families
Team having richer information about context

Therapist's parenthood
Anticipating change once becomes a parent
Becoming a parent increasing empathy
Being a parent inhibiting discussions about client's parenthood

Therapy impacting on children
Child reacting to changes in client
Client locating difficulties in child
Considering how therapy will affect client in relation to child/ren

Therapy impacting on system

- Progress in therapy confusing other family members
- Pacing interventions differently
- Parenthood influencing therapy

Unique relationship

- Children lacking choice and power
- Dependency and responsibility as unique dimension
- Viewing parent-child relationship as a special relationship

Where to go with systemic issues?

- Accessing systemic service
- Adult services can't provide systemic therapy to families with small children
- Lacking clear pathway to family therapy
- Viewing systemic therapy as only for larger families

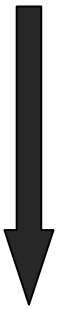
Working around childcare

- Aware of children's whereabouts
- Client contacting service to arrange appt
- Client raising childcare as an issue
- Considering childcare right at the start
- Offering flexibility when working with active parents
- Seeking childcare support from external agencies

Appendix 7: Category Development

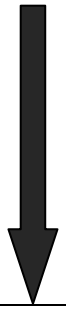
Axial codes (59)

Addressing parenting	Adjusting to service expectations	Assuming childcare taken care of	Being a good enough parent	Being directive	Being non-directive
Being parented	Child-friendliness	Children as strength	Children as part of therapy	Client initiating family involvement	Client's reluctance
Competing demands	Considering parent-child relationship	Co-therapist	Deviating from the model	Dividing work between individual and systemic	Family's beliefs
Feeling pressured as a therapist	Feeling unsupported by the service	Finding opportunities to learn about systemic work	Finding opportunities to practice systemically	Finding parenting services	Finding time for new learning
Focusing on the individual	Formulating parenthood context	Informing assessment	Integrating models to address client's needs	Lacking power to challenge the culture	Maintaining a broad view
Meaning-making of parenthood	Model limiting scope of work	Needing more training	Noticing children's needs	Parenthood as core part of identity	Parents as any other clients
Parents as different	Political context	Safeguarding	Sensitive issue	Service expecting individual therapy	Service supporting systemic ways of working
Slipping to individual mode	Someone else's role	Specific circumstances	Sticking to single therapy model in the room with client	Supporting assessment	Supporting parenting
System stuck	Systemic conceptualisation not always applicable	Systemic model fitting with own worldview	Systemically-minded culture	Team sharing contextual information	Therapist's parenthood
Therapy impacting on children	Therapy impacting on system	Unique relationship	Where to go with systemic issues?	Working around childcare	



The axial codes were condensed to 17 theoretical codes (number of associated axial codes in brackets)

Practicalities of being a parent (2)	System's reactions (2)	Habits and confidence to change (4)	Safeguarding and child's development (3)	Politics and power (6)
Emotional pressures of parents (3)	"Unstucking" difficulties *with* families (3)	Process of deciding whose responsibility it is to consider parenting (4)	Unspoken rules about children in adult mental health services (2)	Therapist's agency (5)
Part of history and current identity (7)	Family's willingness (3)	In/flexibility of the model (4)	Part of work culture (3)	Consistency of therapy approach (5)
Therapist's parenthood (1)	Family members as informants (2)			



These lead to the final 5 categories

Final categories (subcategories)

Psychological theorising (2)	Drivers (2)	Therapist factors (3)
Risks (2)	Client variables (2)	

Category	Sub-category	Axial codes	Sample quotes
Drivers	External powers Service structures and culture	Adjusting to service expectations Child-friendliness Feeling unsupported by the service Feeling pressured as a therapist Lacking power to challenge the culture Political context Service expecting individual therapy Service supporting systemic ways of working Systemically-minded culture Team sharing contextual information Where to go with systemic issues?	I mean, big time, it's actually monitored and put into reports. There are huge pressures at the moment. Payment by results, and going wider, really. The money being much reduced in the health service, and I know it's reality all over, but here it's 5% every 3 years taken out. And this idea of consortia and bidding, there's huge pressure now on meeting specific demands to get paid, and I think it's easy to make demands in terms of CBT, whereas thinking systemically, I think, it's much harder to put it into a PBR approach or a result-outcome approach. I think even now, the way things are going, there's much more of a conceptualisation about throughput, particularly with IAPT, where... very much time-limited interventions, which kind of means keeping a clear focus on what's immediately in front of you. My experience is that that's not totally accepted. It's ok to invite someone in a couple of times, maybe for a psychoeducational element. To help them understand the formulation, for example. But I've certainly found in supervision, that having considered some of these elements there's been questions around "but who are we seeing?", "who's our client?", "if you start to see them, you may need to open them as a case". So that then opens up issues about do we continue to see them together, what's the nature of the piece of work. I'm interested in family therapy but they've just knocked our family therapy room down to make a bigger room, so that's so disappointing. I think there are factors because we separated into these [diagnosis-based] groups and I'm part of the mood, anxiety and personality disorder [group], and I have a colleague who's part of the psychosis [group], and we're in the same CMHT, but she's been told she shouldn't be doing family work on her own, so we tried to negotiate that we could set up a family therapy service, and part of my CPD would be that I'd learn about psychosis and do some family work. But because of the [groups], it's very strict about working for your own [group]. I think that the division of services in that respect hasn't helped. It could be to do with the point of qualification I'm at, and maybe I feel a bit less able to have strong opinions about how things should be done. (participant had been qualified for one year) We're having ongoing discussions about which outcome measures are going to be most useful to us. And there are very mixed feelings, I think, about how appropriate it is for us to try to apply any sort of outcome measures in a service that works in so many different levels in so many different ways.

Category	Sub-category	Sample axial codes	Sample quotes
Therapist factors	Personal style and preferences Managing models Learning and training	Being directive/non-directive Deviating from the model Finding opportunities to learn about systemic work Finding opportunities to practice systemically Finding time for new learning Focusing on the individual Integrating models to address client's needs Maintaining a broad view Model limiting scope of work Needing more training Slipping to individual mode Sticking to single therapy model Therapist's parenthood	It's up to the parent to decide what they want to work on, and if that's something that doesn't come up, then I don't think I'll necessarily push it unless that person decides to bring it up. It features in my work with individuals. The chances of getting the system into the room are very, very slim. But there are plenty of models out there for working systemically with individuals. I am systemic in my worldview anyway, so it's automatic for me to do a genogram, find out who is in the family, find out about the relationships between them. It's very easy to just approach it very individually. I need to make decision very early on, so basically at the time of the assessment, as to which type of therapy is going to be best suited for that client. So, you know, I try to make a decision and stick to it. Either this is going to be a CBT piece of work or a psychodynamic piece of work. I follow the model that I'm using. It will inform of me what I think would be useful. There's a real thing about "oh no, we're not that service" and "we're not that type of professionals", therefore we don't believe we can do that. ... I think people downplay their skills. I have to make sure that I do things within my abilities. I can't offer any systemic work because I don't have training in it, so that obviously hinders that. Where it may be more relevant, and certainly in psychodynamic formulation it's very relevant, you'll be wanting to look at significant relationships, including relationships with children. If I'm using a CAT-informed approach, and definitely if I'm working in a systemic way. If I'm working with my CBT hat on, it's interesting, because just thinking about it now, I tend to not focus on that so much. Even though I'd still be thinking about their early experiences and how they've come to form particular beliefs about themselves and others, and expectations of themselves and others, and how that might influence how they are with their own children. The experience of being a parent is, for me, that you really want to get it right. It matters so much that you do everything you can for your children, and it's very easy to think that you've got it wrong, or be critical of yourself, or feel dreadful that in some way you have upset your child, or you shouldn't have done that, you shouldn't have got angry... you know, whatever it is. Being much more live to the fact that it's incredibly hard job to do well, and therefore, being sensitive, more sensitive I guess, to other people's own perceptions and knowing how very, very difficult it is. Knowing more about how very, very difficult it is.

Category	Sub-category	Axial codes	Sample quotes
Psychological theorising	Positioning of parenthood in formulation Formulation versus therapy	Being a good enough parent Being parented Children as strength Children as part of therapy Considering parent-child relationship Formulating parenthood context Informing assessment Meaning-making of parenthood Parenthood as core part of identity Parents as any other clients/parents as different Therapy impacting on children Unique relationship	I think the experience of being a parent can often really bring to the surface their own experiences of being parented. So there can either be maybe a repetition of their own experiences, or it can be an opportunity to actually resolve some of the difficulties and conflicts that they may have experienced in their early history. I think parenthood can also be a tremendous resource for people, as well. That's often the motivation for them to seek treatment. They don't want their children to experience the same difficulties that they have. I suppose that's how parenthood can be an important therapeutic factor, and be their motivation. It's such an important part of people's lives, I think it can be quite a profound source when you think about it in therapy. That sometimes brings forth unexpected discussions. I work with one client who broke down at the point when I asked that question. He'd actually been jailed and lost contact with his children for paedophilia offence, child abuse offence. To be honest with you, I think they have bigger fish to fry, I think the kids are the least of their worries. The kids are perhaps absolutely wonderfully normal things in their life. You know, I work with a very white working class, almost a kind of an underclass section of [area] that I live in. I think within our culture, I think there is an expectation that a good mother is a sacrificial mother, and that it's very, very easy for a woman to adopt a caring role at the expense of their own needs, and that isn't often challenged. I suppose the difference is to do with dependency. When you're thinking about people in relation to other adults, you're thinking that they're of a bit more equality and responsibility within partaking in that relationship, and who's caring for whom. But if there is a child involved, I guess you've got different thoughts about is this person who is sitting in front of you able to give good enough care to somebody who is dependent on them, how available are they to other people's needs at this point in time, and that there's somebody who can't really choose to be in a relationship with them at the moment.

Category	Sub-category	Axial codes	Sample quotes
Risks	Safeguarding and child development Child's own needs	Noticing child's needs Safeguarding Sensitive issue	I suppose I'd be wanting to know more about the child as well, in terms of how they're coping, whether they've got any support available to them. And a couple of times, actually, when it's come out that the child seems to be struggling a little bit, I've referred them on for support for themselves. I'd always be aware of child protection issues and issues around the safety and neglect of a child, and a parent's ability to protect the child. And all the policies around, you know, everybody matters. That as clinicians we have a code of conduct, to be aware of that and to flag it up constantly and to always keep that in mind. One other lady with OCD, which revolved around anxieties about her child, and because some of the anxieties she prevented her child from doing normal things that all other kids do. So it was actually quite harmful to the child. We had to work really hard on that. Where you think does this parent have a mental health problem at this point and how is that impacting on the entire family. And all the research that says what's the impact on children of parents with mental health problems, and it's huge. And you look at then those children coming into psychiatric services, and the different literature and the different interventions around the world, I guess, which when you include everybody and work systemically, you would reduce the likelihood of those children then becoming depressed or isolated, or having problems at school, or developing difficulties later in life. I guess to do with the therapeutic relationship and things that I was saying earlier about how I think that as a parent it's so easy, very easy to feel judged by other people. And negatively judged. And particularly when you feel so bad about yourself anyway. That if you bring it up in the wrong way, or if you intonate in any way that what's happening at the moment for this adult might mean that their parenting is impaired, or they're damaging their children somehow, or neglecting them. If you get it wrong, then that might damage your therapeutic relationship. Which might, in turn, not be great for the parent and the child's relationship in the long run, and I suppose it's about balancing that. How is it best to think about this so you can keep the person feeling good enough about themselves, that they might be able to confront something that they're not feeling so great about.

Category	Sub-category	Axial codes	Sample quotes
Client variables	Presenting problem Family involvement	Client initiating family involvement Client's reluctance Competing demands Co-therapist Family's beliefs Supporting assessment System stuck Working around childcare	They are more than welcome to make that choice, and I think sometimes it's really important and really useful as well, but I'm always very, very keen that it comes from them. Conversely, often partners are very afraid to come and meet because they don't really want to encounter what they feel they might encounter. Often when it might happen is the very first session, where the person has come and maybe they feel very anxious, and would need that support or that reassurance from a family member. So in those situations I'm quite happy to have a family member, as long as I'm clear that it's what the client is requesting and not the family member. So I'm quite happy to have a family member come and join us for that very session I've always felt that actually working with family members as co-therapists can be very useful. Other issues that have come up, I think, attendance may become a problem, as well. But not necessarily because there's no childcare available, it could be related to the priorities for the children or any other problems that the child may have experienced. I think often, particularly mums, it's not uncommon for me to recognise that they're really isn't any space in that woman's life for her own needs to be acknowledged and to be reflected on. And so, if I'm recommending that this [therapy] is going to be a part of the work that we do, you have to physically find that space, and that can have a real bearing on it. Sometimes that really needs thinking about, it can be very difficult. Some clients can feel uncomfortable to tell too much stuff in front of their relatives, they don't want them to know everything. I think people are very wary of sometimes brining in their partner because they're actually very frightened of the partner revealing aspects of what's going on at home that they're not in control of.

Appendix 9: Example Interview Transcript

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Appendix 10: Sample Memos

Therapists' reflections on own practice over the course of the interview/ Changing mind about current practice

Throughout interviews, some participants seem to redefine their initial reports/beliefs about their own use of systemic conceptualisation or their views about how they conceptualise their clients' parenthood. Might be due to 1) reporting how they think they work, 2) reflecting on their work as interview goes on, and 3) realising discrepancy between what they say they do and what they actually do. This may even be the case with participants who report working/thinking quite systemically.

- Most cases so far: some difference in how the therapist describes their work initially, and how it changes towards the end of the interview.

- Participant two: started by saying he doesn't think about parenthood specifically, but towards the end reflects that if client is a parent, their parenthood is always there in therapy (less so with men).

Contradictions:
- Participant nine: started by saying he sticks to one model and works individually, but later on talks about the benefits involving family members even when using CBT.
- Participant five: initially said he wouldn't ask about parenthood/parenting unless client brought it up, but towards the end of the interview stated that he would ask directly if a client who is a parent didn't talk about their children spontaneously.

Addendum following supervision (May):
Discussed these apparent contradictions in supervision with Margie, and wondered how they might impact on my developing model. Initially I felt that some participants were changing their story as the interview went on, but now I've come to understand this as not changing the story but thickening it. That is, participants' early statements are brief descriptions of what they do, e.g. "going with what the client brings", but they do not necessarily mean it in a sense of a literal interpretation of that statement. As the interviews progress, participants begin to unpack what they mean by "going with what the client brings", which by the end of the interview may look quite different from my initial interpretations of this statement.

- ➔ Check other memos for similar "errors", as this has highlighted how strongly my own thinking and assumptions have impacted on my analysis.
- ➔ This may not be a category in its own right, but probably quite a strong feature that will require some consideration somewhere in the model/discussion.

Presenting problem relational.
Participants talk about deviating from CBT (?from other models too) when presenting problem relational, but it's perhaps not always clear how they define "relational".

Explored further
- when clients talk about others in session (rather than self-focused).
- when others, incl family members, seem to contribute to the problem.
- when client doesn't seem to improve because their system is stuck.

Five interviews later (Dec): have been asking participants to say more if they use this expression, and it seems that they consider issues "relational" if family members contribute to/perpetuate/maintain difficulties. Not been able to establish when they consider difficulties "non-relational", despite directly asking them!

- ➔ Me considering all difficulties relational is clearly my own bias, and a very social constructionist interpretations of psychological distress. Be aware of this, but continue exploring "relational" if it comes up again in interviews.
- ➔ Bear this in mind when coding and analysing interviews.

Finding time to think about clients
Although there may be intentions and interest to incorporate systemic ways of thinking, and thinking about the client's role as a parent, time pressures of routine work can hinder systemic conceptualisation and reinforce slipping to individualistic work mode. Others (in addition to Participant four) have talked about throughput and payment by results.

- ➔ This could form one theoretical code later on?

Check focused codes:
- slipping to individual work mode
- finding time for CPD
- finding time to think differently
- supervisors and colleagus

Search NVivo for "payment by results", "throughput", etc.

Seeing family members with clients
Participants seeing other family members with clients often uncommon. Partners most common to accompany. However, variations in terms of whether or not included in therapeutic work, when (assessment, diagnosis, sharing formulation) seeing family members most often.

Possible issues to consider:
- participant's theoretical orientation (when, how)
- how strictly therapy models followed
- participant's profession
- client group specific in some ways? (psychosis, esp around diagnosis)
- whether home visits common

Later thoughts (Feb): Further coding and analysis seems to indicate that it's actually quite common to see other family members, esp partners, during the initial assessment, sometimes also when discussing formulation or diagnosis (esp. psychosis). Most do this regardless of theoretical model, but seem more likely to prefer individual sessions if service very strict re number of sessions. Consider the relevance of this later, ?specially when generating theoretical codes and final categories. (Reminder set).

Thinking more often mothers because clients more often female.
Many participants seem to mention female clients more often when asked about clients who are active parents. When asked to elaborate of this, they then go on describing that more women access their service, and are thus more likely to form a greater proportion of parents. Keep this in mind and cross-reference to statements relating to own preconceptions about parenting, as this may be of particular relevance re whose parenthood is considered/supported/addressed.

Searched for this today across all interviews done so far (Apr), and so far the issue really has been conceptualised as women accessing services more often than men. Some have mentioned that they can't think any male clients who are active parents!

- ➔ Don't make this a redundant issue yet, search again after final interview.
- ➔ Worth considering in more detail even if it doesn't form a category, possibly important to mention somewhere in results even if nothing more emerges.

Uncertain job, un-established role, not qualified for long -limiting factors in terms of CPD
Basing own training and development on service needs rather than own career development needs? Lacking confidence to ask what would really like to do because service/culture may not support it. Is this happening across interviews? Search NVivo for related terms/expressions after backlog of interviews transcribed. (Reminder set).

Searched interviews (Feb):
- not necessarily directly said so strongly (see Participant one)
- seems to feature in many accounts, especially those that have been qualified for a relatively short time.

Searched interviews (May):
- Not found other particular differences, but more recently qualified seem to be less demanding/assertive re what training they have, and more likely to adjust to what service needs — most are in locum/fixed term posts!!!
- consider later whether this is worth commenting on, doesn't seem strong enough for a category although not a redundant code.

Appendix 11: Research Diary

MONTH	ISSUE	ACTION PLAN
Jan 2009	Broad area of topic: parenthood/parenting, adults receiving parenting training, mental health. Contacting potential research supervisors and defining the topic and research questions.	Find out who the relevant people in the area are and whether they would be able to commit to supervising. Secure internal supervisor asap.
May 2009	Supervisors confirmed.	Develop research proposal.
Jun – Aug 2009	Research area: how much is parenthood and parenting considered by professionals working in adult mental health services	Read about questionnaire design, investigate online surveys, write proposal.
Sep 2009 – Feb 2010	Proposal not approved and family crisis. Spent very little time working on the project as was at home caring for mum. Very low motivation to do any coursework, and I located much of my frustration in the IRP. Contemplated asking if I could take a proper break from the course, but mum's condition started to improve and I realised that I wanted other things to focus on. Reluctantly started redrafting the proposal, but asked if I could hand it in after the April deadlines.	Meet with supervisors to discuss how to address review panel's feedback. Read about other methodologies, esp. grounded theory. Rewrite proposal. Try to find motivation to work!
	Proposal approved.	Complete ethics application.
Jun 2010	Ethics application approved.	Get all the relevant materials together (borrow telephone recording kit from Salomons, by batteries for voice recorder). Contact BPS re my advert on their website.
	First grounded theory peer support group meeting. Quite intimidating, as some trainees seemed to know everything about GT and exactly how they're going to do this!! However, it was also helpful to discuss practical issues and get a sense of who else is around.	

Jul 2010	Mock interview with one of my supervisors. This was very helpful for practising asking the questions and getting a sense of how therapists may approach my questions. The interview schedule was easy to follow, felt appropriately structured, and the length of the interview was as estimated.	Pilot the interview with a participant who is not related to the project. Ensure that interview schedule is used as a guide only, so that it doesn't feel that I'm asking open-ended but still leading questions.
Aug 2010	First pilot interview. Interview lasted longer than expected, and although this was partly because of the detailed examples the participant was giving, it was also affected by the fact that the questions were broad. Consequently, the participant gave very broad answers, often covering areas that came up again later in the interview schedule. Feedback from the participant was very positive, and it felt that we had a good rapport throughout the interview.	Change the order of demographic questions so that they lead to the main questions more fluidly. Signpost future participants so that they will know what areas will be covered later on in the interview. Hopefully this will help minimise them having to repeat their answers. Transcribe before the next interview (in 2 wks).
Sep 2010	Second pilot interview. Flow was much better after changing the order of the early demographic questions, particularly leaving the questions about models and ways of working till last, as this linked better with the first set of questions relating to specific research questions. Participant asked quite a few questions about my research before we started the interview, and seemed genuinely interested in the topic. This felt very encouraging, and I really enjoyed doing this interview. Participant highlighted noticing differences in own perceptions of parenthood, and mainly just considering female clients during our interview. We explored this a bit further before finishing the interview.	Interview schedule seemed to flow very well, so no need to change the order of questions. However, if participants don't mention gender differences, ask them whether they have noticed differences in how they conceptualise their clients who are mothers and those who are fathers. Transcribe asap and start initial coding. Compare codes with the first pilot interview and see if interview schedule needs amending based on the codes.
Sep 2010	Keep the interview schedule as it is (including asking about gender). Initial codes indicating some areas as possibly more commonly considered than others (e.g. risk/safeguarding vs. relationship with child).	One participant reflecting how therapy was more family-focused when working in health setting. Contact a psychologist who

		expressed interest in taking part but I wasn't sure if the setting was relevant (health).
Oct 2010	Started placement in a specialist children's hospital, and asked if I could co-facilitate a parents' group in the neonatal unit as it seemed relevant to my IRP. My experience in neonatology has already affected how I think and feel about parenthood, and it is likely that this needs careful consideration as the IRP progresses. The first time I visited the unit I saw this tiny incubator, and it really shocked me –can you fit a human being in there? Things like attachment and loss seem tangible, and the desperation in the parents' faces is almost physically painful. Where do people find the strength? Not being a parent myself has been highlighted in a very different way, and just witnessing the fragility of the babies is so heartbreaking I can't imagine what it must feel like for the parents!	Keep this experience in mind. Talk about it in supervision. Come back to this later on, and be mindful of how this might be colouring my data analysis.
Nov 2010	Third interview. This interview went well, but felt chaotic at times. For example, the line was bad and we even got disconnected once. I felt quite stressed as a result. However, I found the participant's answers very interesting, and although the setting was highly specialised (HIV), my questions seemed to make sense and the participant had a lot to say. Some examples were obviously very specific to the client group (e.g. guilt regarding child's HIV-status), but it may be worth exploring guilt with other participants as well.	Transcribe asap, do initial coding, and compare to previous interviews. Keep in mind that this participant works in a highly specialised setting, but try to explore similarities in narratives.
Nov 2010	Fourth interview. Haven't had time to transcribe last interview (done day before yesterday, and have been on placement), so decided to follow the interview schedule as it was last time. This was a very powerful interview, and I felt deeply moved by my participant's responses and thoughts. The participant was very thoughtful, held strong beliefs about the benefits of systemic work in all therapy settings, and talked about their own parenthood in a very meaningful way. I felt I	Prioritise transcribing this interview and do initial coding. Think more about own emotional responses to this interview: why so strong, how might this impact on my data analysis? Be mindful of feelings during transcribing and coding, memo thoughts. Consider how my feelings may be

	had an exceptionally good rapport with the participant, and at times noticed hoping that I had her as my supervisor! The participant's openness to share their very personal experiences was perhaps a little overwhelming, but incredibly helpful. I feel I connect with parenting and parenthood in a very different level as a result. Participant reflected noticing discrepancies between what they think they do and what they actually do in therapy with clients who are parents, and how their own preconceptions about motherhood seem to bias how they feel about parenthood in general.	linked with my work in the neonatal unit: am I becoming biased?
Nov 2010	Fifth interview. Started transcribing previous interview, but not finished (only interviewed fourth participant yesterday). Interviews starting feel "routine" now. The last 3 interviews were done in the last 4 days, and I'm starting to feel that I may miss things if I carry on with this pace! However, the interview went well and the rapport seemed good. Not having transcribed this yet, it seems that the participant wasn't highlighting any new issues that I should consider adding to/amending in my interview schedule.	Consider slowing down in interviewing. Ensure that I have time to transcribe and think about the data I've gathered so far before interviewing more participants, especially as next interview booked in less than a week's time and realistically I probably won't be able to finish transcribing/coding the other interviews by then (perhaps arrange the next new one just before Christmas break? Probably ok to move on to focused coding soon).
Nov 2010	Sixth interview. An interesting interview, but quite a specific setting (acute and CRHTT). Participant had expressed an interest in taking part and explained that they used to work across child and adult services, so it seemed relevant to include. Really interesting ideas, although wondered how generalisable they are to general settings... I think this is relevant though, as participant is highlighting difficulties working with the whole system even in settings that are designed to address difficulties at a systemic level. Good rapport with the participant, although we had to be mindful of them needing to pick up their own children	Transcribe asap, but may not be necessary to do initial coding anymore. Do focused coding as soon as previous interviews have been coded. Be mindful of the setting the participant works in.

	from childminders –which actually facilitated interesting reflections on how much/little parenting stresses are considered by adult mental health services overall and in therapy specifically.	
Nov 2010	Seventh interview. The hardest interview so far! I felt unable to connect with the participant, I felt they were constantly challenging my research, and I actually felt completely incompetent afterwards. This person is doing further training in systemic therapy, but seems completely uninterested in parenthood... Why does it feel like we're not talking about the same theoretical approach? Why am I feeling threatened by the participant? Is it just that the rapport isn't there, or is there something else that I need to consider? The participant had quite a "critical psychology view" on the current issues, is that it or is it something more personal? I actually feel that I agree with the participant in many of the things that were said, so I need to reflect more on this to make sense of my emotional reactions.	After transcribing, do initial coding for this interview and pay attention to how things are said as well as the general meaning. Be aware of how my feelings may bias my coding (hence do line-by-line even though it may not be necessary in terms of numbers –actually, consider prioritising this one for initial coding over some of the earlier ones).
Nov 2010	Dropped my laptop on the floor and it's not working anymore!	Get a new laptop asap!!!! And don't drop it!
Dec 2010	Eight interview. Knowing that I couldn't transcribe/code this interview straight away was stressing me quite a bit, but it was an interesting interview nevertheless. The participant had been qualified for quite a long time and was in a very senior position in the service (across three teams), which highlighted some issues that may differ from those of more newly qualified therapists. It seems that being involved at service level and having more experience limit systemic conceptualisation, even when preferred modality considers relational aspects and parenthood as a matter of course.	Not the top of priority, but looking at this diary is making me realise that the work is piling up! Consider the last point when doing axial and theoretical coding, as it may be relevant to the actual vs. ideal practice of a therapist.
Dec 2010	Attended conference "working with families". Although organised by a specialist interest group based in adult mental health services, most of the talks were provided by CAMHS	Remember the inspiration! I feel like I have more allies as a result of attending this conference, so it is important

	professionals (even the ones that were titled systemic work with adults). Therefore, it was not as informative as I had hoped, but very inspiring, and I enjoyed meeting so many other professionals from all over the country who shared similar interests with me. I was particularly interested the views of a previous social worker, who was now writing a book on safeguarding children in adult mental health.	to remain aware of the bias that this has introduced in my thinking.
Dec 2010	Father Christmas contributed significantly to getting a new laptop, but holiday ruined by transcribing nightmare! Mum doing ok, so can focus more on MRP and not worry about caring as much as last year. Feel like I need a break though, and the April submissions need more attention now. How do I prioritise things?! It feels that my MRP is not as ordered as I'd like it to be, but I have to start my critical review and PPR, and they're due way before MRP. Also, doing the interviews at Salomons and the Tavi week, so 2 whole weeks when probably can't do any work... Neighbour invited to go over for some mulled wine and was actually interested in what is going on in my life, not just my research. He gave me a stupid gift that English tourists buy when they visit Lapland, and it took me a while get the joke. Perhaps I should socialise and reconnect with my own culture? It's actually really nice being at home.	Chill! Transcribe min 2 hours/day (except Christmas Eve and NYE), but try not to do other things during break. Things can wait until back in England! However, revisit Gannt chart when back in routine and amend it to make it more realistic.
Jan 2011	Ninth interview. Transcribing previous interviews continues, but it felt ok to do this as arranged. Interview schedule seems ok still, and the participant didn't seem to be saying anything that was considerably different compared to the interviews that I've done so far. Rapport was good, and we both laughed a lot. It's all feeling quite relaxed now. At least in terms of doing the actual interviews.	Prioritise transcribing when you can, but right now the April deadlines need to be sorted first. Go back to notes taken during the interview to see if any specific areas need highlighting in future interviews (it doesn't seem that way right now, but check the notes anyway).
Feb 2011	Tenth interview. This was the first face-to-face interview since the pilots, so I felt quite nervous. However, it went really well and it was helpful to observe the non-verbal	Transcribe the interview.

	communication during the interview. It made me realise that perhaps my participants feel a bit anxious about taking part and worry about how they might come across (e.g. whether there are "right" answers to my questions). Despite this, it felt more like a chat than an official interview (to me, anyway), and it was helpful to utilise my observations of the participant's body language to generate more questions. Overall, I don't think we covered any new areas or touched on things that were different to those reported by other participants, but having that personal contact seemed to confirm that was has been gained through telephone interviews has been sufficient and the rapport isn't necessarily that different.	
Mar 2010	Grounded theory support group meeting. I've lost count now how many times we've met as a group/paired off with couple of other trainees, but realised I haven't been writing about it here... Catching up was helpful today, but for me the current priorities are the April submissions.	Planning to swap transcripts soon.
Mar 2011	Eleventh interview. An interview with a participant who was interested in exploring her own feelings about clients' parenthood since becoming pregnant. An interesting interview and thought-provoking comments, although need to consider the relevance in more generic settings (highly specialised field of working).	Transcribe interview, but, whilst doing focused coding, keep checking relevance to research questions.
Apr 2011	Finished placement at the children's hospital. Meeting the parents at the NNU has continued to be a powerful experience, and what amazes me most every time I meet new parents is how resilient they are despite all the things that are going on –not just with their babies, but often they describe quite traumatic life stories. How do they survive? I have been reading a lot about attachment, psychodynamic ideas about becoming a parent, and perinatal loss. Parents have often been portrayed as particularly vulnerable individuals	

	(particularly in the perinatal literature). I will need to be aware of this bias when analysing my data: I noticed that during my last coding session I was becoming quite critical of what the participant was saying, so I went back to the audio-recording to listen how things were said. I didn't really get anywhere, and I stopped coding for that day but tried to remain aware of my feelings when I got back to it later. I also discussed my patient who died recently in supervision again to make sure I had processed the issue adequately. She was a 23-weeker, only two months old, and her twin had died at birth. Working with the mum was a privilege; she shared with me the joys and pains of parenthood, so many intense feelings in such short space of time, and the numbness when things go wrong. I think the coding I was trying to do earlier evoked memories of this mum, which evoked difficult feelings about what had happened and thoughts about how unfair life can be. I re-coded the interview later, when I realised that I was critical of life, not the participant.	
April 2010 onwards	Drafting Section A. Although I have been reading around this topic a great deal, I haven't started writing this section yet. I have become aware of how much this reading has influenced my thinking about my data, and have occasionally caught myself trying to impose preconceived ideas on the interviews when coding. It has been quite hard to remain open, especially once I started writing the critique section of the review paper –many of my participants have talked about similar issues, so I have had to be mindful that I have remained close to the data when coding and not taken shortcuts in interpreting what my participants have said.	
May 2011	Twelfth interview. A good interview with a relatively newly qualified working in a relatively new setting, but didn't seem to elicit any new information (saying similar things to other interviewees in a different way). Interesting thoughts about having to accommodate own	Transcribe and do focused coding before the next interview. Think about the political climate and how it might be impacting on newly qualified therapists and

	desires for professional development to what services are expecting (no long-term contracts, so having to find ways of being attractive to all kinds of services).	those about to qualify.
May 2011	Peer support group and pairing with two other trainees using Charmaz' GT approach. Previous peer feedback had suggested that some of my initial coding was almost like focused coding, so I sought more feedback on a number of interviews (including both initial line-by-line codes and focused codes). Compared to the other trainees, our approaches now seem much more akin, so feeling reassured that it's going well.	Continue coding and contact supervisors if anything unclear.
May 2011	Thirteenth interview. Nothing new seemed to come up in this interview, and the same information seemed to be said in different ways. A good rapport with the interviewee, and interesting thoughts about incorporating systemic ways of working in secondary mental health settings, so needs considering in conjunction with those interviewees worked in similar settings but who reported not being able to work systemically.	After transcribing this interview: It seems that no new ideas are coming up – saturation achieved? An experienced clinician working in secondary mental health care, so compare closely with the previous interview with a relatively newly qualified therapist (see memo).
May 2011	Study leave.	Examine focused codes, start axial coding (if it seems necessary), share codes with supervisors.
May – Jun 2011	Axial and theoretical coding. This is taking much longer than I thought! I'm starting to realise that I almost have to re-analyse all focused codes; it's so hard to remember my thinking a few months ago! Glad I've written memos, but I have also realised that I have so many focused codes just because I've coded the interviews so far apart that I just haven't been able to hold them all in mind when dipping in and out of the thesis.	Discuss with supervisors and in GT peer support group.
Jun 2011	Supervision with Margie. Discussed Section A and focused/axial codes: what do these codes mean/suggest/indicate and how can they be	Continue theoretical coding and email them to Margie.

	conceptualised theoretically.	
Jun 2011	Theoretical coding and two peer supervision meetings. I feel that things are going well despite feeling perhaps slightly behind others. It actually seems that I get this methodology!	
Jun 2011	Contact with both supervisors. Theoretical codes and final categories agreed with supervisors, and only very minor amendments to the terms were needed –great! Also discussed relationships between categories and wider issues relating to my thesis topic.	Write results and discussion sections.
Jun / Jul 2011	Model finalised, results discussed with supervisors and peers for any final amendments, it all seems to be coming together!	Proof-read section B, email it back to supervisors, finalise section A, and tidy up section D.
Jul 2011	Writing section C. This has forced me to reflect on the process of doing this research and to go back to my earlier memos. I would not have thought that I'd ever say this, but writing this section has been tremendously helpful in developing a narrative of my experience, the results, and the meaning of the results, and it has somehow brought a closure to the project. Well, I know I haven't had the viva or done the final amendments, but it feels that, for the time being, it's ok to consider this project done!	No more actions!

Appendix 12: Letter to CCCU Research Governance Manager

Department of Applied Psychology
Faculty of Social and Applied Sciences
Salomons Campus

Roger Bone
Research Governance Manager
The Graduate School and Research Office
Canterbury Christ Church University
North Holmes Campus
Canterbury
Kent
CT1 1QU

30.06.2011

Dear Mr Bone,

RE: A grounded theory study of therapists' consideration of their clients' parenthood, summary of results

Further to our communication in July 2010, I am writing to you to summarise the findings of the above research project, which was completed in partial fulfilment of the requirements of Canterbury Christ Church University for the degree of Doctor of Clinical Psychology.

13 clinical and counselling psychologists working in NHS adult mental health services were interviewed and the results were analysed using grounded theory. A preliminary model was generated, which highlighted multiple tensions that psychologists manage in their therapy work with active parents. These included balancing the directives from policies and service targets with the psychologists' own preferred ways of working, how flexibly they can adjust the theoretical models that they base their therapy work on, what the client and his/her family appears to want and need, and risks (see figure one for a diagrammatic illustration of the model).

The relationships between these variables are complex and interlinked, and the level of overlap between them determines what type of action the therapist might take regarding the client's parenthood. For example, if the majority of factors or any known risks are present, it is likely that parenthood needs to be addressed, for example to consider the child's needs in their own right or to take safeguarding actions. However, other possible overlaps between the variables either increase the likelihood of considering parenthood or only results in direct consideration and/or addressing the client's parenthood if the nature of the variables suggests that this is advantageous. In the cases of the former overlaps, the attention to parenthood is more likely to be at a conceptual level rather than directly addressing it.

The study highlighted various implications for clinical practice. Despite policies and guidelines recommending family-inclusive care, the current service structures and political agendas can limit the scope of considering the parenthood of clients who access adult mental health services. Adult and child mental health services need better integration and more flexibility in order to protect the future mental health of services users' children, and such services and related policies need to be developed with this in mind. Individual clinicians reported considering their clients' parenthood, and often formulated this thoroughly, but did not always feel that it was possible for

them to support the parenting of their clients, owing to these service limitations. Finding systemic supervision and/or like-minded colleagues can be difficult in adult mental health services, but these were reported as important factors in helping psychologists to keep their clients' children and families in mind. It was evident that many participants were keen to incorporate systemic ideas in their routine practice, but described lacking confidence and support to do so. Therefore, the findings of the study suggest that changes are required at multiple levels of service: individual professional, service structure, and policy.

Yours sincerely

Leena Mylläri
Trainee Clinical Psychologist

Cc: Professor Margie Callanan (Chair of Salomons Ethics Panel)

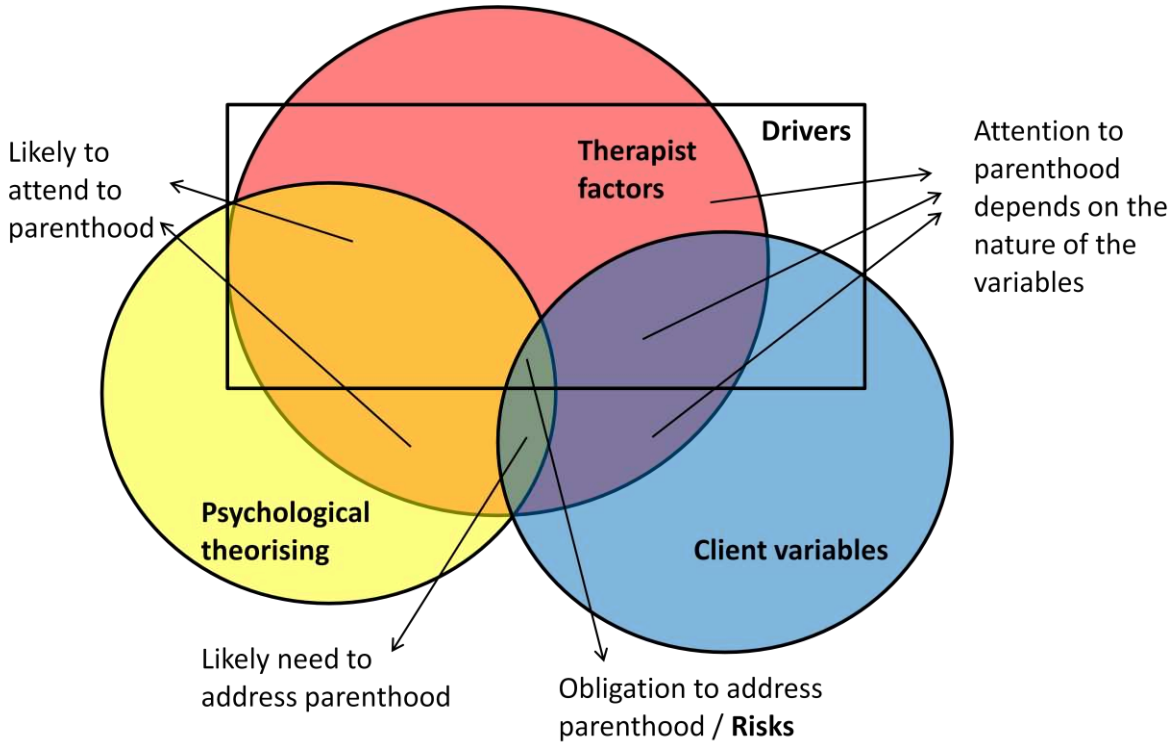

Figure 2. Model illustrating how different variables influence the consideration of clients' parenthood by therapists working in adult mental health services.

Appendix 13: Author Guidelines (Journal of Mental Health)

Instructions for Authors

Further information about the journal including links to the online sample copy and contents pages can be found on the journal homepage.

Journal of Mental Health is an international journal adhering to the highest standards of anonymous, double-blind peer-review. The journal welcomes original contributions with relevance to mental health research from all parts of the world. Papers are accepted on the understanding that their contents have not previously been published or submitted elsewhere for publication in print or electronic form. See the Evaluation Criteria of Qualitative Research Papers and the editorial policy document for more details.

Submissions. All submissions, including book reviews, should be made online at Journal of Mental Health's Manuscript Central site. New users should first create an account. Once a user is logged onto the site submissions should be made via the Author Centre. **Please note that submissions missing reviewer suggestions are likely to be un-submitted and authors asked to add this information before resubmitting.** Authors will be asked to add this information in section 4 of the on-line submission process.

The total word count for review articles should be no more than 6000 words. Original articles should be no more than a total of 4000 words. We do include the abstract, tables and references in this word count.

Manuscripts will be dealt with by the Executive Editor, Professor Til Wykes, Department of Psychology, Institute of Psychiatry, De Crespigny Park, London, SE5 8AF, United Kingdom. It is essential that authors pay attention to the guidelines to avoid unnecessary delays in the evaluation process. The names of authors should not be displayed on figures, tables or footnotes to facilitate blind reviewing.

Book Reviews. All books for reviewing should be sent directly to Martin Guha, Book Reviews Editor, Information Services & Systems, Institute of Psychiatry, KCL, De Crespigny Park, PO Box 18, London, SE5 8AF.

Manuscripts should be typed double-spaced (including references), with margins of at least 2.5cm (1 inch). The cover page (uploaded separately from the main manuscript) should show the full title of the paper, a short title not exceeding 45 characters (to be used as a running title at the head of each page), the full names, the exact word length of the paper and affiliations of authors and the address where the work was carried out. The corresponding author should be identified, giving full postal address, telephone, fax number and email address if available. To expedite blind reviewing, no other pages in the manuscript should identify the authors. All pages should be numbered.

Abstracts. The first page of the main manuscript should also show the title, together with a structured abstract of no more than 200 words, using the following headings: Background, Aims, Method, Results, Conclusions, Declaration of interest. The declaration of interest should acknowledge all financial support and any financial relationship that may pose a conflict of

interest. Acknowledgement of individuals should be confined to those who contributed to the article's intellectual or technical content.

Keywords. Authors will be asked to submit key words with their article, one taken from the picklist provided to specify subject of study, and at least one other of their own choice.

Text. Follow this order when typing manuscripts: Title, Authors, Affiliations, Abstract, Key Words, Main text, Appendix, References, Figures, Tables. Footnotes should be avoided where possible. The total word count for review articles should be no more than 6000 words. Original articles should be no more than a total of 4000 words. We do include the abstract, tables and references in this word count. Language should be in the style of the APA (see *Publication Manual of the American Psychological Association*, Fifth Edition, 2001).

Style and References. Manuscripts should be carefully prepared using the aforementioned *Publication Manual of the American Psychological Association* , and all references listed must be mentioned in the text. Within the text references should be indicated by the author's name and year of publication in parentheses, e.g. (Hodgson, 1992) or (Grey & Mathews 2000), or if there are more than two authors (Wykes *et al* ., 1997). Where several references are quoted consecutively, or within a single year, the order should be alphabetical within the text, e.g. (Craig, 1999; Mawson, 1992; Parry & Watts, 1989; Rachman, 1998). If more than one paper from the same author(s) a year are listed, the date should be followed by (a), (b), etc., e.g. (Marks, 1991a).

The reference list should begin on a separate page, in alphabetical order by author (showing the names of *all* authors), in the following standard forms, capitalisation and punctuation:

a) For journal articles (titles of journals should *not* be abbreviated):

Grey, S.J., Price, G. & Mathews, A. (2000). Reduction of anxiety during MR imaging: A controlled trial. *Magnetic Resonance Imaging, 18* , 351–355.

b) For books:

Powell, T.J. & Enright, S.J. (1990) *Anxiety and Stress management* . London: Routledge

c) For chapters within multi-authored books:

Hodgson, R.J. & Rollnick, S. (1989) More fun less stress: How to survive in research. In G.Parry & F. Watts (Eds.), *A Handbook of Skills and Methods in Mental Health Research* (pp. 75–89). London:Lawrence Erlbaum.

Illustrations should *not* be inserted in the text. All photographs, graphs and diagrams should be referred to as 'Figures' and should be numbered consecutively in the text in Arabic numerals (e.g. Figure 3). The appropriate position of each illustration should be indicated in the text. A list of captions for the figures should be submitted on a separate page, or caption should be entered where prompted on submission, and should make interpretation possible without reference to the

text. Captions should include keys to symbols. It would help ensure greater accuracy in the reproduction of figures if the values used to generate them were supplied.

Tables should be typed on separate pages and their approximate position in the text should be indicated. Units should appear in parentheses in the column heading but not in the body of the table. Words and numerals should be repeated on successive lines; 'ditto' or 'do' should *not* be used.

Accepted papers. If the article is accepted, authors are requested to submit their final and revised version of their manuscript on disk. The disk should contain the paper saved in Microsof Word, rich text format (RTF), or as a text or ASCII (plain) text file. The disk should be clearly labelled with the names of the author(s), title, filenames and software used. Figures should be included on the disk, in Microsoft Excel. A good quality hard copy is also required.

Proofs are supplied for checking and making essential corrections, not for general revision or alteration. Proofs should be corrected and returned within three days of receipt.

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