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PERSONAL GROWTH FOLLOWING THE CHALLENGE OF BECOMING A NEW
PARENT WHILE WORKING AS A MENTAL HEALTH CLINICIAN:
A NARRATIVE STUDY

by

Amie L. Smith

A dissertation submitted in partial fulfillment
of the requirements for the degree

of

Doctor of Philosophy

in

Psychology

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Logan, Utah

2018

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ABSTRACT

Personal Growth Following the Challenge of Becoming a New Parent While
Working as A Mental Health Clinician: A Narrative Study

by

Amie L. Smith, Doctor of Philosophy

Utah State University, 2018

Major Professor: Susan Crowley, Ph.D.
Department: Psychology

The transition to parenthood is rife with both stress and joy which can both increase and decrease a new parent's well-being. Likewise, working as a mental health clinician can also tax one's resources and lead to burnout. Given that many clinicians also become parents while working during the course of their careers, it is surprising that there is a relative paucity of studies (15 located) that address the interaction of new parenthood and mental health work. More research is needed on the experiences of parent clinicians to determine how they navigate their challenges surrounding parenting *and* working. Research on stress-related growth suggests that people can emerge from stressful or traumatic events and perceive that they have experienced positive personal growth as a result.

This narrative study aimed to add to the literature base on parent clinician's lived experiences. Five parent clinicians were interviewed on two separate occasions and the

interviews were transcribed. The transcriptions were edited into five individual narratives that detail the parent clinician's unique challenges, how they navigated their challenges, and how they reflected on their experiences and personal growth.

The five parent clinicians recounted many positive and negative impacts that new parenthood had on their clinical work and personal lives. In addition, they drew from their families of origin and identities to make meaning through their challenges. The parent clinicians all noted that the presence and absence of social support, including institutional and personal support, either aided or hindered their transition. Furthermore, the findings supported studies on stress-related growth that suggest that cognitive processing and social support predict the perception of positive personal growth.

This was the first known narrative study on the impacts of new parenthood on mental health clinicians. This study adds to the literature base on clinician's lived experiences. In addition, the findings of the study can aid training directors, clinical supervisors, and agency directors in developing policies and providing supervision that increases new parents' social support.

(177 pages)

PUBLIC ABSTRACT

Personal Growth Following the Challenge of Becoming a New Parent While
Working as A Mental Health Clinician: A Narrative Study

Amie L. Smith

Becoming a new parent can cause both immense joy and immense stress that leads to increases and decreases in a new parent's feeling of life satisfaction. In addition, working as a mental health clinician is a frequently challenging career. Given that many clinicians also become parents while working during the course of their careers, it is surprising that there is not more research on the experience of clinicians who become new parents. More research is needed to find out how people balance the stresses of new parenthood and their emotionally challenging jobs. There is some research on "stress-related growth" that suggests that people can experience stressful or traumatic events and emerge on the other side feeling like they have achieved positive personal growth. This study attempted to find out if this occurs when clinicians become parents.

This was a narrative study aimed to add to the research literature on parent clinician's (clinicians who were also parents) lives by presenting their stories of becoming new parents. Five parent clinicians were interviewed on two separate occasions and those interviews were transcribed; the transcriptions were edited into five individual stories that detail the parent clinician's unique challenges, how they navigated their challenges, and how they reflected on their experiences and their personal growth.

The five parent clinicians recounted many positive and negative experiences that

new parenthood had on both their clinical work and personal lives. In addition, they described how their families and identities helped them to make meaning out of the challenges they faced. The parent clinicians all talked about how either the presence or absence of social support, or their personal and professional relationships, impacted their lives when they became new parents. Social support included institutional support such as their employers or graduate departments and personal support such as their co-parents, families, and friends. This support either helped or hindered the parent clinician's ability to balance the demands of parenthood and work. Furthermore, the findings supported previous research on stress-related growth that suggest that cognitive processing (thinking about an event after it occurred) and social support predict the perception of positive personal growth.

This was the first known narrative study on the impacts of new parenthood on mental health clinicians and the study adds to the research literature on clinician's lived experiences. In addition, the findings from the study can help training directors, clinical supervisors, and agency directors to develop new policies that increase new parents' social support which may help them weather the storms of becoming a new parent while working as a clinician.

ACKNOWLEDGMENTS

I wish to thank all of the parents and parent figures in my life who made this study possible. First and foremost, I would like to thank the parent clinicians who participated in this study by volunteering their time and being vulnerable with me. I feel honored that you shared your stories with me and feel bolstered by our shared experiences and everyone's personal growth.

My committee is comprised of many of my "parents" during graduate school and I would like to thank all of them. Dr. Renee Galliher was the instructor of the very first graduate class that I took and ushered me into the life of graduate school. I knew she was a parent who did not hide it and is also known throughout the department as being fiercely supportive of students. Dr. Sherry Marx parented me to be a qualitative researcher. When I dragged my 2-week postpartum body to her night class, she was a warm presence who acknowledged that some things, like our personal lives, are more important than academia. She also encouraged me to not shy away from the personal in research and instead embrace my voice. Dr. Marx has been my go-to for all questions about qualitative research. Dr. Amy Kleiner was my practicum instructor and clinical supervisor at the practicum site where I spent 2 years; one year I was pregnant and the second year I had an infant. Dr. Kleiner's willingness to talk openly about the joys and fears of new parenthood improved my clinical work but more importantly made me feel less alone. Our conversations birthed this study. Dr. Kleiner was the smiling, understanding face that I looked at when I cried during a staff retreat, and she also held and fed my daughter when I was called on to present to my colleagues. Dr. Scott

DeBerard recruited me to Utah State and shepherded me into the world of scholarly research. Dr. DeBerard also let me grow up and leave his nest when I decided that I wanted to pursue qualitative research! When I was 8 months pregnant and tearfully questioning the timeline of my return to work, he looked at me and gently said that I could choose to take the whole year off if I wanted to. Finally, Dr. Susan Crowley has been a parent to countless students in her role as the director of clinical training and was my surrogate mother from the very beginning during my graduate school interview. She saw me for who I was and who I wanted to be as a clinician, researcher, and person. She knew when to push me, when to support me, and when to chase after me. Dr. Crowley also supported both my decisions to become a parent and to turn the experience into my dissertation.

Thank you to my co-parent and spouse for, well, everything on this decade-long adventure, not the least of which for being a great father to our daughter. Thank you to my daughter. You made me a parent and were the catalyst for the most important growth of my life. Finally, thank you to my own parents who sacrificed time, money, and their own dreams so that I could receive an excellent education. This meant pulling me out of public school to give me freedom as a child, to funding my undergraduate education, and then emotional support for me to pursue my Ph.D. The instrumental support during my Ph.D. included the many times you parented for me while I crammed on important deadlines. This accomplishment is your accomplishment too.

Amie L. Smith

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CHAPTER I

INTRODUCTION

The Researcher

My first child, a daughter, was born 3 weeks before the beginning of my fourth year as a graduate student in a combined clinical/counseling Ph.D. program. Classes and meetings began when my daughter was 2 weeks old, and I began seeing clients when she was 6 weeks old. Like all parents who work outside the home with a newborn, I was sleep-deprived and anxious. Unlike all parents who work outside the home, my work as a clinician meant that I needed to be emotionally present with my distressed clients, with 10-minute breaks in between. This was hard practically as the schedule allowed no time to “zone out” in front of a computer for my exhausted body and brain, and pumping breastmilk in ten minutes became an all-out sprint.

What was more difficult and unexpected, was the emotional toll that both new parenting and psychotherapy took. I could no longer feel objective concern when clients told me their sad stories. Now every person could be my daughter—every complicated childhood trauma, every heartbreak, every disappointment. I assuaged myself with smug justifications that my superior parenting would protect her, but I realized that I could not protect her from everything. My inability to remain distant impacted both my work with clients and at home. Hearing distressing stories from clients at times took me out of the present moment with them as I worried if whatever they were telling me could happen to my daughter; I calculated the statistics in my head to try to reassure myself. If worries

about home leaked into work, the reverse also happened. I often took home sad stories that I heard from clients and found myself worrying about them while in the room watching myself watch my daughter play. It felt as if I was never fully present with anyone.

I felt very alone during this time while I struggled with how to process both roles. I felt guilty because my own mother and sister did not work while they raised young children. They both had repeatedly expressed concerns about my working and suggested I take time off or quit. I wanted to defiantly prove them wrong, felt jealous of their privilege, and worried that they might be better mothers than I was and their choices were better. In my department I had few close relationships with clinicians who were also parents to help me. I once cornered a faculty member in the copy room to talk about big emotional issues and the meaning of life for an hour and she graciously obliged. My second semester I was lucky and had a clinical supervisor who was also a parent. She helped me improve my work as a clinician and let me cry weekly in supervision about how hard it all was. The conception of this study was therefore a way for me to make sense of my experience as well as to share with others what the cornered faculty and supervisor shared with me. In my mind I hope it will be a refuge or a guide map for others who take on both roles of parent and clinician.

Qualitative inquiry maintains that no researcher is truly objective, and in the spirit of this, I aimed to be aware how my I uniquely influenced this study. In addition to my own transition to parenthood, my beliefs and personal characteristics also impacted how I made sense of the material. As a humanist I privilege individual lived experiences and

believe people to be inherently growth-oriented as they strive to make meaning in life. Those beliefs inspired this narrative study. I saw my transition to parenthood as part of my developmental journey to a place of richer meaning and a deeper sense of self. This likely influenced what I searched for in other people's narratives as well. In addition, I am a White, cisgender, heterosexual, middle-class, married, parent who has a healthy child. I tried to understand my privilege and be open to other experiences and viewpoints. My goal in interviewing other parent clinicians was to attempt to share power in the researcher role, develop true relationships with them and honor their unique stories.

Problem Statement

There is ample literature demonstrating that the transition to parenthood is a difficult one. New parents are hit with a number of stressors in the first few years including increased fatigue (Loutzenhiser, McAuslan, & Sharpe, 2015) and declines in marital satisfaction (Mitnick, Heyman, & Smith Slep, 2009). Parents with children under the age of two experience the lowest amount of leisure time compared to everyone else (Bittman & Wacjman, 2000). New parents report increased stress regarding how their new roles as parents may restrict other activities and interests (Hildingsson & Thomas, 2014). Finally, while there is some debate about the impact of parenthood on mental health, one study found a relationship between parenthood and increased depression and anxiety at five months postpartum (Parfitt & Ayers, 2014). Nevertheless, studies also show that parents can experience an increased sense of well-being (Nelson, Kushlev, English, Dunn, & Lyubomirsky, 2013).

There is evidence that being a clinician is stressful; in particular, the emotional demands of working with people in distress can lead to burnout and indirect trauma. Burnout can cause one to feel exhaustion, cynicism, and ineffectiveness; and can negatively impact one's professional and personal life (Maslach, Schaufeli, & Leiter, 2001). Clinicians who work with trauma may experience effects ranging from negative changes in beliefs about the world to posttraumatic symptoms including but not limited to intrusive thoughts, nightmares, avoidance, and hypervigilance (Newell & MacNeil, 2010). There is some evidence that the incidence of depression is high in clinicians (Gilroy, Carroll, & Murra, 2002). While it seems clear that the job creates stress, there are few articles about how about how clinicians' lives and significant events (e.g., illness, divorce, parenthood) intersect with the emotional demands of a stressful and demanding job (Rytöhonka, 2015).

Given that new parenthood and clinical work are both on their own difficult, it is surprising that there is little in the research literature on how parent clinicians navigate doing both. The available research was limited not only in sheer numbers (15 articles), but also by methodology and perspective. Of the 15 articles, seven were written from a first-person perspective, and eight were phenomenological studies; in addition, seven of the 15 articles were written from a psychoanalytic perspective. The authors of these works provide a number of both positive and negative impacts on both clinicians' work and their experience of parenting ranging from increased empathy and understanding to increased guilt and emotional distress. The findings in the studies are interesting and noteworthy, but at times they read like a laundry list of events that happen to passive

clinicians and there is less of an emphasis on what the clinicians actively do cope with the stress and make meaning out their experiences of becoming a parent. In addition, often the clinicians' experiences feel out of context of their overarching stories that includes contexts such as their own childhood, philosophies of parenting or clinical work, spirituality, or identity. The proposed study aimed to use a narrative approach in an attempt to place sometimes fractured findings into contexts and weave coherent stories that can be meaningful to both writers and readers.

CHAPTER II

REVIEW OF THE LITERATURE

Definitions

Clinician: A term to include any professional who engages in a therapeutic context with another person to provide therapy or counseling. Includes “counselor,” “therapist,” “psychotherapist,” “analyst,” and “psychoanalyst.”

Client: A term to mean a person who seeks out counseling of some sort with a professional. Some other psychological traditions use the word “patient.” One author who works in a college setting referred to his clients as “students.”

Parent clinician: My constructed term to describe a clinician who is also a parent.

Theoretical orientation: A philosophy of therapy that includes epistemology, model of how human change occurs, as well as techniques for encouraging change. Examples include psychodynamic, humanistic, cognitive-behavioral, integrative.

Participant: A term for someone who participates in research. Some authors use the term “subject” but I prefer the more egalitarian and collaborative term participant. Narrative researchers sometimes also use the term “narrator.”

Transition to Parenthood

There is an ongoing debate in both the empirical literature and popular press about whether parenthood makes people happy or not. In a world-wide study examining parents in 94 countries, researchers concluded that having children was negatively related

to wellbeing (self-reported life satisfaction and happiness) when compared to a childless reference group (Stanca, 2012). However, a different survey of 6,906 parents in the United States found that self-reported happiness, life satisfaction, and meaning in life was higher when compared to non-parents (Nelson et al., 2013). Similarly, findings from a large survey across Europe also suggested an association between parenthood and increased happiness (Aassve, Goisis, & Sironi, 2012). A definitive answer is beyond the scope of one dissertation study and is also likely largely unanswerable. This is because as Nelson, Kuschlev, and Lyubormirsky (2014) demonstrated in their review of the literature on parenthood and well-being: *it depends*. Experiencing positive or negative impacts of parenthood depends on which parent, which child, when, and in what context. In their review, the authors posited many mediators (how the relationship might work) and moderators (when the relationship might occur and to what degree) in the relationship between parenthood and well-being. They suggested that parenthood may mediate increased well-being by bringing purpose or meaning to life; serving an evolutionary function; meeting psychological needs of autonomy, connectedness, and competence; increasing positive emotions; and increasing one's social roles. On the other hand, parenthood can possibly decrease wellbeing by increasing negative emotions, negatively impact sleep and lead to fatigue, create strained marital or partner relationships, or increase financial pressure. Nelson et al. (2014) also introduced possible moderators of age of parent, age of child, parent gender, marital status, socioeconomic status, employment status, family structure, residence of child, and psychological factors (social support, parenting style, child problems, temperament, and parent attachment

style). This is a vast literature base, but the factors pertinent to this current study are age of child or the period of transition, social roles, and employment status. There appears to be no definitive time boundary for what constitutes the “transition to parenthood,” but for the studies included in this review it is from birth to 3 years postpartum.

The transition to parenthood is difficult. Young children require a great deal of physical care, create negative emotions, and any “rewards” from an evolutionary or psychological perspective do not pay off until children are older (Nelson et al., 2014). Two topics that receive a great deal of attention in the literature are how the transition to parenthood impacts sleep and marital relationships.

Sleep and Fatigue

To state that the transition to parenthood impacts parents’ sleep is nearly axiomatic; what many researchers focus on instead is how reduced sleep relates to other concepts. One longitudinal study of 293 women found that those with the worst postpartum sleep were the most likely to experience depression (Tomfohr, Buliga, Letourneau, Campbell, & Giesbrecht, 2015). Sleep also is a correlate of fatigue. A study of 108 couples found increased fatigue in both mothers and fathers that lasted six months, and in addition, those with the poorest sleep at one month were more likely to report increased fatigue (Loutzenhiser et al., 2015). Fatigue is associated with an increase in depression and a decrease in wellbeing and marital satisfaction (Elek, Brage Hudson, & Ofe Fleck, 2002).

Relationships

The negative impact on marriages and partner relationships appears to be greatest during the transition period. A meta-analysis comparing parents to non-parents on self-reported relationship satisfaction found that parents reported lower satisfaction, the effect was highest in both sexes when children were under aged 2, and women who have children under 2 years old reported the greatest dissatisfaction (Twenge, Campbell, & Foster, 2003). A more recent meta-analysis examined 37 studies on marriage outcomes of parenthood and reached a similar conclusion on the time period; authors found small declines in marital satisfaction in both sexes between time points during pregnancy and 11 months. Five of the 37 studies extended the time interval to between 12 and 24 months and the aggregate finding was a moderate decline for that later time point (Mitnick et al., 2009). The authors caution that this decline may not be meaningful since married couples who remain childless also experience a decrease in satisfaction over time. To attempt to answer this question, Doss, Rhoades, Stanley, and Markman (2009) compared parent couples with childless couples and found that parents experienced a “sudden” decrease in satisfaction once they had children in contrast to the childless couples’ more gradual decrease. This study also elaborated on specific components of marital stress in addition to a general “satisfaction.” Women in the study showed an increase in relationship problem intensity, reduced conflict management, increased negative communication, and a reduced feeling of confidence in the relationship. Fathers reported a decrease in dedication to the marriage, increased negative communication, and a gradual increase in problem intensity. Another study aimed to find correlates of marriage dissatisfaction;

anxiety and depression during pregnancy, shorter relationship, and less positive communication predicted the moderate decline in relationship satisfaction for couples from mid/late pregnancy to 30 months postpartum (Trillingsgaard, Baucom, & Heyman, 2014). In contrast, social support from a partner has been demonstrated to possibly mitigate the feelings of stress during the transition to parenthood (Deater-Deckard & Scarr, 1996). Twenge et al. (2003) hypothesized that marital dissatisfaction is impacted by “role conflicts” which is discussed more fully below, and feelings of restricted freedom. People with children who are under the age of 10 experience reduced leisure time when compared with other adults, and those with children under the age of two have the lowest (Bittman & Wajcman, 2000). Bittman and Wajcman further specified that mothers with children under the age of 2 only spend 2.5 hours per week in unstructured adult leisure time.

Changes in Roles and Identities

Another dramatic change during the transition to parenthood is in the roles people hold. As the brand-new role of “parent” is introduced, other roles such as “spouse” or “partner,” “self,” and “professional” necessarily either adapt or suffer. In a longitudinal study that demonstrated increased stress during the transition to parenthood, parents were given a stress measure at one year after the birth of their child. The subscales of the stress measure are incompetence, role restriction, social isolation, spouse relationship problems, and health problems (Hildingsson & Thomas, 2014). Parents of both genders rated “role restriction” as the highest score contributing to their stress; role restriction was defined as “narrowing of activities and interests due to parental responsibilities” (p. 44). The authors

wrote that concerns about role restrictions can include feeling trapped, having reduced time for personal interests, less time with a partner, difficulty balancing work and family life, or maintaining a sense of self.

The transition to parenthood can also impact one's sense of self. A qualitative study of mothers revealed that they struggled with a temporary loss of self because caring for an infant was so consuming and they could not meet their own needs (Laney, Lewis Hall, Anderson, & Willingham, 2015). Interestingly, the mothers reported that they worked hard on integrating their identities and felt more confident in the long run. This may suggest that working through temporary stress may have long-term benefits. In a qualitative study reporting on nine fathers' experiences, many men reported that it was difficult to navigate between society's views on masculinity and their own feelings as they helped in the caregiving duties and stayed home (Höffner, Schadler, & Richter, 2011). Many fathers in this study felt insecure if they took parental leave. Nelson et al. (2014) hypothesized that being an employed parent could increase wellbeing by increasing financial resources and by introducing more social roles. The authors explained that having multiple social roles where one can feel successful in one (e.g., parent) can buffer the stress of feeling unsuccessful in another (e.g., employee). However, the authors also cited studies that instead show that working can decrease wellbeing by adding stress in having to balance work and parenthood. A study about the effects of balancing dual roles of parenthood and work compared the health, physiological stress, and psychological stress of parents and nonparents working in academia in the Netherlands by self-report and cortisol measures (Bekker, Zijlstra, & van

Landeghem, 2000). Parents showed decreased psychological functioning when compared to their childless colleagues; mothers' physiological stress was higher than fathers, although this was not statistically significant.

Impacts on Mental Health

Since the transition to new parenthood is stressful, an important question is if this stress leads to temporary or permanent decreased mental health. The literature on this is mixed. Evenson and Simon (2005) found that parents had more depression when compared to nonparents at many time points (when their minor children live at home, when their adult children live at home, and when their children have moved out). Authors of a later study summarized the high incidence of anxiety and depression in parents during the transition to parenthood and provided statistics after administering pre and postpartum measures of anxiety, depression, and posttraumatic stress disorder (PTSD) (Parfitt & Ayers, 2014). At approximately 5 months postpartum, mothers reported anxiety at a rate of 21%, and depression at 11%; the rate for fathers was 8% for both anxiety and depression. Both groups experienced PTSD at a rate of 5%. By comparison, the National Institute of Mental Health (NIMH) estimates past-year prevalence rates in the general adult population at 23.4% for females and 14.3% for males for any anxiety disorder, 8.5% for females 4.8% for males for depression, and 5.2% for females and 1.8% for males for PTSD (NIMH, 2017a, 2017b, 2017c). Kalucza, Hammarström, and Nilsson (2015) reported that women's psychological functioning temporarily decreases during the transition to parenthood but improves in the long-term. McKenzie and Carter (2013) found positive mental health effects of first-time parents during the transition to

parenthood when looking at within-individual changes versus the more typical between-group study design.

Positive Impacts of Parenthood

While there are stressors along the way, new parents' well-being often improves. For every study that finds a decrease in wellbeing, a study demonstrating the opposite can be found (Nelson et al., 2014). What does get better? As children age, their sleep improves as does their parents', and children develop and become physically able to accomplish more tasks themselves alleviating some of the burdensome physical labor from parents. Intervals between feeding become longer; this relieves some pressure on all parents, but particularly women who choose to breastfeed. Parents develop and learn too. One study demonstrated that women's self-efficacy, or perception about being able to successfully parent, increased between 32 weeks of pregnancy and 12 months postpartum, and that there was a bidirectional relationship between self-efficacy and mental health (Kunseler, Willemen, Oosterman, & Schuengel, 2014). The authors found that positive prenatal mental health of parents was a predictor of increased self-efficacy and prenatal self-efficacy also predicted reduced depression postpartum.

The literature also suggests that parents also choose active coping strategies to weather the stress of the transition and to experience personal growth. A qualitative study of 102 new mothers found that they experienced increased mental health and personal growth between their third trimester of pregnancy and two months postpartum (Taubman-Ben-Ari, Shlmomo, Sivan, & Dolizki, 2009). The authors attributed this change to the mothers experiencing stress-related growth by appraising motherhood as a

challenge and relying on marital support. Pioneers of the theory of stress-related growth, Tedeschi and Calhoun (2004) stated that growth occurs when something happens that changes our views of the world and ourselves and we use meaning-making cognitive and emotional strategies to “rebuild” our beliefs. Interestingly, Nelson et al. (2014) found that parents reported more thoughts about meaning in life throughout their days when compared to nonparents! It is possible that in addition to weathering the storms of early parenthood, parents also take active steps to grow that results in improved wellbeing.

Clinician Issues

Like in any vocation, mental health clinicians experience stress, boredom, bad bosses and coworkers, institutional politics, and any number of other common occupational annoyances. One unique aspect of working as a clinician (as in other human service fields such as medicine, nursing, social work, teachers, clergy, etc.), is that the job requires consistently working in a relational way with other people who are in distress. The emotional exhaustion of this work can create negative intrapersonal outcomes above-and-beyond typical “work stress.” A number of syndromes have been identified that are the result of this type of emotional work that include burnout, as well as three others that have been called “indirect trauma”: vicarious traumatization, secondary traumatic stress, and compassion fatigue. There seems to be confusion and conflation with these terms in the literature; some authors suggesting they are unique while others note significant overlap. Of these syndromes, burnout has received the most extensive research and is used to describe occupational stress outside of human services as well.

Burnout

Burnout in general is a state of physical and psychological distress brought on by chronic stress at one's job. Maslach et al. (2001) provided a summary of the concept, history, and research of burnout; they reminded the reader that the concept began within the human services where the

...core of the job was the relationship between provider and recipient. This interpersonal context of the job meant that, from the beginning, burnout was studied not so much as an individual stress response, but in terms of an individual's relational transactions in the workplace. Moreover, this interpersonal context focused attention on the individual's emotions, and on the motives and values underlying his or her work with recipients. (p. 400)

The authors described burnout as containing the following components: exhaustion, cynicism/depersonalization, and ineffectiveness in one's job. The concept of burnout has moved beyond human services professions and some suggest that any number of job stressors can contribute to burnout. However, one study found that when comparing social, organizational, and emotional factors in non-clinical jobs (hotel, bank, call center, children's homes, and kindergartens), emotional variables predicted burnout more than the other stress variables. Emotional factors accounted for more variance than other job factors (e.g., job complexity, organizational problems, time pressures, etc.) when predicting burnout (Zapf, Seifert, Schmutte, Mertini, & Holz, 2001). This finding may suggest it is the relational aspect of jobs that are a key to burnout.

Theorists have posited a number of conceptualizations about the causes of burnout. Maslach et al. (2001) asserted that emotional exhaustion from engaging with others about their distress leads to pulling back to create some necessary distance; this leads to cynicism and depersonalization. Another conceptualization posits that a

combination of existential and psychoanalytic theories contributes to burnout.

Psychoanalytic theory asserts that people choose their professions (in this case, clinicians) to fulfill a need based on their family dynamics, but then they rely on work too heavily as a substitute for social connections and overestimate their importance to clients (Malach Pines, 2002). The author suggested that when people use their work to fulfill an existential crisis of meaning and they fail (no one can “cure” everyone), they begin to feel hopeless and burnout. Campagne (2012), in reviewing early conceptualizations about burnout wrote that highly motivated people have their unrealistic expectations unfulfilled and that leads to disenchantment that then leads to boredom, and then burnout. Lack of meaning and importance in one’s job leading to burnout was supported in an article that found that workplace stressors were related to “strain” whereas burnout was associated with the sense of importance in the work (Malach Pines & Keinan, 2005).

No matter what the proposed mechanism, burnout has deleterious effects. It can lead to poor outcomes on the job including absenteeism, turnover, poor morale that spreads to other colleagues, lower effectiveness, and less satisfaction with one’s job (Maslach et al., 2001). In addition, burnout can lead to psychological problems such as depression, anxiety, and substance abuse as well as physiological poor health (Maslach et al., 2001). Burnout among therapists specifically can lead to poor quality of care for their clients and put clinicians at risk for ethical violations (Smith & Burton Moss, 2009). A recent study investigated self-care in psychologists across their lifespan and found the highest rates of burnout were in early career psychologists (within seven years of earning their doctoral degree) when compared to midcareer and late-career psychologists

(Dorociak, Rupert, & Zahniser, 2017). The authors focused on the work demands early career psychologists experience such as more paperwork (which has been demonstrated to relate to burnout), working more hours, and exposure to more negative client behaviors. Interestingly the authors made only a passing comment to personal factors in early-career psychologists that often coincide to this period such as engaging in long-term romantic partnerships and becoming parents. Unfortunately, no study could be located documenting the incidence or prevalence of burnout in clinicians.

Indirect Trauma

While burnout can occur to anyone working as a clinician, syndromes of “indirect trauma” occur in clinicians working with clients who have experienced trauma. Newell and MacNeil (2010) described and differentiated the three experiences. Vicarious trauma (VT) is when clinicians experience cognitive shifts in their beliefs or thinking when working with victims of trauma; these changes in beliefs are particularly about their views of the self, safety, spirituality, and control. Secondary traumatic stress (STS) encompasses the behavioral and emotional aspects that mirror PTSD symptoms such as intrusive thoughts, nightmares, insomnia, irritable outbursts, fatigue, decreased concentration, avoidance, and hypervigilance. Compassion fatigue (CF) is perhaps the trickiest to pin down and has been described as a combination of STS and burnout, and like burnout happens cumulatively over time instead of acutely (Newell & Macneil, 2010). Other authors contend that there is overlap between STS and CF (Sabin-Farrell & Turpin, 2003). Craig and Sprang (2010) make the argument that VT is focused on changing cognitive schemas while STS/CF are focused on physiological and behavioral

symptoms but add that there is little data yet to suggest differences between any of these named syndromes. A number of risk factors have been identified for indirect trauma effects including a history of anxiety, mood disorder, or trauma, carrying high caseloads, and maladaptive coping skills (Newell & MacNeil, 2010). Other risk factors are female gender, age, having traumatic clients, length of time providing treatment for victims of sexual abuse, occupational stress, and experiencing one's own maltreatment, although the data on this last one is mixed (Craig & Sprang, 2010).

In a review of work on VT and STS from the 1990s, Collins and Long (2003) reported on a list of outcomes of indirect trauma that include: experiencing negative emotions such as sadness, grief, depression, anxiety, dread, horror, fear, rage, and shame; intensive imagery nightmares or flashbacks; avoidance; somatic complaints; addiction; physiological arousal; and impairments in functioning. It was difficult to find empirical studies documenting VT, STS, and CF, and multiple authors have agreed that the data is limited (Deville, Wright, & Varker, 2009; Sabin-Farrell, & Turpin, 2003). Estimates on the prevalence of burnout and compassion fatigue vary wildly. One study found a 5% rate for both compassion fatigue and burnout that the authors stated was much lower than the rate of 27% that a previous study found (Craig & Sprang, 2010). The authors noted that the rates of compassion fatigue and burnout was higher for less experienced clinicians. Another study compared mental health workers and administrative staff who worked at a Veteran's Administration (VA) hospital to find differences between CF and burnout (Newell & MacNeil, 2011). Administrative staff and mental health providers were matched on college degree and pay. The authors found that both groups experienced

occupational stress at a rate of approximately 50%, and that there were no differences on burnout between the two groups. The inconsistent data on vicarious trauma syndromes have caused authors to question whether these syndromes are actual syndrome or just normal reactions to job stress (Sabin-Farrell & Turpin, 2003).

Mental Illness

Given the known job stressors, many have questioned if clinicians are more likely to experience diagnosable mental illness than the general population. The American Psychological Association (APA) surveyed its members and reported that 51% of the respondents reported they were currently experiencing “some challenge or challenges that impacted their professional functioning” (APA, 2010). When it comes to specific diagnoses, however, the literature is surprisingly sparse. Researchers in a 1994 study on mental health in clinicians randomly sent 800 members of APA division 12 (Clinical Psychology) a survey about mental health and therapy use (Pope & Tabachnick, 1994). Of the 400 who responded that they had been in therapy, 61% reported an episode of depression, 29% had experienced suicidal feelings, and 4% had attempted suicide. A more recent study found similar results; 425 clinicians who were APA members reported depression at a rate of 62% and 42% had experienced some suicidal ideation (Gilroy et al., 2002). It is surprising that there appears to be a relative dearth of literature on this topic.

Healthy Coping Strategies

In a similar way that parents may actively cope with stress to ameliorate the

negative impacts of stress, clinicians may also have ways to prevent or recover from stress and burnout. In a study on psychologists' use of self-care across the lifespan, authors describe self-care as being behaviors that promote healthy functioning and include seeking professional support, striving for a work-life balance, and cognitive strategies like increased awareness (Dorociak, et al., 2017). In one sample in their article, the authors found that early career psychologists engaged in less self-care activities than later career psychologists. Other authors have advocated intentionally making meaning out of stressful experiences as a way to combat burnout. Michael White (1997), a therapist and proponent of narrative therapy argued that modern psychology prioritizes both "neutral" expert knowledge and the individual (in lieu of relationships or communities). The effect is that clinicians isolate themselves and fail to look to their personal histories and personal philosophies for support and the result of this failure is often burnout. Instead, White urges clinicians to create meaning-making narratives to recall their sources of support in their lives to enrich their work and lives.

Two qualitative studies further demonstrated the connection between lack of meaning and burnout. Eighteen people being treated in a clinic for burnout were interviewed over the course of a year about their experiences. The authors identified themes and suggested that burnout is caused by not only work stress, but the avoidance of suffering, lack of thoughtfulness about existential issues, and failure to make meaning in life (Arman, Hammarqvist, & Rehnsfeldt, 2011). The authors further asserted that failure to understand ones meaning of life and grappling with it in solitude can lead to distress. A limitation of this study is that the patients had such severe burnout that they were being

seen in a specialty clinic for physiological effects of burnout. Not only do burnout clinics not exist in the U.S. (the study was done in Sweden), there may be important differences about people whose burnout is so severe to require attendance at a specialty clinic.

Another qualitative study followed a nurse, a teacher, and a manager who presented to psychotherapy for burnout (Malach Pines, 2002). The author suggested that burnout is caused by feeling insignificant in one's life and career, and that humans need to believe that their lives are meaningful.

Typical Life Events

Beyond the extreme situations of trauma syndromes and mental illness, clinicians experience typical life events such as death, illness, or divorces that can intrude on therapy and make it difficult for clinicians to do their jobs. Surprisingly, there was little about this topic in the literature as well. A handful of authors have reflected on their personal experiences, summarized the literature, or interviewed others in qualitative studies. Rytöhonka (2015) wrote about themes of feeling guilty about intruding on a client's life, not knowing how much to tell clients when suffering a personal crisis, and pushing one's body too far. On the other hand, the author also stated that work may protect clinicians from aging, fear, and depression by giving them meaning and a task on which to focus. Rytöhonka added that there is not a lot of literature on how to handle stressful life situations. Flax (2011) echoed this sentiment and wrote that the topic is largely absent from the literature. When writing about her experience working when she had a sick child, the author described using supervision, colleagues, reading, and bringing a dog to sit with her in the therapy sessions to cope with the stress of her sick child while

maintaining her practice. Adams (2014) interviewed 40 clinicians about their experiences with a number of life events (e.g., having children, experiencing an illness, death, etc.). She wrote that clinicians cannot leave their experiences outside of the therapy room completely, so it is best to be aware of both the negative and positive aspects. She warns against both the detached “guru” who sits above it all and the “wounded healer” who may let his or her own life impact clients. The authors’ interviewees described experiences with depression, anxiety, and their own traumas; the most often report was that clinicians wished they had taken more time off from their jobs to heal. On the other hand, many of them reported that dealing with their own trauma helped clients make sense of theirs, and that it often led the clinicians to choose their specialties.

Parent Clinicians

A search for literature on the transition to parenthood for therapists yielded fewer articles than anticipated, considering how ubiquitous the situation is. Waldman (2003) wrote that the topic of pregnancy in therapists is well covered in the literature, but that there is little research on once a therapist has the child. The author added that while there was a burgeoning literature on how life events impact the therapist such as illness and divorce, there are still fewer on the (usually) positive life intrusion of new parenthood. Basescu (1996), in a chapter on her own experiences of being a parent clinician, wrote that there is a “fairly extensive analytic literature” on the therapist’s pregnancy but “once the children were born (i.e., no longer physically in the room), it was as if they were no longer an issue” (p. 114). One imagines that the bias toward research about pregnancy

reveals that the literature is focused on the client's experience and less on the clinician's. Since pregnancy is a visible intrusion for the client, it has received more focus.

A search was conducted using the search terms "therapist/counselor/psychotherapist/clinician" with "parent/mother/father." Initially this yielded over 2,500 results but upon closer inspection, only 15 studies were actually about the experiences of clinicians who were themselves parents and about navigating the changes that occurred as a result of becoming a parent. There were seven journal articles, three chapters in books, one book, and four unpublished dissertations. All 15 works are qualitative in nature. There were seven first-person accounts written by the author about their own experiences that approximate memoir or autoethnography: Scholfield MacNab (1995), Basescu (1996), and Gibson (2016) all wrote chapters published in books and Campling (1992), Kibel (2002), Waldman (2003), and Grayson (2011; the sole male author) wrote articles published in journals. The remaining eight studies are phenomenological studies or approximate phenomenological studies. Deery (1992, 1994) interviewed 25 mothers and published the findings in two articles based on those interviews. Adams' (2014) book approximates a phenomenological study in that she interviewed 40 clinicians of both genders on a number of experiences they had while working as clinicians into a published book; it was unclear how many clinicians contributed to the chapter on being a parent. Holm, Prosek and Godwin Weisberger (2015) interviewed ten mothers who were in a graduate counseling program. Finally, there were four phenomenological dissertations: Insko (2008) interviewed five clinicians, Jalowiec (2011) 11 clinicians, Robinson (2012) nine clinicians, and Lyndon (2013) eight clinicians.

I was particularly interested in what the parent clinicians experienced during their transition, or the impact the transition had on them and what, if anything, they did differently or changed as a result of the transition. Qualitative research is rich in detail; however, sorting through all the experiences was disorienting. I have therefore summarized the findings from the studies into two broad categories each with two subcategories: impacts on clinical work, impacts on parenting or personal life, changes in clinical work, and changes in parenting and personal life. The “changes” can be changes in home or work practices, or efforts to protect themselves from negative aspects of their jobs. The changes can be behavioral (e.g., engaging in self-care activities) and mental (e.g., cognitive restructuring), but they needed to be intentional. Many clinicians reported working differently, but it was frequently unclear if the changes to their work were done on purpose as a result of new parenthood or if they happened outside of the clinician’s awareness.

Impacts on Clinical Work

Daily hassles. Parent clinicians wrote about experiencing the day-to-day hassles of balancing parenthood and work responsibilities but had an additional worry of how their home lives negatively impacted their clients. In a chapter about her own experience as a parent clinician, Basescu (1996) recalled trying to balance her tasks as a parent while mitigating negative impact on clients such as when she had to cancel clients at the last minute due to her child’s surgery. In another instance when her childcare fell through, she had to start a session late while she waited for her husband to show up while her children lingered. The client made the decision to walk out and charged her with not being ready

to practice in her frazzled state. Gibson (2016) wrote about a similar experience needing to cancel clients when her daughter was in a serious car accident. Robinson (2014) interviewed nine participants in a phenomenological dissertation and eight cited fatigue as negatively impacting their work. The parent clinicians in Adams' book chapter (2014) also cited instances where their new parenthood fatigue impinged on clients specifically when it impacted their memory during sessions.

Emotional and cognitive impacts on clinical work. Interestingly, while two articles mentioned that participants expressed feeling guilt when worrying that their new lives as parents would negatively impact their clients (Adams, 2014; Basescu, 1996), the reports of changes parent clinicians felt when working with clients was largely beneficial. In general, parent clinicians reported positive aspects to their work. Overwhelmingly among both first-person musings and phenomenological studies parent clinicians reported feeling an increase in empathy with their clients (Adams, 2014; Deery, 1994; Gibson, 2016; Lyndon, 2013; Robinson, 2012; Waldman, 2003). In addition to empathy for their clients in general, many participants reported an increase in empathy for the parents of their clients (Deery, 1994; Gibson, 2016; Grayson, 2011; Insko, 2008; Jalowiec, 2011; Lyndon, 2013; Waldman, 2003). A few people stated that prior to having children, they had a tendency to join in blaming parents inordinately, but after having children they softened and were more forgiving of parents (Scholfield MacNab, 1995). One clinician stated he began to "cut parents some slack" (Grayson, 2011, p.159). Being able to see a client as a child also was mentioned in two articles as being helpful in therapy in increasing empathy and understanding (Lyndon, 2013; Waldman, 2003). On the other

hand, parent clinicians who worked with child victims of trauma and abuse also reported feelings of parent disgust (Jalowiec, 2011).

After empathy, parent clinicians all endorsed an increased understanding of the developmental process and seeing their clients in a developmental context (Deery, 1992; Lyndon, 2013; Scholfield MacNab, 1995; Waldman, 2003). In a phenomenological study about parent clinicians who work with traumatized children, participants reported that their understanding of development meant knowing what the child needed and understanding family dynamics (Jalowiec, 2011). Other participants stated they better understood aspects of human development such as child temperament (Robinson, 2012), attachment (Gibson, 2016), and individual physiological differences (Scholfield MacNab, 1995).

Many parent clinicians reported other positive aspects of therapy that benefited their work such as increased “understanding” (Lyndon, 2013), increased interpersonal connection (Insko, 2008), more creativity (Adams, 2014), and increased understanding of the complexity of life (Scholfield MacNab, 1995). Participants in two phenomenological studies also reported being able to better tolerate strong affect (Lyndon, 2013; Robinson, 2012), and another writer stated she was able to be more in touch with emotions (Deery, 1994). Relatedly, Waldman (2003) wrote about her own experiences and stated that she began to experience transference issues in a “real” (and less intellectualized) way. Gibson (2016) wrote about some of the possible negative feelings she had in balancing both parenting and clinical work. She stated that she had to be alert in session to when she felt resentful when her clients took her away from her own children or felt herself negatively

comparing her own parenting to others. She also reflected that at times when she felt she was not a good parent it made her question her competence as a therapist.

In addition to increases in interpersonal skills, a common theme among many of the fifteen parent clinician articles was the realization that the roles of parent and therapist have many commonalities. The authors of three first-person accounts described how the roles are similar. Basescu (1996) wrote that it is the same type of work to help in the growth of another human, while maintaining the self and other appropriately. In another article, Kibel (2002), a psychoanalytic and parent wrote at length about the role of both roles which includes holding someone else's pain and being able to tolerate temporary disintegration. She wrote, "what sort of spiritual position can allow one to tolerate being the hated, untrustworthy mother? It calls for a willingness to confront the pain one cannot heal. It requires acceptance of playing one part in a larger whole" (p. 91). Campling (1992) added that she realized that change in both parenting and therapy does not happen in big dramatic movements, but in small, every day, sometimes mundane moments. Participants in two phenomenological studies echoed these sentiments. Lyndon's (2013) participants reported that both parent and clinician use the same skills such as listening and nurturing development, and both require the role to often times be the "bad" object for another person. Participants in another study stated that the roles were similar in that they require holding, nurturing, helping another person mentally represent their lives, providing scaffolding, and addressing attachment issues (Robinson, 2012). However, along with the positive aspects of the similarity in the roles, both jobs also share some common pitfalls. Kibel wrote that in both roles as mother and clinician,

she was unsure how much responsibility to take on and at times felt overly responsible about client outcomes. Campling (1992) reflected that roles of *mother* and therapist are frequently both idealized and undervalued by society, and that participants in the roles are forced to be competitive.

Impacts of Parenting and Personal Life

Psychological knowledge positively impacts parenting practices. Since the roles of parent and clinician do share overlap, it is natural to wonder how the work impacts parenting. Indeed, many parent clinicians also reflected how clinical work and/or psychological knowledge improved their parenting. Holm, et al. (2015) asked parent clinicians who were still in graduate school about their experiences. Participants reported that they used information about attachment theory to inform their parenting. Others reported that knowledge about human development led them to encourage their children's emotional expression and social development (Insko, 2008). Another phenomenological study on psychodynamic parent clinicians reported that their psychodynamic views were more general worldviews and impacted *both* parenting and therapy without one necessarily driving the other (Robinson, 2012). Parent clinicians in a study by Jalowiec (2011) reported that they try to strike a good balance between not being too psychologically intense with their children or being too professionally distant. Adams (2014) also wrote that parent clinicians reflected that they did not want to fall into a habit of being too professional and detached with their families. Basescu (1996) wrote that she recognizes that humans have great resources for resiliency and she needs to "get out of her own way" for both her children and clients.

Psychological knowledge negatively impacts parenting choices. Many parent clinicians reported guilt, shame and anxiety about raising their children; the majority of the reported downsides of being a parent clinician were the ways that the work impacted their personal lives and psyches. In a personal narrative, Scholfield MacNab (1995) reflected that she felt guilt and shame when she has moments of realization that she is not necessarily going to be a better parent than her clients, particularly when her children's struggles mirror ones in her clients' reports. One response from a study added that sometimes the increased knowledge "weighs heavily" on their mind and they feel a pressure to do the right thing (Insko, 2008). Basescu (1996) also stated that she felt guilt, separation anxiety, and envy for mothers who could stay home with their children. While many parents feel guilty about leaving their children to return to work outside the home, Campling (1992) indicated that specifically theories in psychology (e.g., psychodynamic or attachment theories) made her feel excessive guilt.

Identity changes. Some parent clinicians reported experiencing positive changes in their identities. Deery (1994) interviewed 25 women parent clinicians about their identities once they became parents. Sixty percent of participants reported that their work was less important to them now that they had kids, but that their role as clinicians was still important to them. The author summarized participant responses into three themes: they added a second role to their lives, becoming a parent legitimized setting limits to their working lives (e.g., limits on the number of hours), and legitimized their own personal experiences as being important (e.g., gardening or relaxing). Women graduate students in Holm et al. (2015) reported that they persisted with graduate school training

after having a child even though it was difficult because their identities as burgeoning psychologist was important to them.

Social support. Many participants credited receiving either institutional or personal support as being vital to their success during their transitions to parenthood. Lyndon's (2013) dissertation interviewed women who became mothers during their doctoral programs about how they navigated competing pressures and desires. Support is one of eight themes in the findings and seven of the eight parent clinicians cited that it was helpful for them to have support from mentors, their own parents, husbands, supervisors, peer groups, and institutional support. Alternately, four of the parent clinicians reported also feeling a lack of support from their husbands or institutions. Holm et. al (2015) also investigated what helped new mothers who were in a counseling graduate program and concluded that one of the three overarching themes was "protective factors" that included mentor and family support. Insko's (2008) participants were also new mothers balancing clinical work with their relationships. The participants reported mixed feelings of support: some received encouragement from their families to balance parenthood and career and had supportive coworkers, while others did not. One participant reported that she lost friendships when she became a parent and another stated that in particular their coworkers without children were unsupportive.

Emotional distress. The most pernicious impact that clinical work had on many parent clinicians was the feelings of emotional distress when having to hear stories of heartbreak and trauma from their clients. This distress ranged from feeling vulnerable or having a "thin veil" during their work (Lyndon, 2013) to experiencing vicarious trauma

accompanied by psychological symptoms (Jalowiec, 2011). Basescu (1996) wrote about her own experiences that being a parent and hearing pain is “distracting, excruciating, and anxiety-provoking as I think about my own child’s vulnerability” (p.114). Six of the eight participants in Lyndon’s (2013) phenomenological dissertation reported that client stories were frequently “triggering” (hearing about someone else’s negative experience triggers similar feelings in oneself) particularly when their children were young. A parent clinician in Robinson’s (2012) study stated “sometimes I think that the world is less safe, I think, than it actually is because of [some trauma work I’ve done].... [S]ometimes I think that over sensitizes you to how safe the world is for you and your children” (p. 61). Scholfield MacNab (1995) wrote that it is difficult for her to hear stories when parents lacked empathy for their children, and it made it hard for her to be objective or relaxed when her own child suffered. She added that she found herself trying too hard to be a “therapist” in her home life. A parent clinician from Adams’ (2014) chapter reported that this vicarious suffering also can impact a session with a client when worrying about the same trauma happening to one’s own child temporarily distracts and takes them out of the present moment.

Some trauma intrudes even further into a clinicians’ life. Participants in a phenomenological study on parent clinicians who work with trauma in children reported that hearing stories of child trauma and abuse negatively impacted their sleep (including nightmares), appetite, mood, and energy levels (Jalowiec, 2011). In addition, many of the participants reported psychological symptoms including fear, avoidance, dissociation, increased vigilance, and becoming more protective of their children. One participant

reported that she tried to shield her own kids and did not watch the news. Participants described feeling acutely the unfairness of life, while another felt angry at their own children for complaining when they have it better than others. Another participant reflected that she felt more in control of her own children in the face of helplessness and hopelessness, but another stated the opposite – they realized that we are all helpless to protect anyone from trauma and accepted that our role as clinicians was to witness alongside and help one another process.

Changes in Clinical Work

The literature reviewed thus far provides a varied and at times overlapping range of experiences for parent clinicians that details many of the different ways parenthood has impacted their work. A second question is what parent clinicians intentionally did either behaviorally or cognitively to improve their functioning at work or at home when transitioning to parenthood. Overall, there was less focus on this in the literature. In addition, while many of the parent clinicians across the literature *experienced* similar things, there was slightly less agreement about what people *did* differently as a result of becoming parents.

One common theme is that parent clinicians reported that they became more intentional when working with clients about using knowledge of parenthood to increase therapeutic alliance or conceptualization. Waldman (2013), a parent clinician who practices from a psychodynamic orientation directly address transference with her clients. Basescu (1996) intentionally talks about her children to clients and a parent clinician in Jalowiec's (2011) study also discloses parenthood to clients to increase the bond between

clinician and client. Basescu (1996) and Grayson (2011) both reported considering their own experiences or own children when working with clients. Two articles mentioned intentionally taking the time to consider the “side” of the parent of the client (Deery, 1992; Grayson, 2011). Increased empathy was often cited as an experience of the transition to parenthood, and some participants intentionally crafted or curated it. Scholfield MacNab (1995) wrote about participating in less parent-blaming, and Grayson (2011) wrote that he remembers that the client is “someone’s little boy or girl, all have been deeply loved – or deserved to have been” (p.162).

Changes in Parenting and Personal Life

Practical changes. In terms of what clinicians did to change their personal experience, many parent clinicians reported that they instituted limits on how much their work could impact their home life. Participants reduced the number of hours they worked (Lyndon, 2013; Robinson, 2012), limited taking work home (Adams, 2014; Grayson, 2011; Insko, 2008; Robinson, 2012) reduced evening hours (Robinson, 2012), or actively tried to embrace balance (Holm et al., 2015). One specific way some parent clinicians tried to limit how much their work impacts their personal lives either physically or emotionally is by limiting the kind of clients they accepted. Some parent clinicians reported no longer taking high risk clients, borderline clients, children, clients going through a divorce, or pedophilia clients (Lyndon, 2013; Robinson, 2012). Across studies, parent clinicians mentioned strategies they used to aid in the stress of balancing both roles such as using consultation (Jalowiec, 2011), engaging in one’s own psychotherapy (Insko, 2008; Robinson, 2012), improving sleep and self-care (Insko, 2008), and

becoming more playful and relaxed in one's personal life (Deery, 1994). Two other authors of personal narratives took more philosophical or spiritual views when writing about self-care; Campling (1992) advised parent clinicians to get in tune with one's own lived experience instead of feeling pressured by society's views, while Kibel (2002) wrote in detail about relying on her Jewish spiritual traditions.

Emotional trauma. While perhaps implicit in many of the changes parent clinicians made, very few described what they did intentionally to handle the trauma they hear. Scholfield MacNab (1995) wrote about her own experiences and reminds herself that she sees only a small sample of the population. A parent clinician in Jalowiec's (2011) study echoed that they are careful to not exaggerate the stories of suffering and think that every child is traumatized. Another parent clinician stated "you have to sort of, at some point, recognize the base rates and not allow yourself to fall into that" (Robinson, 2012, p. 61). Some articles also included pragmatic advice. Scholfield MacNab (1995) wrote that she gets involved in activities outside of psychology. A participant in Jalowiec (2011) reported they became more grateful of the positive and "good" experiences with their own children. However, with only three articles that address this topic directly, it limits the usefulness for parent clinicians in the literature for guidelines on how to handle the emotionally traumatic parts of a clinician's job, particularly when they transition to parenthood.

Limitations of the Literature

The strength of qualitative and particularly phenomenological studies is that they summarized experiences and provided thick descriptions about both shared and unique

stories of transitioning to parenthood while working as a clinician. It should be noted, however, that these stories are limited by their relative lack of diversity. Of the 115 parent clinicians in the 15 articles where the participant demographics were stated, only three were male, 10 were non-White, two single parents, one was gay, and none had adopted their children. In addition, the literature was skewed toward parent clinicians who practiced from a psychoanalytic/psychodynamic orientation (seven studies); of the remaining eight, two articles focused on child therapists with no stated orientation, one study included clinicians who worked from either psychodynamic, humanistic, integrative, or cognitive behavioral orientations, and five studies did not state the orientation of the clinicians. It is possible that clinician orientation impacts how parent clinicians experience the transition to parenthood.

There was also less information or emphasis placed on the experiences of parent clinicians' hearing the emotional pain or trauma of clients as only seven of the 15 studies directly mentioned the phenomenon. This was surprising given what has previously been written in that the relational and traumatic parts of the job may place clinicians at risk for burnout or indirect trauma. Also missing were very many descriptions of what parent clinicians *do* to mitigate the stress of hearing distressing stories whether it be behaviorally, cognitively, or emotionally. Three parent clinicians provided pertinent reminders about not overgeneralizing and taking care of oneself, but largely absent were descriptions about how parent clinicians made *sense* or *meaning* of the intersection of human suffering and parenthood. One notable exception was Kibel (2002); she wrote a personal narrative and described how she makes sense of her role in alleviating suffering

and how she calls on her Jewish beliefs and traditions. While the literature presents description, it feels devoid of the context of parent clinicians' lives. The literature lists varied experiences, but the transition to parenthood is somewhat treated as consequences that happen to passive people. With few exceptions (Basescu, 1996 who wrote briefly about her father who was also a psychoanalyst), missing is the context that may help people make meaning of suffering and parenthood such as choice, how and why they became parents, beliefs, spiritual traditions, family of origin, their own childhood, or philosophy of childhood. Certainly many of the parent clinicians reported a number of positive outcomes in both their personal lives and clinical work, but it was hard to find the thread of what they did to achieve those positive outcomes.

Research Purpose

Given my perceived holes in the literature, the current study aimed to present more stories from parent clinicians and focus on how they perceive of and navigate the interaction of engaging in clinical work while becoming a new parent. Emphasis was placed on parent clinicians' unique challenges and active efforts they made to make sense of those challenges and reach the other side experiencing personal growth. I also particularly wanted to know about any contextual aspects of parent clinicians' beliefs or personal lives that enriched the making of meaning. This study also hoped to open up the literature on parent clinicians to include more clinicians practicing from a wider range of theoretical orientations. Finally, the proposed study aimed to be inserted in a gap between personal narrative and phenomenology by using a narrative methodology; a goal of the

study was for the parent clinicians to actively create meaning by telling their individual stories, while I wove their stories together in a coherent way that invites readers to create meaning as well.

Research Questions

The current study was guided by the following research questions.

1. What is the experience of parent clinicians when working with clients while in the context of being new parents?
 - a. What was the individual's challenge?
2. What do parent clinicians do (behaviorally, cognitively, emotionally, spirituality) to process the interaction of clinical work and new parenthood?
 - a. In clinical work
 - b. In personal life
3. Is there meaning to be made amidst the unique challenges parent clinicians encounter when transitioning to parenthood?
4. What contextual information in parent clinician's lives (e.g., beliefs, traditions, family of origin, childhood experiences, beliefs about childhood, theoretical orientation) enriches the making of meaning?

Theoretical Framework

This study was framed within the idea that personal growth can occur as a result of a crisis or stressful event in one's life. Erikson's (1968) theory of psychosocial development asserted that people pass through eight stages from childhood to adulthood, and that each stage is marked by some crisis or struggle. Erikson defined a crisis not as a "catastrophe" but as a "necessary turning point, a crucial moment, when development must move one way or another, marshalling resources of growth, recovery, and further

differentiation” (p. 16). These crises he writes about are not necessarily linked to external events but are the result of humans’ inherent growth, and an increase in awareness, or a change in perspective in their lives. Each crisis and crisis solved then propels the person to the next successive juncture.

More recently, people have introduced the concepts of posttraumatic growth or stress-related-growth. Like Erikson, stress-related growth theorists assert that growth can happen as a result of a crisis, but in these cases, the crisis is an actual event in one’s life. Tedeschi and Calhoun (2004) wrote that posttraumatic growth is the “positive changes in individuals that occur as the result of attempts to cope in the aftermath of traumatic life events” (p. 406). Changes are typically in how people think about their religious, spiritual, or existential views. The authors hypothesize that the changes occur as a result of cognitive engagement and cognitive processing; cognitive engagement and processing are ways in which people mentally reflect on trauma and assign meaning to their lives. As an applied theory, the authors also posit that change occurs during disclosure in a supportive relationship (such as therapy), and when the client incorporates the trauma story into her or his own life narrative. Parks and Helgeson (2006) wrote that stress or trauma disrupts one’s belief about the self and the world and then the meaning-making cognitive processes that are necessary to repair shaken beliefs results in a feeling of personal growth. They add that “growth” can be either actual behavioral changes or a shift in cognition. Some authors have urged that the concept of stress-related growth be expanded to include not only traumatic events but also typical stressful life events or “peak experiences” such as childbirth, marriage, and profound religious experiences

(Aldwin & Levenson, 2004). Aldwin and Levenson reviewed the literature and posited that stress-related growth (instead of just posttraumatic growth) can provide increased wisdom that can include practical knowledge, increased emotional and cognitive complexity, self-knowledge, greater empathy, and mindfulness which the authors state increases being able to process information in new ways.

One study was located that applied the theory of stress-related growth to the crisis of a parent clinician; a clinician framed the crisis of her teenaged daughter's significant depression, suicidality, and hospitalizations within the model (Slatterly & Park, 2007). In a first-person account, the parent clinician (Slatterly) described the ways that she changed as a result of her daughter's crisis in that she understood more fully what it feels as a client to initiate the therapy process, changed the way she worked with clients by incorporating body awareness, and increased her empathy for parents and clients. Slatterly recommended that other clinicians going through a crisis remember that stress can be growth-promoting, clinicians should feel emotions instead of avoid them, use self-care, recognize the balance of good and bad and keep perspective, know that stress can increase empathy, and search for meaning in the crisis. The goal of the present study was to use the framework of stress-related growth in a similar way.

CHAPTER III

METHODOLOGY

Narrative Inquiry

The present study is located within the interpretivist paradigm. Unlike positivism that posits an objective reality and values causality, measurement, isolating variables, generalizability and prediction, the interpretivist (alternately called constructivist) approach maintains a constructed reality and values understanding the complexity of human experience within unique contexts (Glesne, 2010). The methods typically used in a constructivist paradigm are qualitative. The specific qualitative method I used in this study is narrative inquiry. Narrative inquiry has its roots in the social sciences and humanities, and some note the similarities between it and phenomenology (Creswell, 2012; Schram, 2005). Narrative inquiry is similar to phenomenology in that it aims to explore the lived experiences of a phenomenon and embraces subjectivity. However, in narrative inquiry there is more of a focus on chronology and meaning-making (Creswell, 2012). Creswell asserted that humans' stories are not discrete experiences, but instead part of a larger context. Chase (2011) wrote that narrative is, "meaning making through the shaping or ordering of experience...organizing events and objects into a meaningful whole, of connecting and seeing the consequences of action and events over time." (p. 421). Creswell wrote that narrative researchers "re-story" stories, or place experiences within a temporal order, detailing themes, and providing context and turning points as ways to make meaning. In a book chapter on narrative inquiry, Chase summarized two

goals: one goal is to focus on the content of the story itself or the “what” and prioritize the richness of individual experience without attempting to impose theory or seek generalizability. A second goal is to focus on the “how” and “why” of the storytelling. Telling one’s story is always a social action and so focusing on the “how” and “why” aims to make sense of the story in the context of cultural discourse and the relationship between narrator and audience. The present study aimed to address both goals.

Furthermore, narrative tradition increasingly stresses collaboration between researcher and participant and the researcher will frequently weave his or her own story in with participant narratives so that researcher and participant learn from one another (Chase, 2011; Creswell, 2012).

Positivist research is often focused on the truth or validity of claims; for those working within a social constructivist paradigm, this notion of one truth are typically rejected (Glesne, 2010). However, qualitative researchers do wish to ensure that their findings are valid in different ways such as being credible, useful, or critical of cultural assumptions, and frequently use the concept of “trustworthiness” to achieve these goals (Glesne, 2010). Glesne provided eight suggestions on how to ensure and demonstrate trustworthiness including: prolonged time spent in the field, triangulation, peer review, negative case analysis, clarification of researcher bias, member checking, thick description, and an external audit. Hayes and Wood (2011) offered specific recommendations for achieving trustworthiness in narrative inquiry: the narrator and audience should see the perceived utility of the findings, and the researcher could use member checking, triangulation of data sources, and thick descriptions in the narrative. In

this study I used member checking for accuracy and utility/meaning, triangulation, and thick description. Triangulation describes using multiple methods of data recording including multiple sources, multiple investigators or multiple theoretical perspectives (Glesne, 2010). Glesne stated that triangulation is not used in the positivist way of “validation,” but can still be useful to spot mistakes or to reveal interesting inconsistencies. In the present study I triangulated data by reading the literature and linking findings to extant literature and used two methods of data recording from the parent clinicians. Specifically, I employed two interviews and had parent clinicians choose one “artifact” or scene to present as part of their story. Finally, Glesne urges qualitative researchers to employ reflexivity in their work; this means that researchers should be reflective of how the researcher (including any biases or value-laden perspectives), participants, settings, culture, issues of power and privilege influence one another during the research process. In order to be aware of these issues, I kept a researcher’s journal to note my observations or questions about reflexivity. The journal lived in two places. I started one document as I began the process of interviewing the parent clinicians and reading other narrative studies. Once I began transcribing interviews, I noted my reactions, reflections, and commentary about the differences and similarities in the margins of each interview.

Participants (Parent Clinicians)

I attempted to recruit four to six parent clinicians through a combination of homogenous and theoretical sampling. I was looking for current (still practicing) parent

clinicians who identified as having gone through a stressful transition to parenthood while they maintained seeing clients. Participation was open to parents of any sex or gender who became parents to their first child within the last five years. Parent clinicians needed to be at least one year past this transition to allow for time to normalize their new roles and reflect on the experience. This study was approved by Utah State University's Institutional Review Board (IRB) # IR0042.

Five parent clinicians participated in this study. Four parent clinicians were recruited and I also participated. I sent a recruitment invitation to the email lists maintained by the following APA divisions: Division 17: Society of Counseling Psychology, Division 29: Society for the Advancement of Psychotherapy, and Division 32: Society for Humanistic Psychology. One parent clinician was recruited from these postings. I also posted my recruitment message on a Facebook group that I am a member of called "Academic Mamas." This group contains mainly female members who are in academia and are parents. One parent clinician was recruited from this group. Finally, friends and colleagues sent my recruitment message via email to their friends and colleagues. One parent clinician was recruited from an email from a peer who was on internship with me, and the fourth parent clinician received an email from my internship training director and individual supervisor. Three other people expressed interest in my study; two did not reply after I sent my informed consent document and the third parent clinician signed the informed consent and scheduled the first interview but did not attend that interview and would not reply to further contact. Parent clinicians were given the opportunity to choose pseudonyms for themselves and anyone they named to protect both

their identity as well as their workplaces and the clients with whom they have worked.

I elected to include my experience and participate as a fifth parent clinician for two reasons; I wanted to fully embrace the values of collaboration and reflexivity in qualitative research, and I also wanted to tell my own story! Chase (2011) wrote that narrative researchers sometimes include their own narratives to share the power with their participants by subjecting themselves to the same protocol and in order to explore the phenomenon more fully. I knew if I was going to ask the parent clinicians in this study to be vulnerable I wanted to fully collaborate and be vulnerable as well. Reflexivity, or attempting to understand how the researcher's thoughts and experience impact the study, is another value in qualitative research (Morrow, 2005). I thought that by including my own narrative there was no better way to "put out there," or make overt my ideas and biases. I also felt an urgency to more fully understand my own experience and share it. Autoethnography, or writing about oneself, is an evocative qualitative method that can enrich the understanding of cultural experiences (Ellis, Adams, Bochner, 2010). Ellis et al. wrote that the act of writing about an experience is a way to know and make meaning out of the experience, which was also a goal of mine.

Interviews

Each parent clinician signed an informed consent document and sent it back to me electronically. I obtained parent clinician's narratives through two semi-structured interviews; the first interview was scheduled to be approximately an hour long, and the second was scheduled to be 30 minutes. The actual length of the first interview ranged

from 50 minutes to 77 minutes, and the actual length of the second interview ranged from 17 minutes to 48 minutes. The interviews were conducted via either Skype or FaceTime and I recorded the audio only on “Supernote,” which is a recording device on my smartphone. While each parent clinician was asked the same prompting questions with the intent of generating a story, I followed up and probed at will. If a parent clinician addressed one of my questions before I asked it, I skipped asking that question or changed the question slightly. I also shared my reflections about their story and shared parts of my experience as well. At the first interview parent clinicians were asked to think of something that represents their personal change or growth that they can present at the second interview. This could be textual—a journal entry, a clinical case example, or a scene from their lives. This representation could also be something visual or tangible such as images of themselves, or items in their home or office that provide meaning for them. These objects or artifacts were discussed at the second interview, along with some time to reflect on anything that came up as a result of the first interview, and time to reflect on the entire process. The list of questions for the first interview are as follows.

1. Introductory questions regarding family and work
 - a. Tell me about your family structure (spouse/partner, number of children, who lives at home, etc.).
 - b. Tell me about the breakdown of parenting roles in your family.
 - c. Tell me a little about your work context (roles, schedule, etc.).
2. Tell me the story of your transition to parenthood while working as a clinician.
3. Was there a particular crisis or moments(s) that stand out as being the most difficult? Most rewarding/positive?

4. A particular difficult part of our job as clinicians is to encounter stories of client distress and human suffering. Did this aspect of the job change when you had your child?
5. Did you intentionally do anything differently in your parenting or work as a result of the transition?
 - a. Did you do anything differently about the emotional aspects of the job?
6. What changed for you? Was there a resolution to your crisis? Do you feel or act differently now?
7. Does anything about your personal context add or influence your story at all? Examples are your own parents or childhood, the reasons/events that led you to become a parent, spirituality or cultural traditions, identity, or theoretical orientation?
8. Thank you for speaking with me today. We are going to have a second interview after a period of a few weeks to accomplish two things. I'd like to allow time for reflection on this interview, so that when we meet again you have the opportunity to add any additional thoughts you had about the process or your story. In addition, I'd like you to think of something that represents your personal change or growth that you can present at the second interview. This can be textual – a journal entry, a clinical case example, or a scene from your life. It can also be something visual or tangible such as a picture, or items in your home or office that provide meaning for you.

The interview questions for the second interview are as follows:

1. I'd love to hear from you about your experience with the first interview. How did it feel telling your story? Did anything additional come up for you?
2. Can you tell me about the “artifact” that you chose?
3. Finally, is there anything else you'd like to add about this experience.
4. I will be contacting you at least four more times. After I transcribe your interview, I will send you a copy of the transcription for you to check for accuracy and privacy assurances. Once you give the “okay” on the transcription, I will let you know when I have deleted the media file that contains your interview. After I compile all of the text from all of the participants (including myself), I will also send you a copy of that document to review before it is made public to anyone else such as my committee. In the spirit of collaboration, I will let you know when the project is done and that I have presented our narrative to my committee! In the event that I chose to pursue publication of our narrative, I will contact you again to help me review

your contribution to the document for accuracy and privacy.

I chose a colleague who was not a participant in the study to interview me. I chose someone at the same point in her career (on internship and working full-time) who is also a parent clinician who I felt could excel at interviewing and relationship-building skills. She also became a new parent while working as a clinician. We had worked together on internship for approximately eight months and she knew me professionally as well as a little about my personal life. She interviewed me in person; our first interview was at a local restaurant and our second was in my office.

The interviews were then transcribed. I transcribed them for the “first pass” at a slower speed and then a second time at regular speed. The completed transcription was sent to each parent clinician for them to check for accuracy and to give them the opportunity to make changes for privacy purposes.

Findings

I chose to “re-story” each narrative into a typical narrative structure of beginning, middle, and end and used the research questions to guide which content to include. In order to be fully immersed into one narrative at a time and not get confused, I chose to fully transcribe and re-story one parent clinician at a time before moving to the next story. This means that I transcribed and re-storied all of one interview from beginning-to-end and then followed with the second, etc. After the interviews were transcribed, I read the transcribed interviews multiple times and took notes about what the major themes and turning points in their story were and categorized into the three sections (challenge, navigating the challenge, reflecting) to correspond to the beginning, middle, and end.

After taking notes, I went through the transcriptions and copied-and-pasted content into the narratives. I chose to present each narrative from the parent clinician's first-person voice for narrative immediacy and removed my questions and comments from the narrative. After all the content was put into the sections, I read and edited repeatedly until each narrative was smoothed for content and ease of reading. While doing this recursive editing process I frequently would highlight a potent quote from the narratives to highlight as a title for the sections. After I finished each narrative, I went back to the transcriptions and read them again for what content I shared with the parent clinicians that informed my story. I also read my researcher journal and chose selections of my own thoughts to present in the "researcher's reflections" section.

To achieve the goal of making meaning in individual stories, each narrative was re-storied by organizing the content (Chase, 2011). Each parent clinician's story was rearranged narratively; this frequently meant that the chronology of when *during the interview* a parent clinician said something was re-storied into a different order in the finished narrative. In a text on narrative inquiry, Kim (2016) suggested that narrative researchers employ ethical "narrative smoothing" to ensure the stories are coherent. These techniques include carefully omitting things, "brushing off the rough edges of disconnected raw data" (p. 192) and leaving out peripheral content. I did not add any text to the parent clinician's narratives but did omit some false-starts and fillers such as "um," "like" and "you know" if they created a burden for the reader to understand the meaning. I left some fillers in to provide an accurate cadence of each speaker. I also selectively left out trains of thought and comments that I felt were not central to the parent clinician's

story.

As I was doing this process I extracted themes by making notes in my researcher journal on similarities and differences that I noticed. Each possible theme was written on a note card where I continued to add content when I did the other parent clinician's re-storying process.

Data Analysis

When I finished all the re-storying for all five narratives I re-read my research questions and structured the discussion section according to the research questions. I also re-read the parent clinician literature and made a list of the findings and compared what was found in my study to the literature. The "data," or stories, were analyzed in multiple ways to address the multiple goals of the study. The "what" or the content and themes of the stories make up the bulk of the analysis. In addition, the content was examined for themes that helped shed light on the meaning; themes were analyzed both within each parent clinician's story and across them. Themes within the stories are highlighted in the "Narratives" section below.

Themes that span across parent clinicians are presented in the "Discussion" section. I specifically addressed themes that I was searching for by recalling and answering the research questions, and also found emergent themes. The goal was not to generalize across people or collapse into a few unifying conclusions, but to suggest possible larger themes in the experience and to see into the social and cultural structures or discourses behind the stories (Chase, 2011).

Reading the stories to uncover social larger cultural meaning is also the purpose behind Czarniawska's (2004) suggestion to "interrogate" or deconstruct texts; interrogation will address the second goal of finding meaning in the "how and why" stories are told within specific cultures and performances. The author looks at not only what the text says but what it *does* (e.g., uncover hidden meaning) by using deconstruction. Czarniawska listed multiple methods to deconstruct a text: dismantling a false dichotomy, examining what is not said, looking at disruptions or contradictions, focusing on the most peculiar element, interpreting metaphors, analyzing double-entendres, and reconstructing the text. In this study I looked at the "silences" or what was not explicitly said in the narratives and looked at the contradictions or specifically the differences between the narratives. Finally, I asked the question "why?" What about the act of telling this story to this audience revealed meaning?

CHAPTER IV

NARRATIVES

Introduction

The narratives that follow are the results of the “re-storied” content from two semistructured interviews and each parent clinician’s artifact. After both interviews were transcribed, each set of transcribed interviews were sent to the parent clinicians for them to check for accuracy, privacy concerns, and for them to choose pseudonyms for themselves. All four parent clinicians approved of the content and one parent clinician, Elizabeth, requested four minor aspects of her story be obscured to protect her and her spouse’s privacy. These four changes were to hide her and her husband’s places of work and where Elizabeth grew up; the changes did not impact her narrative. Allen and Elizabeth chose their own pseudonyms (and in Elizabeth’s case, pseudonyms for her spouse and child), and Jessica and Rachel allowed me to choose theirs. I did not choose a pseudonym for myself but chose pseudonyms for my spouse and daughter. The resulting narratives follow below after my brief introduction of each parent clinician. The content in the narrative is each parent clinician’s own words pulled from the interview. I removed all of my questions and comments and did not add any words to their story; I used brackets to designate anything that was not in the parent clinician’s words. Parent clinician’s behavior, such as laughs or pauses, are included in brackets. In addition, I occasionally added content to clarify the meaning of the parent clinicians that is also in brackets. After each narrative, I present my own reflections on the parent clinician’s story

and if their stories reminded me of aspects of mine. The reflections are based on a reading of the transcriptions for content that I shared with them during our interviews as well as content from my researcher’s journal. A summary of participants and demographic information is presented in Table 1.

Allen

Allen’s Introduction

Allen is a 35 year-old married man who has two children, ages 5 and 16 months. He identifies as White and cis gender. He works from an existential theoretical orientation and works in private practice approximately twenty hours per-week and takes care of his children and household for the remainder of the week; his wife works outside the home for 40-50 hours per week. Allen was the first person who I interviewed, and he

Table 1

Participants/Parent Clinicians

Variable	“Allen”	“Jessica”	“Elizabeth”	“Rachel”	Amie
Age	35	33	Mid-30’s	30	41
Gender identity	Man	Woman	Woman	Woman	Woman
Race/ethnicity	White	White European-American	White	White Jewish	White
Relationship status	Married	Married	Married	Married	Married
Current job	Private practice	Graduate student	Part-time college counseling; part-time private practice	Graduate student	Doctoral psychology intern
Age of child(ren)	Five years-old; 16 months	Five years-old; Two years-old	One-year-old	Two years-old	Three years-old
“Artifact” chosen	Client drawing of his child’s hand	“Ugly” running shoes and a pink quilt	Re-told a scene from her life	A picture of herself as a graduate student	Daughter’s drawing

could not have been a better first interview! He has a calm and measured presence that in turn calmed me down. Allen was thoughtful and frequently paused to consider his responses. We spoke while he was at home and I could see pictures of his family on the wall behind him. At one point early in the interview we paused so he could ask his son to leave the room saying, “You need to go out of the room, 'kay? 'Cuz I'm talking and doing work here” and he explained to me: “this story’s all about him.” I think this story is about both of them.

Allen’s Story

The challenge: “In terms of neurological surgeries, this is an easy neurological surgery.” My wife probably wanted kids earlier than I did. I was already in grad school before we got married and then we’d been married (let me do the math here) we’d been married for seven years and so I was on my post-doc internship by the time my wife was like “well, um, we can see the light at the end of the tunnel now, so let’s get started on having a family!” So that was the deal—she kind of felt like she had waited as long as she could to see me through my program and then when I was on the post-doc side of things, we decided to go for it. So getting pregnant was super easy, no problems, and then during the pregnancy, I probably felt more stress than my wife did, and I think she was really, really amazing in terms of how smooth and easy it was for her to be pregnant. But, I always had, um, worry and concern in the back of my mind and it was really stressful, I guess. I had a lot of worry about the pregnancy.

I had two, I’m not really sure if it’s like an anxiety attack but here’s what happened. I was, the first time I was at my work, at my postdoc, and my face went numb.

And um, so the first thing that I thought was a stroke, but no other actual symptoms but just the side of my face just went numb. And so that concerned me and I called my friend who's a neurologist and "I—look my face is numb" and she's like, she knows me, so she said, "you're under stress." I said, "yeah, okay." And then a week or two later we were sittin' in church and during the service my face went numb again. And even though I kind of had that reassurance that it was probably stress, um, by the second time I was just I was beyond the point of being able to help myself with any stress. So I went to the emergency room. And, had a brain scan for stroke. And nothing again. It was the stress.

I just like had this feeling that, you know, something was going to be a problem. Could have been coincidence. Could have been intuition of some sort. There actually weren't any issues during pregnancy but then when our son was born the nurse was inspecting the newborn baby and, um, she discovered there was a hole in his back, down by his spinal cord. So that was concerning and so we stayed in the hospital for a week and did a lot of testing and what they came up with is that he had a tethered spinal cord. So that's where the spinal cord, you know, attaches from the brainstem and goes all the way down and then at the end of the spinal cord there's a, a small connection of fatty tissue that connects the spinal cord to the vertebrae. In a normal person that, that would not be connected. So the concern there is that because the spinal cord is tethered to the vertebrae, as the body grows, that spinal cord doesn't have room to move freely up and down between the vertebrae. And it pulls on the spinal cord and sort of, um, shocks it and damages it over time. And so the spinal cord begins to die from the very tip and it just works its way up the spinal cord as the damage just increases. So, that was the news that

we got right away with our son, and he needed to have surgery as soon as he was old enough to undergo anesthesia and they decided that would be about two months of age.

We took him home and in the first couple weeks he had a separate medical condition come up; the symptoms were just like uncontrollable vomiting, couldn't eat anything, and so we went to the emergency room and have a full day in the ER, and had another diagnosis that he had pyloric stenosis. Which is, there's a muscle that closes the stomach when it's not, when you're not swallowing. And that muscle overdevelops and becomes too strong that it permanently closes the stomach and so the solution is to have surgery around the front, and you kind of cut that muscle and then it heals but the problem is gone. So at one month he had that surgery—that was an emergency surgery - and then at two months we had the spinal cord surgery which was the planned surgery.

That was hard, um, it's really hard to take your kid and hand them off to a surgeon and say, "here you go." It feels like saying goodbye, because there are risks with surgery and you never know what the outcome would be. We had to do that twice. That was hard. The hardest part was after his spinal surgery he was not able to be given any pain medication, so he had about a two-inch incision in the lower of his back of his spine, and he, you know if you can imagine a two month-old lying in a giant, kid-sized hospital bed, and he just laid there and had this moaning sound [because] he was in pain, for about, at least 24 hours. And my wife, up to that point, had never left his side, you know, except for him being in the surgery room. She slept with him in the hospital bed, she slept on those stupid little chairs that they have, it's not, it's not a happy place. She made a lot of sacrifices. The pain that he was in recovering from the surgery was just too much and

she actually did leave for that time. And then my grandmother and I stayed with him during that time and just, we just kept touching him and just kept singing to him, just kept soothing him. You know everything you can do to dull pain without using medicine. That's just all we had available.

And so, the first couple months of his life were just really hard. We spent a lot of time in the hospital, which is a really terrible place to spend time. [chuckles] And, um, we got through it, and we finally got to take our baby home. And have him, which was the experience you expect to have when you have a kid—you wanna bring them home and have that time with them. So there we go; three years passed always kind of assessing for side effects, but in terms of in terms of neurological surgeries, this is an easy neurological surgery. He's been healthy and no problems.

So that was going on at home and then I was trying to complete my post-doc during that time. I had a lot of conflict with my supervisor in my postdoc experience. And that started after my child was born and all the way through the end of my postdoc. So even today I can't really explain what changed for my supervisor that changed how she supervised me. I closely examined my experiences during my postdoc to see if there was a change in me that I missed that she noticed that she changed her approach to supervision and um, that might be the case but I actually can't pinpoint what might have changed in me. But there was a turning point and so my supervisor, did not have kids, she became much more constrictive and, and more controlling in her supervision. It was super uncomfortable to be micromanaged at the level of detail that she wanted to do that. And then she, she increased my stress in ways that maybe she didn't realize. But she

would—I remember like one of the first days I was back at internship and of course I had let her know that my son was born attached, a tethered spinal cord, you know, so one day she just walks up and says, “well I’ve done some research on this and you need to watch out for these and these and these things that could all go wrong” and so it just like, shoots your anxiety through the roof when um, when she’s thinking that way. I get that she may have been trying to be helpful, but she definitely didn’t say something positive or something affirming about becoming a parent. Definitely her focus was on the problem part of it, and not the other part of it. She would say, “is your child rolling over yet? Is he walking yet? Is he”...[chuckles] she just wanted to make sure he’s getting all these milestones [because] that would’ve been at risk for this condition. Um, and it, sometimes I had to say “no he wasn’t” [because] he just wasn’t there yet. He got there. But every time she would ask a question like that it was just like, it felt really hard. And then the work that I was doing she would just become much more constrictive over. And that was hard. It was really baffling to me. Um, as much I’ve been able to reflect on it, in the, you know four or five years since that happened, I still believe it was just mean. I believe she was, she was just mean about some things that she said and did.

Navigating the challenge: “I’m a little bit, just enough stronger.” When I look back on that time in my life there was a lot more, um, loneliness that I think I wish I would been able to address. I think my mind was really focused on the challenges, the hardness, how to figure this out, how to do that, how to—just the problem-solving part of it. But emotionally I think I felt lonely not having someone that either—my peers, you know, you know the ones not in my program or in psychology—my friends—didn’t

really “get” what that experience is like, and I think we can agree it’s a pretty unique! [laughs]. You know my friends were working then, well most of my friends don’t have kids and so they didn’t really get that part either. It just puts you in like this super-unique experience of being a graduate student plus being a parent that is, um, it was just, it was just lonely and I wish that, I wish that I could have said “aha this is loneliness that I’m feeling. Let’s, let’s get connected to people for that and make that better.” But, you know, I was just like feeling it and just struggling with it and going through it, and then just focusing on all the hard things.

I never felt lonely with my wife; I mean she was the one that was like totally understanding what we were going through together and it was like a huge, huge support, her for me. So that’s just amazing I don’t know how you explain that. I’m really thankful for my wife, I give her a lot of credit, she’s like, just amazingly strong and like I can’t, [laughs] I can’t imagine being pregnant, carrying a kid, doing that but she does that and, like that whole thing is amazing to me.

My wife wanted to have a second child and I was again terrified and didn’t want to. And so that was a tremendous source of conflict for my wife and I for about a year. Did do therapy, couples therapy, to try to help each other to get through making the decision to have a second kid or not. I just, there’s just no way that I was willing to repeat the experience of the first child, it was just, it was absolutely too much. My wife was committed to having a sibling for our son, and I don’t know that we ever really reached an agreement but we have a second kid. If that makes sense [laughs]. I think that people suffer when they don’t have experiences that they want to have. I know that sometimes

suffering is having an experience you don't want to have but it's happening, but there's suffering when you want to have an experience that's not happening. And I see both sides of that now. And I see my wife suffering when she wanted to have a kid and didn't have a kid, a second kid.

Licensure was a little bit hard I had to take the EPPP after postdoc. And studying for that was hard [because] at that point I was on my own I didn't have any colleagues to study with; I was trying to do it all by myself. I do have one really clear memory of working in my office, studying, and could see my son standing outside of my office door and I was like, "yes, I'm gonna do it for him. I'm gonna pass test this for him. Like, this sucks!" [laughs] It was really hard, you know, I was, I don't know, I always studying like four hours, five hours a day just doing like, huge, mass practice studying—it's just the way I did it. But it was hard and I looked at him for motivation, like "I'm gonna get a career that's gonna support you, kiddo, you know we're gonna be happy together."

I'm from Wyoming and one thing that I tell myself [laughs] is that I'm just a little bit tougher...[both of us laugh] being from Wyoming. I don't think that's actually ever talked much about you know, it's not really a thing, it's just a thing in my mind, but I named my son after a ghost town in Wyoming, which is just an incredibly beautiful place. I wanted him to have that spirit of, of nature, of strength of, self-reliance that kind of comes from living in a really rural place like how I grew up. And so I just believe I'm a little bit, just enough stronger that I get through tough times. It definitely informs and is a source of strength in terms of who I am, and even what you could call "manhood" or "fatherhood" to me that also includes more than just stereotypical masculine traits or

roles. So, being a psychologist I offer my children a lot of emotional depth, a lot of caring, a lot of tenderness. It's just like everything that you know, humanly possible to do regardless of gender, I want to be able to do a little bit of all of it. And not be limited by gender stereotypes. I know that it might sound like hyper-masculinity; for me it's actually masculinity with a lot of femininity, just because having both makes you a little bit better.

Reflecting: "Being near a life-and-death experience." I know that I had personal growth after that period. And I think that I definitely brought that to the table working with clients that I had perspective about being near a life-and-death experience and contrasting that with just a stressful experience. I had a whole—so my frame of reference had been adjusted.

My son was four and he came up to me one day, and he said, "hey dad can you tell me some of the ways that people kill themselves" and um, [chuckles] another parent might have been alarmed, but my specialty is suicide prevention and suicidology and so I'm thinking he maybe overheard a conversation or something. And it wouldn't be unusual, like in our house [laughs] to, we don't talk about suicide, but he's heard the word suicide he knows the concept of it, and so you know his mind was just reasoning, "well how does that work?" [laughs]. And so, he came up with that question "tell me some of the reasons why, tell me some of the ways that people die," or "tell me some of the ways people kill themselves" was his question and so, you know, you gotta roll with that, and give him a way to understand that's age-appropriate. That he would not have a necessarily had, had it not been my work [laughs]. And so I think it's probably gonna continue, there'll be other things that he hears and that's just, that's just what he'll just be

exposed to.

I definitely think that it's helped me. It's added depth to what I understand about children who have lost a parent to suicide, or parents that have lost a child to suicide. And now that I have a parent-child relationship in my life, when that type of relationship has been impacted by suicide, it's much more vivid for me. Yeah and it's just when you hear about—either way—you know you hear about a child who's lost a parent to suicide and it's like, um, I can't, I can't grasp choosing not to be in my child's life and so it's like this thing about suicide is super powerful. And vice-versa. Parent who's lost a child to suicide it's like, parents believe that they love their children and care for them 100%, invest their entire lives in them, a child chooses to die by suicide, and isn't that, isn't that kind of touch everything about that parent, what they believe they did for their kid? There's a story I tell in therapy sometimes it's that a man, goes to a priest/rabbi/guru, some sort of spiritual leader and says, "say a prayer for me." And the priest says, "the grandfather dies, the father dies, the son dies." And so the prayer's saying [pause] that's the right order. You have it go in that order; it's a blessing.

The best thing I got was working with a client who was pregnant and I felt really good that I could relate to pregnancy, talk to her about where she was at with pregnancy, talk to her about what was going on with her [because] before my wife had been pregnant, I would have been thinking that was something I just wouldn't know about, definitely wouldn't get reading a book in any sort of academic way. I think it's given me a lot more to relate to with clients. Whenever I work with a client who's a parent even if parenting is not a focus of therapy, I still feel like I'm able to relate to that client better. I

appreciate the depth that I get from parenting. Just the, sacrifice and, and, you know, just knowing that you get through hard things and that hard things are temporary. Relating to people who are either pregnant or parents is like, the really cool thing I got from this, but the power of stress, and even anxiety—I get that now. I appreciate that experience. I’ve definitely not had stress or anxiety to that level before I ended up in the emergency room with my facial numbness. But when someone says I’m afraid to leave the house [because] of anxiety—yeah I get it! [chuckles]

My very first client in private practice—and so at that point in my life, you know my son was probably um, one year-old, and just kind of getting life back together after [chuckles]—you know, it’s like the first year of a kid’s life is like, “whoop! uh we just came out of a really dark tunnel!” And so the focus of the therapy was her going through a divorce and it wasn’t about my being a dad or having a kid, but she also had a kid and only had one kid but wanted to have more than one kid and then the divorce kind of really closed the door, she thought it really closed the door on the possibility of having one kid. So there was a sense of motherhood kind of closing for her that I think was definitely was a focus of therapy. But she knew that I had a kid, you know, just through some small talk, and she said “well uh, why don’t you trace your kid’s hand on a piece of paper and then I do this type of drawing”; she takes the hand print and then just incorporates it into this really intricate design inside and all around the handprint. Then, so a few weeks later she brought it back and it was this wonderful colored drawing and it’s got my kid’s handprint in there and so I framed it and just kept it at my office at home. That’s one of the few times that I’ve gotten a gift from a client in therapy but just

like, this really close synthesis of the therapy work plus parenthood. I guess [I] appreciated it just because there's just so many times where clients lead us or educate us, or help us, in private, in our private lives. It really just represents, "I did it. I got to be in private practice and have a kid" and those, you know, those two things being pulled together like this.

But it's, it's worth it, I guess. Um, it's [pause] the point that my life is at now is like, it's beyond amazing I could never have predicted this for myself. It's still hard but it's I think pretty easy to like see it objectively and be like, "oh my gosh we're so lucky, what we have, the family we have, the health that we have." It's just, I mean it's worth it. Sometimes it's a question mark, but you know it didn't, you know, it didn't break me.

I survived it.

I, I can't tell you every single time I sit in my office I'm, I literally just feel so lucky to sit in that chair.

Researcher Reflections

As I read Allen's story I was struck by the parallels. He and his son both experienced neurological problems. Allen and his wife struggled to decide to have a second child and his first client in private practice was grieving not having a second child and gave him the drawing which symbolized his growth balancing parenthood and private practice. I also saw many of my experiences paralleled in Allen's and I shared with him about my experience of watching my daughter have an ultrasound at six weeks-old and feeling out of control. When we talked about losing a child to suicide I told him my story of realizing my child was going to die someday. Later when I was transcribing

his interviews, a student on campus died by suicide and I recalled feeling myself switch from clinician to parent role during a session when I heard about how the student's mother heard about his death. This interview really reminded me of many of my early worries about my daughter getting hurt. Finally, Allen's appreciation of the help of his wife reminded me of the help I got from my spouse as well as my mother.

Jessica

Jessica's Introduction

Jessica is a 33 year-old married woman who also has two children, ages five and two years-old. Jessica identifies as White European-American who works from a Time-Limited Brief Psychodynamic theoretical orientation. Both she and her husband work full-time outside of the home; her husband is a high school teacher who teaches algebra, and Jessica is in the final stretches of earning her PhD in counseling psychology. She currently works twenty hours in the community providing assessment and therapy to sex offenders, and then also spends twenty hours as a graduate assistant supervising PhD students learning to be counselors. When her first child was born, a son, Jessica was already a social worker and was working with community members approximately thirty hours a week, teaching a class, working in the department clinic, and taking classes. Jessica said that she got her "direct" interpersonal style from her "Oma" (grandmother), which I fully enjoyed. We seemed to "click" and both of us talked quickly and our conversation was littered with lots of laughs and "I know!" or "me too!" statements. Our first interview was when Jessica was hiding in the study in her home while her son and

dog attempted to bust in, while I hid in the guest room of my spouse's aunt's house while listening to my daughter run and scream with laughter outside. Our second interview she took while in the car at her job after needing to take a crisis client which reminded me how busy graduate school is.

Jessica's Story

The challenge: "I just never had a moment to just relax and kind of breathe." I was in the [Ph.D.] program and then I thought "no this is crazy," did end up getting pregnant and then going through classes and then working at the same time. Having my baby, it was just, I mean, it was really sucky because I didn't get any time off; I really felt like I had to actually negotiate just to be late to a class. We just didn't have a support system network, and so I think it was very much like scrambling to figure out where's a good place to leave the child, can we leave the child? What can I do? My husband and I really worked our schedules to where we would be as opposite as possible for that first year, it was really important, for [pause] I think both of us to have as much attachment and attachment parenting, was very important, is very important for us. So I was working a lot of nights, he was working during the day and then we would flip and it was crazy. My first [child] was also very colicky, very colicky, and so we just also didn't get any sleep, it was just—I don't think any of us were making very clear decisions! It was isolating I think that's what was really hard. We managed to do that for a year and then it just was just impossible. I didn't have any time to self-care at that point, I didn't have any time for myself, it became absolutely, um, selfless but then to a point where I sacrificed a lot of things that, made me not a very great functioning adult anymore.

[laughs]

I have a history of trauma and so that history just came full-force. I think, part of my childhood—I was sexually abused—and then when I became a parent, that was absolute hell. It brought up—and that was really what triggered me into therapy. The birthing process, being exposed to everyone. You're like “oh it's back there, you know, the memories and the stories are back there” and I don't think I realized how much really wasn't just “back there” until it was full-throttle, until I had a baby. It was like, oh my God, it was like I was coming out of my skin, like it was horrible. I think that became my crisis, where I was like I really needed to address these things that I didn't realize I was not addressing, um, I don't know, openly? Transparently? In order to be, I think, a better parent. And so it's really played into some of my anxiety of my child and feeling kind of, um, paralyzed at different points in choices.

There's a history of sleep apnea in my family, but infant sleep apnea. I had lost, I had never met her, but I had lost an older sibling. She was a little bit under a year and she had stopped breathing. So we all had sleep studies growing up, we all were on a monitor growing up and so, the idea is that it's probably congenital, and so my child Robert [pseudonym], my son, was on an apnea monitor. So his heart, lungs, everything—and that thing does not let you sleep 'cuz it goes off, like for anything! I think it added on top of the anxiety, on top of the anxiety of my history, the anxiety of like “is he gonna be okay?” Having to write a paper and the alarm's going off. I started writing my paper and my notes and different things on my iPad like with one finger! [Because] he would just be on me but I would know he's breathing and then we're like “okay” he's fine, you

know? But it was like, it was just such a crazy year. I just never had a moment to just relax and kind of breathe.

I think having a child while being a counselor was like you're being kind of like triggered the whole time! [laughs]. I couldn't work with children for a while. I knew that's so extreme but they wanted to put me on the children's unit [at her practicum site], they automatically put me in "child" because I'm bilingual and so they're like "well we need you so you need to just go over there." I was processing some of my history of trauma but having a child triggered this like, um, "Mama Bear" [laughs]. Like, this almost overprotection it was very hard for me function with a client kind of one foot in the door one foot out, if that makes sense. It was "Acute Child," so trauma-central but like everything is a mess, and the parents, they don't have anything, everything is foster care they're in and out of the system, they're miserable. It was just like "no" it was like, it was just too much. I think it that "high-stakes" always feeling like you're in crisis mode [because] you're caring for like a fully dependent human being. And then and knowing there's other kind of children—I think for me it was like my mind was going places like "Oh well who's caring for them?" And I was like "I never thought this way." Like my empathy—it was almost like compassion fatigue? I stopped going to Walmart for six months, (and I still don't really go to Walmart) but I stopped going to Walmart because you'd walk in and there would be these kids at 9PM like not looking great and no shoes on, and mom's yelling and I'm like "just stop! Like, I just wanna like steal all of you and take you home!" Like, oh this isn't good for me, I need to go to not Walmart!

It was exhausting and it wasn't like that before. And so I feel like my empathy

really skyrocketed; I think I was dealing a lot with my hormone changes and all that, and I was tired, but it was this realization that um, something was different now that I was a mom. My emotional, like acuity! I think our program is very emotion-focused, some supervisors are very much like, “cry with your clients” like, to a certain extent, you can deeply connect with your clients, and I appreciated that, but after becoming a mom there were moments where I was like “no, no, no, I think there’s a limit to that” that client was almost a mess, like I was almost a mess with that client! [laughs]. And it was difficult for that period of time. I think I needed to make some boundaries [limiting] what I could do with clients, what type of clients I could take, and it sounds so extreme, kinda, when I’m saying it out loud but I think it was the best thing I could do for my clients and also for myself.

And recognizing that there were some stories that I just can’t, it just connected too strongly and I needed to back off of. Like, I was working and there was a mother who lost, a really young mom, had a baby that died of SIDS and not my history, like I wasn’t alive when my sister died, yeah the story carries in my house, but not, not anything where I grieved, per se. But being a mom! And then holding your baby and thinking “oh my God” this could have been, like my God! And so I was like, “okay this is not going to work” and recognizing that when I had to refer a few times because it was just too—I would not have been effective. I was like “I can’t do this” I need to make this boundary for myself until I’m back into my own skin, I’m getting sleep again, and I have more understanding around what’s going on for me.

Navigating the challenge: “Holy shit, like I am safe...and can that be enough

right now as I'm working through some of my things." So my history I think very much influenced [the transition to parenthood] and that's why I started going to therapy again. Um, I think I didn't have any great attachment models. My grandmother raised me. I lived overseas for probably half of my childhood [because] my dad worked in factories and stuff. My mom was very addicted to a lot of different substances, so my mom was not a great mom. So my mom wasn't present [because] she was on substances and my dad wasn't present because he was always working so my grandmother, my Oma, really came in and raised us. I had an Oma and an Opa, which is German for grandma and grandpa, and they came with my mom as refugees from Yugoslavia; they got a lottery ticket from a church in Chicago and they came in on a U.S. submarine. It's crazy. And so there's like, historical shit, there, like trauma! My mom, she doesn't remember it, but it's like I think when you live, when you grow up in a household that survived, my grandparents survived and most of their families didn't, I think that just carries in and creates a theme. Everything was very old-world, traditional, um, and so it was not—I mean my grandmother was wonderful, I was very close with my Oma, but it was kind of confusing. I think identities were very different, learning how to navigate two identities and having to just code-switch in a lot of different domains and so I had very different experiences of attachment I think, between different family members.

I felt almost as like my anxious attachment started to dictate this need to make sure I'm doing it all. I think that was when I started going to my own counseling; it was like, "this was overwhelming I'm doing something and this isn't attachment anymore this is like, a need to stay in control and just feel like I'm quelling my anxiety probably."

Therapy. Therapy [laughs]. Oh my god. My psychologist – she’s amazing. Um, that was my biggest advocate and she was my biggest just like, “you are allowed to say no” or “you just can’t, why would you do this? Like why would you do this?” Not like condescending, but like, “really? Are we thinking this through? Do you want to put yourself in this situation like in the children’s unit?” I was like “what do I do? I need to say yes, they are my boss” and she was like, “no you don’t! Like, ethically, you are not in a place to be able to do this right now” you know?

I started to find my balance and started to communicate my needs more clearly as a mom and as just a professional. Before I kind of had my “aha moment” when I was becoming really overwhelmed in my attachment parenting, I think it carried over professionally where I still felt like I had to do a lot of things on my own and just figure it out and be uber-independent. I needed to, um, [pause] I had to make a boundary at work. I asked, I kind of begged and had to bring it up a couple times, to go back to the adult unit. It was difficult for me to not feel almost like shame and guilt for saying “no” when I could always say “yes.” And so and I didn’t realize how much of a “yes person” I was until I had a child and had to start saying no. And so having to, like, when my child was sick, just being like “sorry I can’t, like I can’t come in today.” I had a male supervisor and he was not completely understanding but I had to become, learn how to become more unapologetic with my boundaries and just be like, “no, my child does come first” and um, and not having to explain myself all the time and be like “you know, like this is not gonna work, sorry.” And it was really powerful for me to practice advocating for myself in that way. I mean supervision helped, my supervisor was much more behavioral and

just like, cut-and-dry and so it wasn't a super safe place to process emotion.

So therapy, therapy was the big thing for me, recognizing that I needed to talk to someone. I just needed an outside person to just sit with me and help me understand, and then I had actually had taken a course in mindfulness and it totally changed everything for me. Before sessions I started just doing mindfulness. I had to like become better with, reinforcing [time limits in session]; five minutes of the hour I'm going "we're done" so that and I can just be in my office for like a minute and just kind of deep breath, and decompress and then be prepared for my next client. And that helped a lot. I still do that. Like I think that really grounds me again. And in those loving kindness meditations [a meditation to increase connection to others where sometimes one repeats mantras such as "may others be safe"]? Were like, "holy shit, like I am safe. And may other people feel safe and I just have no control over that, but I'm safe. And can that be enough right now as I'm working through some of my things?"

I had to more intentionally just take care of myself also. Like, go for walks with the baby, things like that. Get out! [laughs]. So it wasn't just baby, client, baby, client. I have those really ugly, um [running shoes] the ones that look like feet? Like, Vibrams? So I have them and I actually got them after I had my first child. I've always ran, like, always in high school and college I ran competitively and I stopped for a while [because] my knees and my hips were really bad and so someone recommended these to me and they're so ugly! But I wear them and they fixed everything and I felt like I was free again and so it was another kind of like self-care thing for me where I could actually run again. I got a running stroller and I was able to take Robert everywhere with me. We could

reconnect but I could still do something for me and like, re-center and decompress.

Which I feel like, I mean, is so necessary for me as a counselor. How to take care of me even though so many things were requiring my attention. [Because] I think I forgot who I was in the mix for a while there.

Reflection: “For me having a child was very corrective.” My work changed a lot. So theoretically I changed. I was more concrete, like structured interventions and that was kind of like the name of the game for managed care. Now I’m time-limited dynamic [theoretical orientation] very much so like EFT-based style. I feel much more comfortable integrating attachment. Like attachment *is* my conceptualization. Like it feels like I was able to experience this absolutely with my own [child], and it just changed my ability to be able to connect, and work and build alliances with my clients. And I felt like, and I don’t know if that sounds crazy, but it is an authentic, deep way that I don’t know if I realized I wasn’t as comfortable before but now the risk was easier. I felt absolutely even more present with my clients than I had ever before. Like, just my empathy, my compassion, my ability to sit in the interpersonal process and discomfort of it at times, um, the suffering, I think changed how I could sit with other people’s suffering changed. I don’t know, it was, I don’t want to say like it was something switched for me, but it really did feel that way. Like, I don’t know. I just I think I became more willing to try different things with clients.

There’s more awareness for me around suffering that I had not, I think I had kind of like detached myself from. Um, and maybe protectively but when I had a child I think I was more aware of my client’s suffering and I was more aware maybe of the greater

suffering around me that I was, I felt more like mindful I guess? In just being able to sit in it, and not feel this, like, pressure to fix it. And just, and really focusing the control I did have, like just, like having to remind myself that there's only so much control I actually do have. And each time my son would get sick and I would start all the anxiety would pile up, all of these things that was just like, there's only so much I could do. I find that time-limited dynamic has been like a release for me; you don't have control, like, the theory reminds me of that, but I do have the ability to provide a corrective attachment interpersonal experience.

I honestly I think I for me it had a lot to with, for me having a child was very corrective in my attachment, big time, and it's still a process for me. And like I said, like simultaneously I had that "aha moment" within my own crisis that I needed to just go to therapy again. I don't, just something clicked for me and so I think it was that parallel process of having my son, feeling just a sense of I think empowerment in the attachment of my son, and a closeness that I had, it just, it was very corrective. And I think that played out into my client work and I think I felt very grounded in an attachment that I hadn't before and I don't think I realized the extent to it until I had my son. So it was powerful for me.

With my second child the difference was, that I could say "no." I made a list with my midwife and I said "I want no men in my birthing room, I want no male doctors, I want no male nurses, like how do we make this happen?" They honored every single thing, and it was really awesome and it felt very safe. I think that took a long time for me to recognize the impact that it had on me and then in therapy it was like, okay like, can I

honor this and honor the impact and what happened? It was very powerful, I think I don't know if I didn't have kids and if I wasn't a clinician, I don't think I would have experienced the amount of healing that I have in the last few years, as I have from having a child. Like it was the crisis, then it was seeking help, and seeking support and having to really go back into my history narrative and exploring those things for me to find closure and healing. It forces you, I think I felt forced to look at things I never would have, like I said – I would never been forced to look at, if I didn't have a child. I think being a counselor's one thing because you're already in that mindset per se, but it's easy to not go there, it's easy to not challenge yourself or to grow. I mean I don't think I'd be as an effective counselor but it forced me to look at things that I would never have looked at. I think I didn't realize how much my history would start to tie into the experience of having a child and then how that was going to impact my work. Then it was also how far I've come, I think, as a mom and a clinician and being at the end of my doc program I'm like "alright! I made it!"

It brings back things from my history and my identity. My husband is Puerto Rican so it's important for my children to learn Spanish, it's important for my children to have an understand[ing of] Puerto Rican foods and um, the dances, and I mean all the traditional things but then there came a point where it's like, there's a part of my traditional background that I was so good at code-switching, that I think I code-switched it out for a while [laughs]. I realized when I had Robert that it's really important for me to bring that back in. And to really honor my background. Even though there's a lot of aspects that were very traumatic, there was a lot of things that I wouldn't want to lose,

and it would be important for me not to.

They [her grandparents] had market where they were in Yugoslavia and the market was bombed to the ground and then they were transient for probably ten years after that but my Oma had saved this two-liter [bottle], it has in German “two liter”; they would serve out measured grains and liquids and everything at the market—it was like a general store. She gave it to me and it was a big deal because that was the thing she had from the market still and it represented what they had and then moving forward I think what I’m bringing to the family.

[As she thought about my request for an “artifact”] I kept coming back to it, this quilt that my grandfather had made me when I was like ten. I had put it away for a while, and then after I had my second child I pulled it out again and it really became this weird like self-care, like reminder, again of how far I’ve come but also it’s always brought so much comfort to me and it’s like, bright pink and so girly and not me but he put so much time into it. So for me it really became like a source of comfort, especially when things were so difficult like, whether a kid is sick, whether I was developing into a new identity as a mom and as a therapist, like I mean everything changed very quickly after I had a kid. I feel like that really, that still represents a large source of like, I don’t know a reminder for me of where I’ve come from and where I am now.

Researcher’s Reflections

When I transcribed and read Jessica’s story, the phrase that she used twice “it carries” resonated with me. The death of her older sibling carried in her house. Her grandparents’ traumatic immigration carried in her house. Jessica’s realization that her

history of trauma and insecure attachment carried into her transition to motherhood. In addition to the difficult events in Jessica's past, she also had the realization that her past was a source of meaning for her and she would not have gotten where she is without the experience. We connected on how clients "triggered" us. Jessica used the term a "divided self" and we both experienced not being able to leave clients at work and our children at home. We both had the realization that we cannot control everything in counseling or life, and both went back to therapy after a time off. As I was transcribing Jessica's interview I sat on the pool deck watching my husband and daughter play in the pool and felt sad that my work meant I was not able to participate fully in family time. I also was reminded of what Jessica said about not having family nearby to support her because the same was true for me. Finally, I appreciated that Jessica shared her history of trauma and it reminded me that while I do not have a history of trauma, other aspects of my past came back and impacted my transition to parenthood.

Elizabeth

Elizabeth's Introduction

Elizabeth was the newest parent and we spoke just a few weeks after her son turned one! She is in her mid-30s and married with one child and one reportedly needy dog. Elizabeth identifies as White. Elizabeth works from an existential/humanistic theoretical orientation and worked at a university counseling center when her son was born. She took two months off before returning to work part-time. Her husband travels for work and is gone one week out of every month. When we spoke she was currently in

the process of working part-time at the counseling center and starting her own private practice. Elizabeth and I had a lot in common: we both worked at university counseling centers, identified as being “older parents,” shared many of the same ideas, and a similar sense of humor. Our interviews were the longest because we were both so chatty.

Elizabeth’s Story

The challenge: “I am SO mind-bendingly soul-crushingly exhausted my body hurts...um... and I don’t want to go back to work.” It was [sigh. long pause]. Yeah, it was very re-orienting. Um, my [sigh] identity for most of my adult life was very much wrapped up in work. Like, I spent a lot of time in school and then I very much wanted to be a counseling center psychologist—that was my identity. On internship I worked my butt off. Then in my first job I worked my butt off and I worked a lot of later hours and it was very important to me to, to make a good impression and to do really good work. When I got pregnant I just didn’t have the same energy and I was tired and uncomfortable and starting to think about timing and you know when it’s just, when it was just my husband and I, I could come really late and, you know, he didn’t like it and I didn’t like it, but I felt good about what I was doing and liked my clinical work and I could burn myself out and it didn’t affect anybody aside from me and that was fine that’s all I knew how to do.

The hardest part uh, [long pause] just the, the weird combo of days lasting an eternity [laughs] and then weeks all of the sudden being gone. So Sam [pseudonym] was a very unhappy newborn. He was he was very high-needs, he didn’t sleep, um he’s still not a great sleeper we’re finally at one year-old he finally only wakes up three times a

night. So early on he just needed held constantly. Like you could not put him down he needed held and he needed bounced. Because I don't know if I was very bouncy when I was pregnant but the only thing that calms him down is to sit on a yoga ball and bounce him like, furiously. Like up and down and up and down and so I spent a lot [of] time – nothing else could get done because if you put him in one of those little Moby wraps he just was unhappy. And uncomfortable. And like I ended up, this sounds really cheesy but I ended up just like loving it so much more than I thought I would. I don't know, something about like having to spend that intense amount of time with this really like wonderful squishy little person and I'm not maternal. Like this is very weird for me to say [laughs] it just like, I loved it! Like I loved *him* and was exhausted and I cried a lot and I was hormonal and like, so it's not really like there was a crisis moment it was like this weird sense of like this is the hardest thing I've ever done. I am SO mind-bendingly soul-crushingly exhausted my body hurts my back hurts because I'm in this weird contorted strange position constantly I haven't showered in a week, um, and I don't want to go back to work [laughs]. I knew that would be temporary and every month he just got more and more cool and I was like more and more like, in love with him. Having to invest that amount of myself and be so stretched and then realize that I was up for it. Like realizing that I could do it and I was actually pretty good at it and I was a lot more patient than I thought I would be. I don't know that was kind of this weird shift. I can't go back to working as many hours as I was working and, and not be there in this way. Wanting to just be able to do that as long as I needed to and as much as I needed to like I didn't want anybody else to do that. It was, he was mine and I wanted to keep doing that. I remember

looking down at his little face and thinking like “capture this, like just memorize this. Memorize this little face in this moment.” Like, this is it. This is our chance, this is our little person, um, so it just every single moment was like “this is awful and wonderful and memorable.”

My mom really has a long history of struggling with emotion regulation. She had three little kids right in a row and she became an alcoholic and had many years where she was just very disordered. And I have these very strong memories of childhood, um, of just feeling very affected by her stress. In her benefit she was full of love. She is a loving person, she wanted the best, she was, she did everything she could. But her own [pause] I think, difficulty with managing stress, feeling secure, really had an impact on my siblings and I. I consider grad school as having been the best therapy ever because it just really forces you to sort your shit out. I am a better person having had to really intimately get to understand myself, and um, understand some of the psychological principles of healing, and taking care of yourself and coping. [Because] my mom couldn't cope. Um, so when I see Sam in his innocence and his, just curiosity and I, I, I [pause] picture my little brother doing those same things and seeing that my mom wanted to be patient and wanted to do her best but because of her stress just struggled. I don't, I don't want to do that, like I don't, I don't wanna...assume that it'll be okay [because] sometimes it's not. I wanna do everything in my power to take care of myself and set up a schedule and an environment and a career that helps me be healthy. Because if I wasn't, if I got to a place where I wasn't healthy before, or I was burnt out, um, yeah okay maybe I wasn't the best clinician if I was at a point of burnout, but you know, it's different when it's this little

innocent human being who you're so attached to and [pause] that drives me. Like that, that connection of just wanting so much to be my best self even if it means not having the career that I anticipated that I would have. So that's big, I think had a huge influence on, okay "what kind of job do I need to have, what kind of clients do I need to take, what kind of um, boundaries do I need to set in order to cope and be healthy and be rested and be happy?"

Navigating the challenge: "The biggest thing was like normalization of finding as many people who would tell me what I needed to hear." So the biggest thing was just having to completely re-think boundaries. Becoming a parent was a whole identity shift. It wasn't just me getting to do clinical work at whatever pace I wanted to and take on as many clients as I wanted to. It's one thing when you're not emotionally available for your partner which I wasn't a lot, and it's a whole other thing when it's this human that didn't have a choice about whether to be born. I call Sam my most selfish choice. Like he, we really went back and forth about whether we wanted to become a family. Ultimately, you know, we made the right one and he's awesome. So the idea of bringing him into the world and then being like, "hi you're second fiddle to all my clients and I'm gonna be burnt out because I am constantly talking to people about suicide and manic episodes and drug abuse I'm gonna come home, and you know, put you to bed and that's it. Um and then on the weekends I'll be doing notes." It was like, very horrifying to suddenly make that realization that I'd have to make a really radical shift in how I approached my job and how I approached my schedule. Last year I worked five days a week so I had a full, I worked 35 hours. The university that I work at it's an hour

commute each way. When I had Sam I knew that was not gonna work anymore [because] I have to leave at 7:30 and I get home at 7:30 and it just was, it was too much. So I went down to four days a week and over the course of the semester just realized I was not happy losing so much time with my little guy. So I'm transitioning to a private practice so I do two days a week at the university [because] my boss is amazing and I'm spoiled. He's letting me stay on two days a week and two days a week I do I'm starting to build my private practice.

There is such a shift in being my ability to consume hard information about people and about kids in situations. I could watch hard news stories and learn about Syrian refugees and look at pictures in National Geographic and be like "that's terrible" and now it's like [pause] I can't breathe it's like I can't I have to put a limit. I have never wept while reading news until now. Like I, like it hits a nerve that I didn't even know existed. I think before I had Sam even when I was pregnant and super hormonal and really anxious I could read that stuff and just be sad and now it like it really [pause] I don't know it opens up a part of me and I have to sort of grieve. Like grieve the reality of how much pain and suffering people really experience and what that would be like. Like I can put myself there in a much more meaningful way than I think I ever would have been able to before. So I think empathy is something that like, I didn't have a choice about it, it just is bigger. I just, things just make sense, like they make more sense when you see on a day-to-day basis what a little kid is like and then I think the only thing separating you and this little boy in this picture is luck.

I work at a college counseling center where most of the students are pretty

privileged so I think one of the things that shifted is I have less empathy for some of the things they're going through? I think prior to pregnancy, prior to Sam's birth I could go there like I could really put myself in somebody's mind, like working with perpetrators. Or working with people who harm other people. I could have, I could have done that. I never worked in a prison system but I could have empathized with them. And now I can't because it's too like, raw, it's too, I'm too very much aligned with um, protecting vulnerable people. So empathy's gone down in that regard. But empathy for folks who have gone through something in childhood, struggling with relationships. There's a client that I had recently who [left] behind her young siblings in the home in an undocumented family; her parents don't have a lot of means so she raised her siblings and sitting with her while she like, struggled with leaving them behind there's, there's no way I would have really been able to empathize as genuinely as I could empathize pre-Sam.

One of the things that occurred to me is like, "wow you know it's funny how um, easy it is to get to a nostalgic place" and to get to a spot where it's like "you know I've grown so much and I'm a better person," because that's not 100% true. There's a lot of ways in which I'm a lot more selfish, um, and a lot more, I think, protective of my time with Sam, and I don't really listen as well, to people because I'm kind of constantly in my own head with checklists and I need to get stuff done and still sleep-deprived and you know, it is not sunshine and roses and wonderful. The whole month of November was eye-opening in terms of just how crazy, like crazy with a pathological edge, the brain can get when the body is deprived of sleep and rest. I think it was eye-opening to me in the sense of like, recognizing what my clients might be going through when they're not

taking care of themselves. I went for two weeks without sleeping more than two hours a night and never having rest during the day because Sam was like so, so sick then passed on to us and Jason [pseudonym] was out of town and so I was by myself and trying to work. I'd go into work and I'd do therapy all day and then come back and not sleep and um, like the level of, just bad mental space that I got to was like "oh wow that happened real fast" like I, this is, this maybe like somebody should probably come check on me! [laughs]. Having that experience was like, "oh that's really interesting" [because] I consider myself a pretty solid stable person; I can't imagine how somebody who doesn't have the support that I have goes through that. So that was one of the things I was reflecting on I don't know how much people talk about just how bad it can be. Like how it's the hardest thing I've ever done and how it has taken me to some of the craziest places I've ever been. Um, and it doesn't, like, it doesn't counteract the fact that it's still awesome and wonderful and I love it, and I am a better person overall, but yeah. I've been to some dark places.

I, and it's hard to tease apart and this is maybe why I keep stumbling over my words and why I'm a little clumsy in answering this question because for me it's hard to tease a part what is a shift in my own clinical approach and what's just sleep deprivation. I'm not smart! [laughs]. I'm just not intellectually capable to do the gymnastics that you have to do with more chronic, more difficult, more emotionally evocative personality disorders or you know suicidal people and so that's the thing has been hard is just not feeling like I'm sharp. Um, and that I could make a mistake. I mean because I'm slow and foggy and that's been hard to just like, own that this is not my top-tier work that I'm

doing right now. And I don't know if I'll ever do that top-tier work again because I don't know when my brain will be itself again. Plus then there's a piece of recognizing that I'm always a tiny bit distracted. And so always knowing that a tiny part of my brain is somewhere else.

A huge test for me is reaching out for help. I'm a very open person I don't have a problem like sharing openly and being honest but I don't actively seek out, like, conversations. I've been a very kind of insular person. And that just doesn't work, that doesn't work when you're doing mental health and like, in that space of raising a child because there's so much that happens that just throws you out of your comfort zone. Somebody wrote an article recently and it was all about the fact that by the time a year happens, things have improved to the degree that those first few months are sort of like a blur. And people get nostalgic about them and so conversations don't happen about how just how overwhelming, just how frightening, just how like, awful [laughs] they can really be. I was really fortunate because I had a friend send that article to me and it opened up a conversation about when you have spent your whole life seeking a career and being competent and having to-do lists and being able to check things off, and there's like this ability to constantly like, finish things. And then you've got this tiny human being who's, like, you don't have any control over. And when your sense of competence is built around being able to get things done and you can't get things done, it's very overwhelming.

So within that place I really had to learn how to have those conversations and so I fell back on calling friends that I had gone to grad school with, I talked to my boss a lot,

like I was in his office a lot even just for conversations like, “how did you do this? What was your, like did your kids go through this?” I was really lucky that I had a boss that even though I wasn’t in supervision, he was very open and very warm and very relational. I was very lucky to have a partner who’s pretty emotionally savvy and he could have those conversations with me. The biggest thing was like normalization of finding as many people who would tell me what I needed to hear as possible. And then finding out who I would talk to who would start giving me advice and be like “okay I’m not talking to you anymore.” Because I don’t really need advice right now I just need to know that I’m okay and this is normal and this is what is to be expected and I’m, I’m great and it’s fine and he’s healthy and happy. I was lucky that enough of those people knew that the added dimension of also doing clinical work having been part of it.

Reflecting: “genuinely accepting, with no strings attached and no conditions, just the kindness of people.” I definitely parent differently. There is no disentangling my knowledge as a clinician from my approach to parenting. Because as a feminist raising a little boy, understanding and having seen so many young college-age male clients who can’t communicate their feelings, the disservice that it does them and their approach to the world? I just, that’s always on my mind when you know, Sam throws a tantrum. I’m grateful for my training because I get to say “it’s okay that you feel this way and I’m still gonna, I don’t know, change your diaper” [laughs]. You know there’s that balance of “here are the boundaries for you and let’s communicate what you’re feeling, yeah let’s emote, that’s great, I love that you get to have your opinions and um, we’re still gonna do this.” There’s so much that I know as a, as a result of my training that I just

kind of take for granted and what a blessing that is that when, you know Sam throws his food all over the place and I tell him “no” and he throws it again like that it’s good and it’s wonderful and I get to celebrate that instead of feeling constantly, which I saw my mom do growing up, of being constantly frustrated and um, feeling like she was doing a bad job because we wouldn’t listen to her rather than recognizing that no, developmentally this is just how it works and actually it’s a good thing! I think my training allowed me to mature to a place where I can do that. I’m glad for that. I don’t think a lot of folks have that benefit. And I see that because they come into my office!
[laughs]

I think I do things a little differently in terms of slowing down. I feel a little less pressure to have to fix things right away. And I don’t know why just because my mental capacity has slowed a little bit and I can’t do quite as much as I used to be able to do. Like I’m not as fast and I’m not as sharp so I just have to sit back a little bit more and slow down, um, and listen and let the person do more of the work. I think maybe prior to parenthood I took a little bit more responsibility on myself as a clinician than maybe was necessary or helpful or therapeutic. I put a lot more back on the client now. I just kind of have to [pause] trust the process? And trust that probably a lot of stuff that I was doing before in the room, even though I thought it was pretty snazzy and neat and, you know uh, had had some connection it maybe didn’t land with the person. Like it was more for my benefit to feel smart than it was necessarily because it actually was what the person needed. It does make it hard for me to decide like how much of my ability to slow down and relax and sit and trust the client is because of this miraculous change that’s happened

because I'm a parent [chuckles] now and how much of it is because just of the boundaries I've set I now have a different kind of caseload.

I think the biggest change of sitting with clients that are experiencing a great degree of suffering um, is probably the patience piece. In my work I've always used the analogy of like in the therapy room I can't take anything away from you but I can help you hold it for a little while and give you, maybe kind of like a muscular break like, you can rest your arms a little bit, I can hold it with you and you get to breathe a little bit um, and then I'm gonna hand it back to you and you still have to carry it out but maybe you have a little bit more strength as a result of having rest. I think it holds much more true now because I feel the deeper impact that connecting to human sorrow has on me and feeling it to a greater degree not really having the buffer anymore. Um, and again whether it's because of a relationship that you develop with a child that's so unique or because of the sleep deprivation or because of the hormones.

One of the areas that I really like working is trauma. I do a lot of work with sexual assault survivors and I do a lot of work with survivors of childhood sex abuse that's the area that I really like working in and so hearing the stories I feel it differently now than I did prior to having a kid. Um, and I don't think that's a bad thing, it just means that I am glad for the time boundaries that I'm setting because there's only so long you can do that. I think that's why maybe the patience piece has come in of, there's nothing fancy that I'm gonna say that's gonna take away the weight of someone's experience but there's something pretty important about being able to just sit and not be shocked and not be disturbed or judgmental. I think there's a message that can be conveyed when you rush into fix

something that like, “what you’re feeling is not okay, ew that’s gross and ugly and we need to get rid of it” and instead slowing down and pulling back and letting, trusting the person that just, has everything they need in order to heal and recover. And if I can support them in getting to that place, um, and maybe it’s just like the exposure to a little human and [laughs] (this is so cheesy) the freaking miracle that this little potato comes out and just knows what it needs to do. It’s pretty amazing! He’s starting to walk now and just his instinctual drive to continually push himself. That’s so just mind-blowing to me when I see him do the things that every human that has ever come before him has done. That we just take for granted. Something about really being exposed to that on an intimate level I just have a whole lot more um, faith in people’s ability to get to where they need to go if the environmental needs are met. If they’re, if the environment is right or if they have the right type of support.

I never imagined doing private practice. Like ever, ever, ever. I have a lot more confidence that I can do those things now. Because when you have a little human being that you’re responsible for it just kind of jolts you into having to trust yourself. All the insecurities of “oh I don’t want to make a website that advertises myself and it has my face on it.” I’m an introvert. Um, but I am doing it. The situation necessitates that I suck it up and face my discomfort. I would have never, ever done that had I not needed to make a change in order to be a better parent. And it’s funny because with each step that I do that, uh, I don’t care as much. Like I don’t, I’m not as worried about how people see me; I’m not as nervous, about like what will they think or, you know, I just don’t care as much! And I think that’s very much directly the result of I have bigger fish to fry. Like I

have bigger priorities and so the most important people whose opinions I care about are you know, with me in the evenings. Like I see them in my daily life. That is something that I may have said previously, like “oh the only people whose opinions really matter are like my family” but I don’t think I would have meant it before. But I really mean it now.

I described earlier, just how self-reliant I’ve always been, and how important that’s always important been to me. And that was kind of a side effect of how I grew up and also a side effect of kind of the context I grew up in. The expectation for young women in my high school was you get married and you have kids and you maybe work as a dental hygienist for a little while, but there was very much an emphasis on relationships and family. And I really was so chafed by that notion so I think it did something to strengthen this idea of like “no, you go to get your advanced degree you get a career, and if you have kids they’re sort of like this side project. You like, you are a strong feminist woman you have a career and that is, that’s your priority.” And so, um, it...sort of created this lifestyle where I had really good strong relationships with people but spending time with people was often an added responsibility to the stuff I needed to get done. That mentality doesn’t work when you’ve got a kid. And it’s not satisfying. And it has taken me the whole last year to completely kind of reorient and Sam has been such a good prompt for this; my whole kind of way of thinking about relationships has been shifted. This weekend Jason is out of town. Um, and we’ve got this dog who requires a lot of exercise and we’ve got Sam who requires, you know, parenting. I create this schedule of like, “okay here’s when I do this and here’s when I do this and maybe I’ll eat at some point” and two nights in a row, on one night a friend invited us over for

dinner. I had no energy to cook and I just went over there and ate her food! And took her leftovers! Um, and that was it. Like I just, I let her feed me. Like I let her feed us I took food home because I knew I needed extra stuff. That's just that sounds really small but it's really a very big shift for me in the sense of, I genuinely just let someone take care of me. And let somebody take care of Sam as well. Then the following night some friends stopped by just [because] they were on their way through and they had something that they wanted to drop off and instead of being like, "oh no I've got this schedule I need to stick to" like, I invited them in, and they sat down, and we had tea, and we relaxed. And my dog started kind of whining because it was time for his walk and they said "oh why don't we take the dog for a walk and you can work on dinner?" and I said yes! Okay! The energy of those two things of like a genuinely accepting, with no strings attached and no conditions, just like the kindness of people, like seriously filled my sails. That's a very big difference in my life.

It's neat because I'm finally like practicing what I preach. Because I can't tell you how many clients that I have, where asking for help and receiving help is a gift. Like I never really 100% did that [laughs]. So I knew, you know, logically but you don't genuinely know and it was really meaningful, like that was just a really sweet weekend. That's really a good example, like, a good description of my personal growth and I think it's neat and now there's some authority when I tell people, "you have to ask for help. You have to accept it." And, like everything else is secondary.

Researcher's Reflections

Elizabeth and I connected on being "older" parents and I shared that I felt like

being older meant parenting was more fun and more heavy at the same time. It was heavy because we knew time with our kids was precious, and because we knew more fully the suffering of other parents. I also shared with her that my parents too had difficulty knowing how to cope with stress. We laughed together talking about how we try to use our knowledge of emotion regulation with our children who are testing their boundaries and our patience. I said, “I really see that you’re frustrated but you know, what other ways can we communicate besides biting your daddy?” Elizabeth’s comment about how parenthood takes us to crazy and dark places reminded me of some of my crazy and dark moments, and I felt more connected to other parents in hearing that she had some too. I was happy for Elizabeth that she could change her schedule but did feel pangs of guilt and mourning as I worried if my unwillingness to reduce my schedule impacted my relationship with my daughter.

Rachel

Rachel’s Introduction

Rachel was the last parent clinician with whom I interviewed. She is a 30-year-old woman who is married and has a 2½-year-old son. Rachel identifies as White and Jewish. Rachel works from ecological systems theory and behavioral theoretical orientations. Both she and her husband work full-time outside of the home; Rachel is in a school psychology PhD program and balances three full days of practicum as a school psychology extern at a high school, and as a psychology extern at two different hospitals, a full day of classes, and a day in her lab to work on her research. Rachel’s husband is a

physician. She stated that she typically cares for her child in the morning before taking him to daycare and her husband cares for their son in the evenings, and Rachel also takes her son away for one weekend per month to allow her husband to have the weekend for billing, and he is on-call for some evenings as well. She asked me thoughtful questions about my daughter and my experience. Rachel was warm and spoke in a gentle and thoughtful manner and I frequently had the thought that I could see she was well-matched in her chosen profession; I would love to receive parenting solutions from her!

Rachels' Story

The challenge: “You’d have to be crazy to have a kid in this program.” I got pregnant during my second year. The way that my program worked we’re in practicum our second year but like it really kicks off our third year. And so for me, like, that sort of break between second and third year I thought was like a good sort of transition time and I took a leave of absence from my program. I took off my fall and my spring semesters and then went back part-time for summer classes and then was back full-time with prac, a graduate assistantship and a full course load the following fall. I started my graduate assistantship twenty hours a week and that was providing academic counseling and skills-building in a college, um, like academic support center. And I was doing one full day of clinical work in a school, one full day of clinical work at a hospital, and then I had ten credits of coursework on top of that. It was really rough [laughs]. I would say that it is the hardest thing I’ve ever had to do [chuckles]. I think it just demanded more of me than anything that I’ve ever done. The time and the energy and sort of like the self-doubt. I think um, I think that something that was and continues to be challenging about having

transitioned back in to clinical work [is] I work with kids and so sometimes like going into work to work with other people's kids while I'm sending my own son to daycare was sort of challenging.

My first month back was just really rough. It was also my son's first full month full-time in daycare and so you know he was sick pretty much every other week. I was either calling off from a new prac position or my graduate assistantship, um, and felt a lot of like guilt and, like, anxiety over that how that would reflect on me professionally and if I wasn't calling out then I was scrambling to find someone to take my son to the doctor or could stay home with him. I actually had a babysitter; someone from my program actually came up to babysit for my son one morning when he was sick so that I could go to work and he cried—I had never left him with someone who wasn't family before. She basically drove like an hour and a half to my house and got there I, like after twenty minutes of debating what I should do I just told her, like I basically paid her for her time and said “you know I can't do this I can't leave him like this.”

And I was also just worried, [chuckles] I was so worried about taking time off that I would have to call out when my son was sick. Because my husband won't take him, my husband has never taken off when my son's been sick so it's always been me. And, um, and so that was a concern of mine also was like, what's gonna happen if I have to take time off or I can't go to my practicum position because my son's sick? I mean there were definitely days where like, my clinical work was not getting 100% of me. I remember one day my son had had a stomach bug and I went to work and I knew I was getting it and ended up having to leave early and the whole day all I could think of was like, “just don't

throw up here! Don't throw up!" [laughs] Um, which isn't, you know, like the preoccupation of parenting exactly but definitely a way that parenting impacted my ability to be present there.

I think part of it is traditionally in my program people don't have kids. I'm among the oldest, and my program right now is a lot of people who came straight out of undergrad and you know not a lot of people are married even and it's just such a demanding program. People have made comments—not to me—but in passing even before I was pregnant about like “you have to be crazy to have a kid in this program.” No one in recent like history could remember anyone being pregnant.

I think [pause] I didn't [pause] there was nothing that anyone in my program ever did that made me concerned about how they were viewing me. It was more people who I was establishing new relationships with who I didn't have relationships with previously, who didn't necessarily know my work or could, you know, necessarily believe that I was gonna bounce back, you know what I mean? I think it all, it was all of my own self-criticism and like internalization of all the, “what are they gonna think of me or how does this reflect on me?” or “my work is not getting as much of me as it did before I was a mother” and so I think that was definitely like a time that stands out to me; it continues to be a challenge. Was there a resolution? Um, I mean I remember having like a really good, long cry.

Navigating the challenge: “I've drawn on support from a lot of different places in a lot of different capacities.” Both of my parents always worked. My mom worked from the time that I was born and so I think that was always modeled for me,

like, working motherhood was modeled for me. When I was in high school my mom actually switched jobs and was just working a ton more hours and so when I was in high school, I picked my brothers up from school every day, I made dinner every night. I remember like going to parent-teacher conferences, like, I spent a lot of time [pause] caring for my brothers and I think I was pretty resentful of my mom about that for a little while in young adulthood. Um, so I think that for me, what I'm trying to, I'm trying to have [pause] I guess I'm trying to have it all! Like I don't want to be working so much that, you know, I'm putting my kid in that kind of position. But I also wanna be working and modeling that for my kids also. And I think another cultural piece to that is I consider myself a strong feminist. So I would say the other thing that I'm really striving in working toward is to have more equal partnership with my husband. And just to sort of understand that, like, supporting me doesn't just, it doesn't just mean being there and taking care of our son, like, when he's home and when he's around. Like it also means that sometimes he's gonna have to make sacrifices; like for me that's really what equality is. If I'm making sacrifices, you should also be making sacrifices. If I'm doing however much of the work at home, you need to be doing however much of the work at home. So that I can be working as often as you're working.

I think those sorts of things have definitely influenced the transition; I would say the other thing is that, you know, I'm doing clinical work, but I'm also in school right now. And so I have a lot of flexibility in a lot of ways. I think being in grad school it's a really hard time to have kids but it's also a wonderful time to have kids. I had the option to take a leave of absence. I know not all programs are the same and not everyone has

those same options, necessarily, um, but for me to take that time off and to have the first year home with my first child, it was time that I would never, you know, that I would never get back otherwise and I was really happy that I was able to have that. I think that was something that was really important to me that I didn't expect to be. I just really cherished it a lot. I think because I sent him back, when I sent him to daycare he was a little bit older and so I think that made it easier for me. It's also a local community center and my mom—actually her office is in the same building in the community center is—and so I think just knowing that she was there and would check on him if I really need it.

The advisor that I came in with was a woman who had had her two children when she was on the tenure track and she was really supportive of me from the beginning. I was up front with her; I remember one of my first conversations with her was like, “I don't want to wait, you know, six years when I'm out of my program to start having kids” and she really was supportive and said “you know what, no one—it's never a good time—it's always, you just have to make it work for you when it works for you and we'll support you whatever you decide to do.” I think that was reassuring in the beginning. My program has been supportive and has made accommodations for me every step of the way, like I've called into my classes, I've taken on practicum positions where my supervisors there have been very understanding. I think all of those practicum supervisors I've had have either been young mothers or mothers with high school or college-aged kids. And so they've all been just really accommodating, um, and I think that some of that has also been self-selection I think I've sought out those types of opportunities.

I think for me, something that I did sort of intentionally is that, um, I would say

probably like 90% of the time if it's ever a question, as to like if, if I'm needed in both places, like as a parent and as a clinician, parenting comes first. Unless there's something extreme going on, like, clinically and honestly, there's really nothing that I can think of. This past summer it was the first day of my new practicum position for this year and, um it was over the summer my son had gotten a mosquito bite on his forehead. I took him to school and I got a call from his school that his eye was swelling shut. But I was an hour and a half away, and so I didn't know what to do and if it hadn't been my first day, I would have dropped everything and I would have just left, like that, I would have just left! But because it was my first day I was like, "I just can't, like, I can't leave" and so my aunt ended up going and picking him up from school and taking him to the doctor and taking him home and she spent the rest of the day. My supervisor was so kind and she was like, "you know, leave early, go ahead, like go home" and so she was, you know, so supportive and so kind about it. I just remember thinking "do I stay, do I go? Like, what do I do?" but I think because my aunt was able to take him, and that was reassuring that I knew he was in good hands. I knew he was going to be cared for. Um, but any other time, like if my son's sick or if something is like not right with him, I've tried to make it so he's always the priority

I think I draw my social support from a lot of different places. I don't have a lot of friends in grad school who also have kids, but I have one woman who's in my cohort who had a baby the year after I did. I've definitely relied on for that, sort of that, um, like true understanding of some of the challenges. [Because] I'm in school, I have supervision every week with my cohort and we can process all of our experiences. And I think that

that's been a way that, even when things have come up that have been upsetting or difficult, I know that in a few days I'm gonna meet with my cohort and I can discuss and process with them. And I think I've drawn on support from a lot of different places in a lot of different capacities that I think has just also been so critical to my, you know, feeling good about all of this. I think I've always tried to really process the emotional aspects of the job. I talk to a lot of people about the job, like, you know, peers but also my brothers, and I try to just, I have a lot of social support. And so I think something that I've tried to do is continue and really make an effort to tap into that. So that I can sort of process and accept and, you know, sort of like just go through the emotions of some of the more emotional aspects of it. I think that's helpful for me to have people that I can talk about it with so that I'm not bringing it home with me. Or bringing it home as much. I guess I'm always bringing it home.

It's hard. It's hard to be present, I think. Um, and I think you know for me it's not so much that I'm thinking about my work as much as like, I think that when I'm with my son, I'm not present all the time because I'm doing other things like I'm on my phone or doing something else to give my mind a break. Because I go from being present for people all the day long to this one more person to be present for and I think that's just really hard. Sometimes that's at the expense of my son and that sucks, but I think it's also just sort of like another reality of what we do, like, you know if we are not turning off sometimes [long sigh] I don't know it will get us, I think.

I think the resolution came at the end of my semester my first semester back and I had a 4.0 and I had, you know, everyone was pleased with my performance and I think

that was just so validating. Like, that, okay like this is tough, it's the toughest thing I've ever had to do, and um, and I'm doing it. You know, I'm getting through it.

Reflecting: “Whatever I am doing is good enough.” I would say I became a lot more empathetic to parents. I don't think that it changed the way the way that I practice, necessarily, but I think the way that I relate to parents is so much different. Like I understand the challenges of meeting your kids' needs and the kids that I work with have a lot of, like, pretty intense needs and so, you know, how draining and how difficult that is on parents and on the family system. I think that's something that I've just become a lot more attuned to.

I would say, um, [laughs] it's funny, I made a joke the other night in class that, like, having a two and a half year-old has like really made me reconsider whether I'm in the right career or not [laughs]. Um, because I think a lot of what I do is parent consultation and behavior plans and making behavioral changes and so for me, I think because that's what I do on a regular basis as my work, it's a lot of easier for me to do that with my son also. If I'm recommending things like they're probably things I'm doing with my son also. Um, not always, you know, it doesn't always work so well and like sometimes I know what I'm doing is like not what I would ever recommend to a parent! [laughs]. So I think I'm really aware of that but I would say that my professional life in my clinical work really guides a lot of what I do as a parent.

I think I also [long pause] at the end of the day I think am sort of, I feel more like not that it doesn't matter, but like I think I've been really intentional about the practicum position that I have chosen—the people. Like if I've gotten a sense when I've

interviewed for different positions that they are not going to be flexible or things are really rigid or, you know, not people who would be empathetic and supportive, um, it's not the right fit for me. The other thing sort of I think I have a better understanding or appreciation that like, I'm not a typical grad student. My timeline is not gonna be the same. My experiences are not gonna be the same, and if at any point in my career, somebody takes issue with that, probably it's not going to work out. So I think I've becoming a little more accepting of that sort of reality.

I would say that the growth I just, I'm just a different person as like a parent than I was before I was a parent. I mean, well I wouldn't [say] that my values have changed, but I was say like the emphasis on those values has changed. Like the fact that my family was always first and foremost I just feel like it's even more critical now, you know. My school is my school and my son is, there's just not, like, a comparison and I think that was huge. I think I'm also just more secure in knowing what I need from people and as a grad student and practicum positions; I think I feel a lot more secure in, um, saying no to things and saying, "that's just not a realistic possibility for me" without, I mean there is guilt over that sometimes. Like it's important work but like at the end of the day, I think I feel more confident, more secure in being honest and upfront. When I think back at the beginning and how hard it was for me and how nervous I was about disappointing people I think I've gotten enough support and positive feedback over the past year and a half or ever since I've been back that whatever I am doing is good enough.

There's a picture that I have, it's just a picture of, um, it was a weekend, I guess my son was probably like, I don't know like maybe eight or nine months old. It was

during my first class back after he was born. And um, he was sick and so and I had an assignment due and he only wanted to be held and so I'm wearing him in a ring sling so he's asleep on me and I'm sitting typing at a computer and we also had a wedding that night and so like my hair's all done like for this wedding and I think it just really encompasses everything. That work-life balance, and, you know, just trying to get it done, but also within the constraints of having a life that isn't just my school or just my work, and, you know, that balance of like figuring out how to give my son what he needs and get my work done and do what I need to do as a mother and as a person and all of that. I think of about that picture fondly but I remember at the time it was a really stressful, you know, it was a really stressful day. And it's at my parent's house which I think just speaks to how much all of like my balance sort of relies on the people around me to help maintain it and to provide it.

Researcher's Reflections

I shared with Rachel that I too had a supportive supervisor who made all the difference. We talked frankly about social support and I wondered with her what about my experience would have been different with family nearby. I really connected with her experience of having some resentment of her mother but then later being grateful about how her mother (and her entire family) was really instrumental in her success. Amusingly, Rachel talked about needing to call out when her son was sick, and during the two weeks that I interviewed Rachel my own daughter was sick and I had to stay home and we commiserated together. We also laughed about how *most* of our psychologically-guided behavioral interventions work with our own children. She

inspired me to make a sticker chart for my reluctant teeth-brusher. I appreciated that she destigmatized using smartphones and other distractions with children; so often mindlessness gets a bad name, but sometimes we clinicians need to turn our brains off. Finally, similarly to my experience in meeting Elizabeth, I felt some regret that I went back to work and school too soon after giving birth to my daughter.

Amie

Amie's Introduction

I am a 41-year-old, married mother to a 3-year-old girl named Gertie (pseudonym). I identify as a White woman and work from a primarily existential-humanistic theoretical orientation. I am currently doing my internship at a university counseling center and work 40 hours per week doing a mix of clinical and administrative work. Throughout my year on internship, my husband, John [pseudonym], has been struggling to find work and so has been working doing online contract work out of his father's basement where we live. Our daughter has gone to preschool for 28 hours per week. When I had my daughter, I was working 20 hours per week at the university counseling center and taking one class. These duties meant I was gone for about 30 hours per week so our daughter had in-home nannies. At a few points in the process of this project, I had moments of panic that my story wouldn't be "pure" because I was continuously influenced by each of the parents I interviewed and learned from. My interview would be different if I had had it first, or after each parent clinician, or at the end. I then remembered that of course all of the people I met influenced my story. That's

how stories are. We are always being influenced by the stories we've heard before and by the audience to whom we are telling it to.

Amie's Story

The challenge: "It was supposed to be a magical time when I was with her but I wasn't, I never felt fully present." I knew if we were going to have a child we were going to do it while in grad school, but for the first couple years I was too afraid to tell anybody because I feel like there's a stigma in academia, like why would you [pause] you're here to do research! And you're here to be a professional. Got pregnant in, like, November which meant I knew she was going to be born in August; she was born two weeks before the semester started. When I was pregnant I had accepted a, a 20-hour practicum assistantship at a college counseling center and I remember that summer, like in June or July, then calling, the college counseling center called she said "you're gonna start [sooner than I wanted]." And I had a major meltdown [because] I didn't want to give up that much time; I didn't want to go back right away. I didn't even know that I wanted a kid until I got pregnant and then suddenly now I don't want to give up all of this time. And my mom had been a stay-at-home mom and I didn't want to be a stay-at-home mom but I wanted more time. I started class right away which was one class, and then I was gonna attend meetings at the counseling center but I was not going to do clinical work until like week 8? And I just, like, really I didn't want to regret not having time with her when she was little. But I didn't feel—I felt really trapped. Like I didn't feel like I could [ask for more time]; I didn't want to get so far behind in my program.

So I went to back to class when she was 2-weeks old and it was once a week at

night and John watched her. And then when I started at the counseling center it was like, five hours for a couple weeks and then I went up to the full 20 hours at like six or eight weeks [postpartum]. And we had my mom come for a week and we had John's mom come for a week and then John took a month off. And so we got a nanny when she was twelve weeks-old. And that first semester was just terrible. Because I was like, so I really wanted to breastfeed. I got mastitis two weeks after Gertie was born. I went to Urgent Care and they gave me antibiotics and I was super sick. And so [chuckles] I had a really hard time producing any milk. But it was really important to me; everyone was like "just give her formula" and for some reason I felt like it was a big failure to do formula. I remember we finally had to do it [because] she wasn't gaining weight and my pediatrician was like, "you have to give her formula" and I made John do it [because] I was, I just sobbed the whole time. I was *crazy* trying to increase my supply. I was waking up in the middle of the night to pump, like every two hours I would pump. I went to three different lactation specialists to try to increase my supply so I was pumping at night, pumping during the day, pumping at work and I was just miserable. I was trying to pump more and I would measure [the pumped amounts] and I would, like, freak out; I remember being in-between clients pumping and then I'd be disappointed [about] the amounts. And so yeah I was like, my clinical work was probably shitty I'm sure. [laughs]. I don't even remember, like, good client experiences that first semester. So yeah it was really hard, um [long pause] feeling like I was failing at work, feeling like I was failing my daughter, my body couldn't even, you know, produce milk. I was angry all the time [because] I was so tired and so frustrated.

There was a time when my parents were visiting me and I was doing this thing where I would tape this little tiny tube then I would get her to latch so she'd be nursing and she'd also be getting extra formula. And I was super frustrated and it wasn't working and she was crying and, like, she was biting me and I had this moment where I stood up, and I knew like, you know they say "give the baby away?" So I handed the baby to my mom and she took the baby, she took Gertie. And then I walked around and I took a beer bottle and I threw it on the fireplace. We had this big family fight and I felt like I didn't have control over my emotions. And months and months, like maybe a year later my mom finally admitted, like, "no you did the right thing you gave the baby to me." But at the moment my dad and mom definitely shamed me for that like moment of anger. And then a couple weeks later again I was home with Gertie alone and I threw an alarm clock against the wall. And again, I don't think, like neither time did I put Gertie in danger but feeling like I had no control over my emotions. And I remember when I threw the alarm clock against the wall she was maybe, I don't know maybe three or four months old, and she was in her little bassinet and she looked at it. It didn't scare her, but she looked at it and then she looked at me. And there was this moment of like, "holy shit, like I can't like have her, I can't be this way, like I can't be volatile, I can't have no control, because she's watching me" you know?

I remember pumping watching old "I Love Lucy" reruns and being so lonely [because] I don't know if you had this, but at some point when she was little I remember waking up in the middle of the night and being like "my life is never going to be good again." "This is the rest of my life, like I'm always going to be worried. I will always be

worried about her.” Even if I fix one thing it’ll like, something else will happen. By Christmas I finally figured the milk thing out but then it was like, then I think my anxiety kicked in of all the other things that could go wrong. I think for the first four months I was focused on milk and nursing so much that my anxiety all just focused on that and then when we calmed down a little bit, then it was like all that anxiety didn’t have any place to go and then I just became worried about [pause] everything. So the second semester was hard because I was much more aware of sad things that my clients were telling me and much more aware of Gertie becoming hurt. I remember my supervisor told me this story of a toddler [who] died. I felt like there was no distance. I couldn’t just hear that and be like “oh that’s a sad story.” You know, like *all* the news stories were sad, they were all like, I felt like everything that could ha—that I heard about from clients or Facebook or the news it all felt like it could all happen to Gertie and I felt like I didn’t have any control over keeping her safe. I would go to work [and I] worried about her with my clients; I didn’t feel great like I wasn’t present a lot of the time. I’d hear a story in session and I’d worry “would that ever happen to Gertie?” A girl would talk about her sexual assault and I would be like, “oh my God. How do I stop that from ever happening to Gertie?” So I felt like [pause] I didn’t feel like a great clinician and I didn’t, I felt like a terrible mom too [because] I wasn’t fully present at either place. And then I would go home and I’d be with Gertie but then I would take all that stuff home with me. I remember trying to play with her in her bedroom but I’d be worried and I was constantly trying to be vigilant about danger. I was home alone and like there was this pressure that it was supposed to be a magical time when I was with her but I wasn’t, I never felt fully

present, I guess. I feel like there was never any place where I could feel like happy; I wasn't enjoying her as much as I could because I was worried about stuff. I feel like part of that was just life; if I had any other job, I feel like part of it would happen if I was like a lawyer or whatever. But I think being, doing clinical work was hard because it was much more apparent that I had to be "on" and hear people's stories and then go home and be "on" for a toddler and I was just exhausted. Like emotionally exhausted.

The other big thing is that my mom was a stay-at-home mom and there was a lot of grief that I think I felt for working. Like I really wanted to be a working mom and I wanted to be a psychologist but I didn't [pause] I was surprised how much I wanted, how sad that was for me to have to go back to work so soon. And I felt really jealous of my sister [because] she was a stay-at-home mom, and I felt like my mom and my sister were these like perfect stay-at-home parents while I was like the one throwing beer bottles and like losing my shit and working. I feel like that made it hard for me at the beginning to be like, "I'm doing this wrong." Like I couldn't even breastfeed right, you know? I feel like everything sucked at the beginning because I was working where as I felt like if I hadn't gone back to work maybe things would be better and I wouldn't have been [pause] and maybe I would have been more present with Gertie. I think at the beginning feeling ashamed that I wasn't a stay-at-home parent.

Navigating the challenge: "like trying to get myself some distance from the thoughts of "what if, what if, what if?" I was a psychologist and I should know better. Like I should know about child development and know about emotion regulation and here I am, an older parent, you know, and a psychologist and I still just couldn't control

myself. And then I didn't really have a lot of people nearby in graduate school who I could talk to about this, like, no one in my program had a child. There was one woman who was three years ahead of me who had a child but she lived like an hour away and she didn't ever come back for classes. And then we had a next-door neighbor who had a child but she was stay-at-home mom and at the time I felt so much like I was comparing myself to her; "why is she, how can she get this together?" She breastfed and she carried her children in wraps and I was struggling and I'm like, "what's wrong with me?" My sister was a stay-at-home mom, attachment parenting and I felt like I couldn't really tell her what was going on and so I didn't have anybody who was doing both and working and having a kid.

I used supervision. My supervisor that second semester was a mom and so I talked to her about the meaning of life. I was lucky to have that supervisor but it's still weird because she's my superior and so I couldn't be like, "yeah I threw a beer bottle!"; she was good but I still had to put on a front with her. She's like, evaluating me. I remember I was pregnant and I met the department head on a walk. And she was boasting about how she had twins and she went back two weeks later and I was just like, "well that's great for you" and that's coming from the department head! And I think it was hard to admit, yeah I have a real life besides grad school and I don't care about research number of publications, like I'm sad that I'm not home with my girl.

I went to therapy. I think that I realized that my anxiety had come back and so it must have been spring, late spring semester [with] my clinical supervisor—I finally just broke down and asked her. She recommended somebody in town and I went to see him,

maybe for like six or eight sessions and that's when I was finally able to get my anxiety under control. I started doing a lot of activities like trying to get myself some distance from the thoughts of "what if, what if, what if?" I remember in counseling the guy was like, "do you need this much social media?" [laughs]. So I stopped, I tried to, I stopped reading the news. I remember writing a paper and reading about this story of this couple who had had a child with Trisomy 18 or something which is like normally not survivable but they had this daughter. It was like on the Huffington post or CNN and I was just *sobbing* at this story and I was trying to write a paper and I was like, "I cannot live like this." So I just tried to limit social media a little bit. Like if stuff came on my Facebook feed I would not click on some of the sadder things that people share. I just decided there's too much in my consciousness I can't be sad for everything that happens to everybody. [Because] there's this threshold of suffering that I could handle and it was enough to have my clients and my own thoughts and my daughter; I didn't also need to have everybody's suffering all over the world.

Then the other big thing that changed was that after throwing the bottle, throwing the alarm clock, I realized I didn't want to be that kind of mom. I realized like I wanted to be more in control of my emotions. So having gone through both of those crises made me on the other side be like, "nope I'm a mom, I want Gertie to, to learn how to regulate her emotions better." I think I'm trying to be much more [pause] calm as a parent. I mean I'm still having times when I've yelled at her recently. So really trying to kind of just use skills to stay more even. My parents were really young when they had me. And they were, they're still married, but there was a lot of like, they fought a lot, they had a lot of

volatility so I think that has made me be like “oh I don’t want to do that.”

Eventually I would take her to the library on Monday[s]. I remember walking in my neighborhood and it was beautiful and we would walk in the stroller; I think walks in the stroller felt the most rewarding because I felt like I was active again, I was doing things with her, I was like being the kind of mom I thought I would be. Like throwing alarm clocks and beer bottles wasn’t the mom that I thought I was gonna be. Getting out made me feel like a good mom. When I actually felt like I had enough energy and emotional, like, resilience to just go do something like the library or the park. Feeding her solid foods was rewarding [because] I felt like there was so much stress about feeding with breastfeeding that once that pressure let up it was fun [because] I really like to cook and so when we got to start feeding her food it was fun because I felt like I could be the kind of mom I thought I was going to be.

Reflecting: “Cuz like all of us are just trying our best as parents.” But then eventually I think I was able to find my way? As a mom and realize, I think after counseling, I became a lot more chill. Like I was able to manage anxiety and I felt sort proud that I did it. Proud of myself that I was working and that I was doing clinical work and proud of myself that even though I wasn’t a stay-at-home mom I could [pause] like I was, I was a calmer mom. I feel like I’m doing a good job with her, encouraging Gertie to process her emotions and I feel like my work and my knowledge has helped me be a good mom anyway even though the route felt different?

I think she knows that I’m empathetic. Like I think, last night she didn’t want to go to daycare. She was like crying and John was just like “get in there! You gotta go” and

I like sat down with her in the hallway and I just sat and I'm like "tell me why you're, tell me what you're feeling now" and it was like a very intentional thing that I don't want to just brush over her feelings [because] we have to like get, do things. So I just sat there and it kind of turned it around and I think that she knows me to be somebody who will listen – to give her space and then listen to her. I think I'm, I think I'm trying to be more in-tune with her instead of just bossing her around all the time. She likes to do art. Like, that's her favorite thing is when we just stop micro-managing her and put her down with her art supplies, she's got like tons of crafts, and she's just allowed to do whatever. I woke up in the morning and we're trying to go out for school and she's like "I'm gonna make you a drawing" and my gut was like "no! you can't make me a drawing we need to get your teeth brushed, we gotta get dressed," but I was like, "fine. Go draw" and I got in the shower. And she came up to me and she was like, "look!" and she gave me that [points to art on the wall with a number of "G's" for "Gertie" and festooned with purple feathers for decoration] and you know it has her "G's" and her feathers.

I chose that drawing because in thinking back I would hate to, like I think a big thing for me was not being present and having some regret that maybe I wasn't as present with Gertie as I could have been. I was so caught up in my head and so stressed that I didn't remember those good, joyful times. Because I mean you asked me, "what were the good parts?" and I think I get so caught up in the negative parts that I don't remember "hey there's a lot of good going on." I really was like, I'm gonna bring it in to work because things are so stressful right now, but I don't want to repeat that [pause] era of things are so stressful that I don't take time to like connect with the good stuff. Especially

with her because like, [pause] this is [pause] she's only three once. There's only 52 weekends when she's three. I don't want to look back like I sort of do at her infant days and be like, oh I was so in my head with stress that I didn't realize like, "whoa I've got this amazing kid!" It reminds me like, when I'm typing notes, when I'm pissed off, [chuckles] or when I'm freaked about money, I can be like, "okay, well Gertie doesn't know that like John's struggling to find a job and that all my clients are irritating and there's crisis all the time. She's like, in to her feathers!" I'm not going to do the same thing, maybe as much. I'm gonna try to be more present and more celebratory of good stuff right now. She created it at a time when my gut was like "no! get dressed" but for some reason I was like, "okay, go do your thing" and that was like [pause], that was probably important to her. It not only reminds me to be present but it represents like I can still make time for what's important to her even if I have to get like, my dissertation [in], you know? My biggest fear is when she looks back, which she won't, probably, but I don't know! You know we're psychologists so we know, we know that like kids are resilient and we know that sometimes things leave a mark. So I'm trying to balance like, okay she's resilient and I want [her] to be like, "remember Mommy was working, she was a working mom and she took my drawings to her work."

I think in some ways it made me closer to my mom because when my sister had my nephew, I felt really distant from my own mom because she was full grandma-mode and I was in Utah doing grad school which no one really understood and I felt like I was the outsider in our family. But then being able to raise Gertie while I was doing clinical work and while I was in grad school I think made me feel proud and then I got closer to

my mom. And in fact, when Gertie was two I remember I was like trying to get my dissertation done and I was cutting it really close. And our nanny quit. So I left and I went home to my mom's house and spent a week just like completely gung-ho on my proposal and it was really a nice full-circle story. As I was typing upstairs I would look out and [I] saw my mom parenting Gertie and I was like, [pause] I spent so many years being mad at her for maybe not understanding what I'm doing but here she is, like [tears up] supporting me. I didn't have to be mad at her anymore because she was supporting me the way she could which was raising my daughter. I think that coming into my own identity as a mom, that it's okay that I was different than my mom and different than my sister. And it made me realize like families can be supportive even if they're not doing the same thing. And I'm really lucky.

Another thing I realized when I saw my mom parent Gertie I feel like parenthood gives you a window into seeing how much your own parents loved you. You know? [Because] you don't remember what they were like when you were a kid but watching her be with Gertie was like "oh, she was a great mom!" It was like she loved *me* this much. And so that moment was a nice full-circle of like, I could see that she loved me, I could see that I loved Gertie, and I was still a good mom even if I did things differently than her. I think I've also in this whole process forgiven my mom a lot for things; she was just trying her best, you know? 'Cuz like all of us are just trying our best as parents.

Researcher's Reflections

Being on the other side of an interview made me realize how great it felt to talk about my experiences. My colleague also shared that being a new parent can be a lonely

experience and there were many times when she lost her cool and felt like everyone else had everything figured out. It felt healing to talk and make sense of it. I also was surprised about how in looking back I had focused only on the hard parts and was temporarily stumped when she asked me to recall the good moments. I realized how our memories change over time and how the process of engaging in this study—meeting my parent clinicians and the passage of time—has altered my memories and changed the meaning I have about that time in my life. As I was transcribing my own interview I teared up a number of times remembering how sad I felt to give up so much time to work during Gertie’s infancy, and how my relationship with my mom had been so interwoven with my own transition to parenthood. I realized that even though much of that time had been difficult, I felt like I was a better person and had better relationships as a result.

CHAPTER V

DISCUSSION

Introduction

The goal of this discussion is to answer the research questions and synthesize the individual findings that are within each parent clinician's narrative. The discussion in this chapter is based on the findings from the previous chapter and while each parent clinician's individual narrative contains some answers to the research questions, what follows is an attempt to highlight some broader themes and points of divergence between the parent clinicians. In analyzing the findings, I have attempted to not fall into one of two traps in presenting the data. I did not want to feel pressured to only present similarities across the parent clinicians and collapse their stories into one message; in qualitative research, differences are noteworthy and interesting and outliers are not discarded. In addition, I wanted to avoid the tendency to parse and categorize every utterance into themes and subthemes or re-present the same data again; it is important for me to let the narratives stand. Nevertheless, there are similarities among the stories and connections to the literature on parent clinicians that are meaningful.

Discussion

I have presented the research questions again as a guide to analyzing and making sense of the narratives.

1. What is the experience of parent clinicians when working with clients while in the context of being new parents?

- a. What was the individual's challenge?
2. What do parent clinicians do (behaviorally, cognitively, emotionally, spirituality) to process the interaction of clinical work and new parenthood?
 - a. In clinical work
 - b. In personal life
3. Is there meaning to be made amidst the unique challenges parent clinicians encounter when transitioning to parenthood?
4. What contextual information in parent clinician's lives (e.g., beliefs, traditions, family of origin, childhood experiences, beliefs about childhood, theoretical orientation) enriches the making of meaning?

However, I have chosen to reorder the questions in the following way in this discussion:

What were the challenges and the experiences of parent clinicians? What about our contexts enhanced our making of meaning? What did parent clinicians do differently in our clinical work or personal lives to process the transition? What meaning did we make of our experiences? Reordering the questions assisted in me seeing the narrative arcs within each story and across the narratives.

What was the Individual's Challenge?

The literature on the transition to parenthood does not focus on parent clinician's unique challenges or crises. The studies contain many stories of difficult experiences and authors list themes across their participants, but it is not clear which difficult experiences are a central "challenge" that were a catalyst or turning point for an individual's story. In this study I specifically asked each parent clinician what their unique challenge was or what was the "hardest part." There was both variability and similarities among the parent clinician's challenges. Allen's experience was perhaps the most unique in that his son suffered two unique medical crises and Allen himself experienced somatic symptoms of

severe stress. In addition to these medical challenges, Allen also reported having unsupportive supervision which added to his distress during his crises. He also felt a reluctance to have a second child which created stress between him and his wife. Jessica's challenges included lack of support, no time for her to practice self-care to "relax and kind of breathe," particularly in light of her child's risk of sleep apnea. In addition, Jessica reported feeling re-traumatized by the birth of her child and the clients she was seeing, and realizing her insecure attachment was dictating her anxiety and parenting choices. Elizabeth described a "re-orienting" shift in her identity as a previous high-achieving "strong feminist woman" who subsequently loved being a new parent and wanted a change in her career. Rachel also identifies as a feminist and wanted to ensure that her work would not suffer as a result of new parenthood, but experienced self-doubt and worry that others would find her work lacking. Similarly, I experienced anxiety, extreme emotions, and feeling "triggered" all the time. Like Elizabeth, I also questioned my identity and like Rachel, worried about comparisons to others; I compared myself to other idealized "good moms."

Parent Clinician Experiences

Impacts to clinical work. The narratives of the parent clinicians contained many experiences that impacted our work and mirrored experiences of parent clinicians in the literature review including recognizing the daily hassles of having to call out sick when a child is sick (Rachel), experiencing fatigue and memory problems in sessions (Elizabeth), and some guilt when having to cancel work responsibilities due to their parental responsibilities (Rachel). A significant theme from the literature was an increase in

empathy with their clients (Adams, 2014; Deery, 1994; Gibson, 2016; Lyndon, 2013; Robinson, 2012; Waldman, 2003) or the parents of their clients (Deery, 1994; Gibson, 2016; Grayson, 2011; Insko, 2008; Jalowiec, 2011; Lyndon, 2013; Scholfield MacNab, 1995; Waldman, 2003). Similarly, four of the five parent clinicians in the study expressed an increase in empathy in their work. Allen stated that hearing about suicide became more “vivid” to him after he had his son. Jessica said, “I feel like my empathy really skyrocketed” and Elizabeth echoed “I think empathy is something that like, I didn’t have a choice about it, it just is bigger. I just, things just make sense.” Rachel specifically felt more “more empathetic to parents” and

like I understand the challenges of meeting your kids' needs and the kids that I work with have a lot of, like, pretty intense needs and so you know how draining and how difficult that is on parents and on the family system. I think that’s something that I’ve just become a lot more attuned to.

Elizabeth noted an increase in empathy, but also reflected that she felt less empathetic with some clients such as perpetrators. She said that she may have been able to work with them before becoming a parent, but now is “very much aligned with um, protecting vulnerable people.” A parent clinician in Jalowiec’s (2011) study also reported lowered empathy and disgust of adult abusers when working with child abuse victims.

Many of the parent clinicians in the literature reported increases in understanding of various topics that improved their work including understanding human developmental processes (Deery, 1992; Gibson, 2016; Lyndon, 2013; Robinson, 2012; Scholfield MacNab, 1995; Waldman, 2003) and an increased understanding of the complexity of life (Scholfield MacNab, 1995). The parent clinicians in this study also expressed similar increases in understanding. Jessica reported that after becoming a parent she better

understood attachment. Rachel talked about being able to experience successful behavioral interventions at home with her son that increased her confidence in recommending them to her clients. Elizabeth spoke excitedly about better understanding a developmental perspective when she said,

it's just like the exposure to a little human and [laughs] (this is so cheesy) the freaking miracle that this little potato comes out and just knows what it needs to do. It's pretty amazing! He's starting to walk now and just his instinctual drive to continually push himself. That's so just mind-blowing to me when I see him do the things that every human that has ever come before him has done. That we just take for granted. Something about really being exposed to that on an intimate level I just have a whole lot more um, faith in people's ability to get to where they need to go if the environmental needs are met.

Allen talked about experiencing an increased depth of understand of suicide; when thinking about the bond with his own child, he has realized that breaking that parent-child bond meant that he realized "this thing about suicide is super powerful." Elizabeth and Rachel also looked to their own personal lives to gain an increased understanding of client work. Rachel remarked that she realized that parenting is hard even with the amount of support she has and she considers how much more difficult single parents must experience parenthood. Elizabeth reflected on a recent weekend when her spouse was out of town and her son was sick and as a result she wasn't getting much sleep. She remarked that her mental health took a dive: "wow that happened real fast like I, this is, this maybe like somebody should probably come check on me." In a similar way that Rachel did, Elizabeth reported realizing that if parenthood is hard for someone like herself with resources and awareness of psychological principles, it is easy to imagine how hard it is for clients who frequently have fewer resources. Allen reported that based on his own experiences, he was better able to relate to a client who was pregnant, other parents, and

clients experiencing anxiety.

The parent clinicians in this study also reported situations that were not highlighted in the above literature review. Jessica, Elizabeth, Rachel and I all stated that we had moments where we were not present in sessions with clients. Jessica used the term “one foot in the door one foot out” and also used the term “divided self.” Elizabeth said, “plus then there’s a piece of recognizing that I’m always a tiny bit distracted. And so always knowing that a tiny part of my brain is somewhere else.” Rachel relayed an amusing anecdote when she realized at work that she had caught her son’s stomach flu and thought to herself “just don’t throw up here! Don’t throw up.” I told a story of hearing a client’s experience of sexual assault that took me out of the moment with my client as I worried about the same thing happening to my own child.

A significant stress for Allen was experiencing unsupportive supervision; his supervisor reportedly became more constrictive, negative about his son’s recovery, and just “mean.” In addition, both Rachel and I reported feeling afraid about what our doctoral institutions would think of our impending or new parenthood. On the other hand, Rachel and I also reported experiencing supportive supervisors, and Rachel cited that she appreciated the increased flexibility of having a child during graduate school.

Impacts to parenting or personal life. The parent clinicians in this study reported that our transition to parenthood also impacted our parenting and personal lives. Elizabeth, Rachel, and I all stated that we found ourselves using psychological knowledge when parenting our children. Similarly, the parent clinicians in Insko’s (2008) study reported encouraging their children’s emotional and social development. Elizabeth

and I both talked about encouraging our children to regulate their emotions. In one of the biggest laughs of our interview, Elizabeth said,

I'm grateful for my training because I get to say "it's okay that you feel this way and I'm still gonna, I don't know, change your diaper." [laughs] You know there's that balance of "here are the boundaries for you and let's communicate what you're feeling, yeah let's emote, that's great, I love that you get to have your opinions and um, we're still gonna do this.

She added that she realizes that her ability to understand normal developmental processes like testing boundaries helps her parent better and not be constantly frustrated like her own mother frequently was. I also talked explicitly about encouraging my daughter to express her emotions by sitting with her and asking what she's feeling and said, "I think I'm trying to be more in-tune with her instead of just bossing her around all the time." Rachel took inspiration from her practicum site and created a sticker chart for her son to encourage him to brush his teeth. Parent clinicians in the literature cited ways their jobs negatively impacted their lives such as increasing guilt or shame about their parenting (Basescu, 1996; Scholfield MacNab, 1995). Only I expressed this theme when I worried that because I did not stay at home with my child or because of my anxious and volatile behavior I was a bad mother.

Two studies in the literature (Deery, 1994; Holm et al., 2015) focused on how parenthood impacted parent's (in both studies specifically mothers) identities. Identity change or a parent clinician's awareness of identity was a significant theme in three of the parent clinician's narratives in this study. Elizabeth reported a drastic shift in her identity away from solely being a "burnt out" counseling center psychologist to incorporating new identities as a parent and as a clinician in private practice. I struggled

with how to create a working mother identity with no guidance on how from family, close friends or colleagues; I also then later changed my identity from “lacking mother” to “good mother.” Rachel did not necessarily add to or change her identity, but identity was a salient concept in her story. She wanted to be a working mother and model that for her child but early on struggled with confidence before settling in to her role.

Furthermore, her feminist identity meant that since she became a parent she has been working hard to have a more equal partnership with her spouse.

One of the experiences that stood out to me when I was conceiving this study and reading the literature was how parent clinicians handle hearing about emotional suffering and if it became more difficult after becoming a parent. The parent clinicians in this study were split on if we felt this aspect of the job changed for us once we became parents. Jessica, Elizabeth, and I reported that we felt more impacted by stories of human suffering both in counseling sessions and in their personal lives. Jessica felt triggered working in the child trauma unit and at Walmart when she saw children she wanted to rescue from perceived bad family situations. Elizabeth echoed that she felt more empathetic sitting with a client who had to leave her undocumented family and outside the therapy room when reading the news. She said that stories of suffering impacted her differently and stated that “I can’t breathe” when hearing about Syrian refugees and “I have never wept while reading news until now. Like I, like it hits a nerve that I didn’t even know existed.” I felt distress in session and asked “what if, what if, what if” outside of sessions too; I also added that I had to stop reading sad news stories. Jessica and Elizabeth both brought up their changed ability to hear stories of suffering even before

they were asked about it in the interview, which suggests that this was a salient experience for them even without my prompting. In contrast, neither Allen or Rachel felt that this aspect of the job was changed when they became parents. Allen stated,

You had a question about the maybe being better able to understand client's pain, or hold their sense of pain a little bit better. I really reflected on that question to see if anything matched and I guess I would just say that it just didn't connect with me on any of my experiences working with clients.

Rachel also echoed this and said,

You know it's a really interesting point you're bringing up in terms of like, like their level of distress and how that impacts me. Um, but maybe because the kids that I work with are older [pause] I don't know. I can't think of anything that makes like that aspect of it particularly different for me.

This variability suggests that increased distress at human suffering is not a ubiquitous phenomenon, which was also reflected in the literature as only some of the studies highlighted the emotional distress of the job. Parent clinicians in the literature reported an increase ability to tolerate strong emotions (Lyndon, 2013; Robinson, 2012), which is something that Jessica echoed when she said, "my ability to sit in the interpersonal process and discomfort of it at times, um, the suffering" increased. Elizabeth highlighted increased patience when working with clients who are suffering:

Elizabeth: I think the biggest the biggest change of sitting with clients that are experiencing a great degree of suffering um, is probably the patience piece.

Amie: Mhm

Elizabeth: Um, I'm a lot more patient with the process.

Amie: Like not feeling like you have to fix it right now?

Elizabeth: Yeah.

Amie: Or that you can't even fix it right now?

Elizabeth: Yeah. Um [long pause]. That I can't fix it, like it's not mine.

Parent clinicians in the study felt distracted and not emotionally “present” in sessions and two reported not feeling present in their personal lives either. Rachel stated “I'm not present all the time because I'm doing other things like I'm on my phone or doing something else to give my mind a break. Because I go from being present for people all the day long to this one more person to be present for and I think that's just really hard.” She added that,

Sometimes that's at the expense of my son, and that sucks, but I think it's also just sort of like another reality of what we do, like, you know if we are not turning off sometimes...[long sigh] I don't know it will get us, I think.

I loved this statement from Rachel because it normalized the need to just be “off” and distracted by our phones or television. Short-term distraction gets a bad rap both in psychology circles and outside, but Rachel's statement put it into perspective for me. I stated that being at home with my infant “was supposed to be a magical time when I was with her but I wasn't, I never felt fully present.” On the one hand, being so overcome with client despair that it is intruding on a clinician's home life with your infant is terrible. On the other hand, like Rachel indicated, the reality of a clinician's job is that being “on” all the time is exhausting and turning “off” even temporarily with distraction is necessary. Also coded in my comment about it is “supposed to be a magical time” suggests an unrealistic expectation of parenthood.

A final theme that emerged from the parent clinicians is one of loneliness or feeling disconnected in their lives. Allen stated,

When I look back on that time in my life there was a lot more um, loneliness that I think I wish I would [have] been able to address...I wish that, I wish that I could have said “aha this is loneliness that I'm feeling. Let's, let's get connected to

people for that and make that better.

He also lamented that he studied for the EPPP licensure exam alone without colleagues as support. I reported that getting up in the middle of the night to pump was “lonely,” and then added that it was hard to feel disconnected from other parents, and particularly those who worked while raising an infant. Jessica did not use the word lonely but did state that she and her spouse “didn’t have a support system” because their families were not in town, which added to her stress about how to take care of her newborn. In addition, both Elizabeth and I also pointed out that we did not have family support nearby which was difficult.

Contextual Information

Families. Parent clinician’s families were a common topic of discussion and four of the five clinicians talked about their families when asked about what personal contexts shaped their stories. Jessica talked about the lack of secure attachment she felt in her family as her father and mother were both absent for different reasons and as a result she was raised by her culturally “old-world” Oma and Opa (grandparents). Jessica also noted that her history of trauma also greatly influenced her story. Elizabeth, Rachel, and I also brought up our relationships with our mothers as having a significant impact on our transitions to parenthood. Elizabeth reported that her mother was “full of love” and yet “couldn’t cope” so as a result, her “difficulty managing stress, feeling secure, really had an impact on my siblings and I.” I also talked about how growing up with volatile parents left an impact and I did not want to repeat that with my own daughter. Rachel reported that her mother worked a busy schedule and as a result, Rachel had to take care of her

younger siblings “and I think I was pretty resentful of my mom about that.” As a result, she wanted to model being a working mother but did not want to work so much that she put her own son in a similar position. Allen did not name his family as a contextual influence on his story, but he talked extensively about his wife’s support and shared how his grandmother sat with him at his son’s bedside.

Identities. In addition to families, all of the parent clinicians reported that aspects of our identity influenced our transition to parenthood. My stay-at-home mother was a source of identity conflict for me as I struggled with comparing herself against my mother. Jessica talked about having to “code-switch” between her Oma and Opa’s traditional way of raising her and the mainstream culture where she was living in the United States. Elizabeth and Rachel also had identities as feminists as contextual background that influenced them. Elizabeth cited understanding that her feminism meant that she makes specific choices in raising a son. Rachel’s feminism meant that she actively is aiming for an equal partnership in her life so that she is not always the one to take time off work for parenting duties. Aspects of Allen’s identity influenced his story as well. He stated that “I’m from Wyoming and one thing that I tell myself [laughs] is that I’m just a little bit tougher...[both of us laugh] being from Wyoming.” He went on to link the concept of strength to “fatherhood” and noted that he combines the masculine and feminine aspects of himself. He reported that he incorporates strength from his rural upbringing and his tenderness from his psychological training to give the best for his children.

The personal contexts of parent clinicians were found in four of the studies cited

in the literature review; interestingly, the contexts mentioned were also family and identity. Basescu (1996) talked about how her psychotherapist father influenced her. The graduate student mothers in Lyndon's (2013) phenomenological dissertation also cited that their own mother's identity (maternal and professional) impacted their choices and some of the parent clinicians in Holm et al.'s (2015) study expressed that their mother's identity influenced their professional identities. Kibel (2002) looked to her identity as a Jewish mother for meaning.

What Do Parent Clinicians Do?

Personal contexts seemed to be catalysts for many of the intentional choices we made when becoming parents. Jessica's attachment and trauma history propelled her to seek psychotherapy and address her trauma; she said that she realized her own insecure attachment led her to make a change and she begin intentionally using attachment in her case conceptualizations with clients. She also learned to say "no" and limited her work with potentially additionally traumatizing clients such as when she said "no" to working with traumatized children or a mother whose baby died of Sudden Infant Death Syndrome (SIDS). Jessica added that once she realized her insecure attachment was leading to anxiety and subsuming her own needs, she sought out self-care activities. She added, "I think I forgot who I was in the mix for a while there." Elizabeth's experience of her own emotionally dysregulated mother led her to make radical changes in her schedule and work location. She wanted to "do everything in my power to take care of myself and set up a schedule and an environment and a career that helps me be healthy." Rachel also wanted to do things differently than her mother so she puts her child first, intentionally

seeks out practicum sites who will be flexible with her work schedule, and employs social support for help. Like Jessica, I also sought therapy to address my anxiety and emotional dysregulation and sought out activities that helped me embody the kind of mother I wanted to be like cooking for my daughter and taking her out in the stroller. Finally, Allen used his combination of strength and tenderness to weather his son's medical crises. While he was not explicit about using tenderness, he repeatedly spoke with tenderness about the support he felt from his wife. In addition, there are few more poignant and tender scenes than imagining him sitting with his grandmother soothing his son as he recovered from spinal surgery without pain medication: "I stayed with him during that time and just, we just kept touching him and just kept singing to him, just kept soothing him."

The parent clinicians in this study employed other strategies to process the transition to parenthood. Like parent clinicians in the literature review, Allen, Jessica, and Elizabeth stated that they used their knowledge of parenting to increase their alliance or conceptualization with clients. Elizabeth added that she slows down and "trusts" the process and stated "there's nothing fancy that I'm gonna say that's gonna take away the weight of someone's experience but there's something pretty important about being able to just sit and not be shocked and not be disturbed or judgy."

While all of the parent clinicians intentionally made changes that were influenced by our unique contexts, seeking support from others either through professional help or from family and friends emerged as perhaps the strongest theme throughout the interviews. Both in the therapy room and outside in their personal lives, parent clinicians

sought social support to help them during their transition.

Professional support. Clinicians in the literature review employed support through psychotherapy (Insko, 2008; Jalowiec, 2011; Robinson, 2012) and consultation (Jalowiec, 2011). In addition to Jessica's and my use of therapy, Allen also sought couples' therapy with his wife. Rachel described using group supervision to help her process some of the more difficult aspects of clinical work. Elizabeth is a licensed psychologist who is not in supervision but stated that she used her relationship with her "boss" similarly to receive support. Some parent clinicians in the literature also reported feeling support from their graduate programs (Holm et al. 2015; Insko, 2008; Lyndon, 2013), which was echoed by Rachel and me.

Support from family, friends, and peers. Parent clinicians in the literature also reported feeling support from spouses, family, and friends (Holm et al., 2015; Insko, 2008; Lyndon, 2013). As previously written, Allen and I described feeling lonely, and Jessica, Elizabeth, and I all lamented lacking family and friend support when becoming parents. In addition to noting the lack of social support parent clinicians felt, all of the parent clinicians described seeking and receiving support from others. Allen mentioned multiple times the support he felt from his wife including "I never felt lonely with my wife; I mean she was the one that was like totally understanding what we were going through together and it was like a huge, huge support, her for me." Later he added that "I'm really thankful for my wife, I give her a lot of credit, she's like, just amazingly strong." While not included in his re-storied narrative above, Allen reflected that one of his supervisors he had while in a practicum setting before he had his son was also a

parent. Allen stated that he wished that he could have been more supportive and understanding to that supervisor; he then added that it was not too late and might seek that previous supervisor out anyway.

Seeking and accepting social support was a central theme in Elizabeth's story as well. She reported that she traditionally had been an "insular" person but that "doesn't work when you're doing mental health and, like, in that space of raising a child."

Elizabeth had previously not made the time for relationships but was thankful that she had friends who would start conversations with her about new parenthood and named two recent experiences of friends who dropped by her house to help. She stated that her child was a "good prompt" for understanding that she needs to receive support from others.

Likewise, Rachel described being very deliberate about looking for support "from a lot of different places in a lot of different capacities" including supervisors, colleagues in graduate school, and family. My family was not nearby, but in my interview I told a story about how when I was under an academic deadline I traveled to my parent's house where my mother could help me parent.

Social support and stress-related growth. Having social support through a difficult time aligns with findings in studies on stress-related growth. In an early study validating a measure of stress-related growth, researchers found that religiousness, positive reinterpretation of the stressful event (looking for something positive in a situation), and social support satisfaction predicted the personal growth following stress (Park, Cohen, & Murch, 1996). A more recent review of multiple studies on stress-related growth cited variables that were associated with stress-related growth included cognitive

appraisal (how one appraises a situation), problem-focused coping, acceptance, positive reinterpretation, religiousness, optimism, positive affect, and cognitive processing (Park & Helgeson, 2006). These authors also noted emotional social support and social support satisfaction was associated with growth but wondered if social support was just a confound with satisfaction in general. Tedeschi and Calhoun (2004) suggested that growth happens through cognitive processing which is thinking, ruminating, and making sense of an event, and further posited that cognitive processing may be helped by use of support and disclosure to others. In re-reading the stress-related growth literature, I realized that as a parent clinician, *this study* was my attempt at reaching out for social support to help me process my experience! I decided to dig deeper into the interviews to see if I could find more demonstrations of seeking, giving, and receiving social support.

Social support in the study. In a chapter on narrative inquiry, Chase (2011) urges researchers to also look for the “small stories” in narrative inquiry. If the “big stories” are the significant narrative findings, then the small stories are the “small talk” about everyday life events that reflect the environment and process of telling a story. I looked back through the transcriptions to look for the small stories to see what they said about the relationships of narrator and audience. Looking for the “small stories” in the transcriptions made me realize that we were providing social support to one another in the process of the interviews. The interviews were casual conversations where each member of the conversation was able to agree, disagree, interrupt and laugh. Significant small stories or process comments fell into three rough categories: shared experiences and enthusiastic agreement and feeling like the other person “got it,” giving advice, and

explicit statements that the experience of interviewing was comfortable or useful for them.

As parent clinicians, we bonded over our shared experiences. We commiserated about technology problems, our children being sick and home from childcare, our children getting *us* sick, and our children and pets interrupting our interviews. There were many instances where it was clear that we truly understood one another. In an interview with Elizabeth, I said, “I’m more easily taken out which makes me frustrated as well” to which she replied, “Yes. Oh that’s so well put. Yes, exactly. Exactly.” Rachel and I talked about receiving support from our spouses and I said, “there’s tolerating, acceptance, and then there’s like actual support. And that really, that’s hit home for me for the last year” and Rachel replied, “yeah, that, that’s exactly. It’s like so, so accurate.”

These small stories where we “got” each other and connected also often centered around issues of support. I talked with two of the parent clinicians about how a temporary internship makes it difficult for my spouse to find a job. Elizabeth and I talked about how taxing pumping breastmilk at work is and she insightfully stated that she realized that she often missed out on collegial conversations with coworkers because she was locked in her office pumping. Rachel and I had a small story conversation when we both marveled about how we do not know how single parents survive without support from spouses, knowing how hard it was for us even though we are married.

I also looked closely at some of the most enthusiastic moments. A moment Jessica and I shared was also about social support or getting feedback, in this case negative, from others. We both felt that we got a “lot of crap” from other people for parenting choices

we had made, and we were talking about feeling judged from others when they found out that our infants slept in the bed with us. Jessica realized that she did not have to always feel interrogated by others.

Jessica: So when someone would ask I got to the point where I was like, “well why is it important?” Or I would be like “no they have a crib” and I’m like technically they have a crib they just never use it.

Amie: Technically it’s for laundry, so...

Jessica: Yeah no exactly! No it’s for laundry or it’s like overspill from the bed in case they rolled off, it’s there! [both laugh]”

It was a joyful relief to know that other parents did the same thing (sleep with their children) and also felt judged by others. Rachel works with parents and children as part of her clinical work and she talked about how she uses the interventions she learns with her own son and had been successful getting him to brush his teeth. I shared that I am not always able to use the best interventions.

Amie: I’m yelling and I’m like turning into my mother and like, “I know better!” So I’m impressed that you’re able to follow through with your own professional recommendations because I am not always able to do that.

Rachel: I’m not always able to do that! [laughs] when it’s five o’clock in the morning and he’s like kicking me because he’s awake and he’s like ready to play and like yeah I’m yelling at him like, [both laugh] you know. It’s not every time. It’s the one successful thing I’ve done! [laughs]

Rachel appeared composed and professional and it was a relief to me when she started laughing and we both admitted that even with the best of intentions, our parenting interventions don’t always work. Again, it was nice to feel less alone. Elizabeth and I shared many joyful moments as well, and we both laughed hard when talking about when we hear stories from our college-aged clients about how terrible their parents were, we

feel a little defensive on behalf of the parents. Through our laughter I squealed out, “they [the parents] are trying really hard!”

The parent clinicians gave each other advice during the interviews. Allen, whose oldest child is older than my daughter assured me that it is all “worth it” on the other side and I appreciated knowing that in the middle of it now. I in turn gave advice to Elizabeth whose son is younger than my daughter that a parent’s tiredness does improve as children sleep more. Rachel expressed worry about childcare when she goes on her internship, and I also tried to assure her that as children get older it gets easier as children enjoy daycare more.

Parent clinicians also made statements about how the process of being interviewed was positive for them. Allen stated that the study was:

a totally wonderful topic... the fact that you chose this as a topic is really just admirable to pick that out. That’s very cool. It’s something I’ve thought a lot about, privately, but it was really easy for me to reveal all this with you. So it felt very comfortable.

At the beginning of the second interview, Rachel said,

I didn’t know what it was going to be like or like some of the questions you asked um, but like I found myself over the past couple weeks like you know sort of reflecting on some of the things that you asked and um, you know thinking about some of those questions, um and so it was interesting for me. I enjoyed it.

Jessica was surprised about the depth that she shared in the first interview and that the interview was a realization of her growth:

Um, I thought I was just gonna kinda talk about my child and then I was like, “oh no! this like all complicated and messy!” and so I think that was the only takeaway that um, and then it was also how far I’ve come, I think, as a mom and a, and uh clinician and being at the end of my doc program I’m like “alright! I made it!”

Elizabeth echoed this sentiment and was more direct about the process of talking to me being important:

Elizabeth: Yeah! No it was it was really nice. I um, you know, I'm usually not on the speaking side of a discussion, usually I'm on the questioning side and I realized just how nice it is to just talk about yourself. It's, uh

Amie: So common factors really work!

Elizabeth: It's very therapeutic just to, just to like, share kind of what has been going on and that change 'cuz it's, yeah it was absolutely. Having my little guy has been a huge life-changing experience. I mean that's cliché but it's so true. Um, and so I loved talking about how that's been and what's been happening and you're a very easy person to talk to so that makes it, nice. You have a very nice, warm um, style so I feel very comfortable sharing all of that with you. So in the kind of following week it was just nice [because] thoughts just kept coming up and I was like "gosh, everybody needs to do this!" [laughs] just have questions asked of like "how has it impacted you and what's you know what effect has it had?"

These small stories suggest that like me, the process of participating in the interviews was a source of social support for the parent clinicians.

Absent social support. In a text about using narrative in social science research, Czarniawska (2004) urges researchers to "interrogate" texts by looking for silences or contradictions in an effort to find what a narrative may reveal about the cultures that storytellers inhabit. After I had interviewed the first two parent clinicians, Allen and Jessica, I began asking myself what was missing and began hypothesizing that social support was often missing. Allen relied on his wife but did not have institutional support and experienced worse than no support—he had an unsupportive supervisor. Jessica talked about having lackluster supervision, not having any family support, and initially poor childcare support. When I interviewed Elizabeth she echoed that she did not have family support but did have a supportive boss and workplace. Rachel did report having

good family support and good institutional support, however, she still felt insecure about her performance and heard the murmurings “you’d have to be crazy” to have a child in her program. I lacked family support and close friends; I had good institutional support in a good supervisor, but worried about the repercussions of parenthood. It is interesting that even with good institutional support, some parent clinicians still worried about the support they would get. Some parent clinicians in the literature also reported experiencing a lack of institutional support (Insko, 2008; Lyndon, 2013).

Family and institutional support was highly variable for the parent clinicians and very salient when it was present or absent. These places of failed support can be viewed in context of typical struggles of working parents in the modern world. Many people raise children without family or community support. It is certainly dangerous to romanticize parenting in previous eras when people may have more often lived closer to families or had smaller communities, particularly since psychologists know that not everyone has a supportive family of origin. However, there are benefits to having family or fictive kinship (kinship not based on genetics or marriage) as a source of constant and reliable support during monumental human events like births and deaths. I often talk to college-aged clients who are frequently distressed by social media about how the rate of developing technology has outpaced our human evolution to hear bad news. In the past few months as I’ve worked on this study, I have often wondered if our tendency to be on the move and disperse has outpaced our human need for a consistent community. Current parents are lucky that we can rely on technology to share videochats of our children with their grandparents, but we still miss the ability to have someone bring you a dinner, being

able to send your child down the street to be cared for at the last minute, and having support who will be with you even when things go poorly. Lack of support for parents in the workplace is a continual topic as politicians debate family leave policies, job-seekers negotiate accepting positions based on family-friendly policies like flexible hours, and everyone laments the high costs of childcare.

If family and institutional support are important for all parents, they are perhaps particularly salient for psychologists for a number of reasons. First, to be a psychologist one needs to attend graduate school, internship, and sometimes postdoctoral training and it is likely that one or more of these sites will be in a brand-new place away from previous family and community support. Many people enter graduate school training and take new jobs that require moves during their childbearing years when they need support. In addition, psychologists understand the principles contributing to mental health such as social support and self-care and understand aspects of human development like attachment. Knowing what we know, should psychology not be the most family-friendly field? Allen had a bad supervisor who increased his worry and Jessica had to negotiate to be late to a class. Rachel did feel support from the people at her school, and she still felt worried and was riddled with self-doubt. Parent clinicians in the literature also reported feeling either lack of support from their institutions or worry about lack of support. Parent clinicians in Lyndon's (2013) study on graduate students who became new parents while in school cited supportive mentors as beneficial, but some also noted that their programs were not supportive and felt a pressure to deny their parenthood. One parent clinician in Holm et al.'s (2015) reported feeling "relational aggression" (p. 12) from her

department. A few of Insko's (2008) parent clinicians stated that they felt it was "unacceptable" (p. 58) to talk about children at work especially to childfree coworkers.

I hypothesize that this fear of repercussions despite some support from individuals may come from the institutions of psychology and academia that can often feel cold and not family-friendly. Two authors and licensed psychologists both echoed this sentiment. Campling (1992) stated that she is dismayed at the tendency to blame parents when they struggle instead of blaming the culture in which they are embedded. She adds that society as whole and psychology in particular need to share how parenthood actually is not how a "hopeful child inside us would have wanted" (p. 75) and suggested forums for sharing what parenting is actually like. Kibel (2002) wrote that her paper was born out of her frustration that a mental health agency would not honor a clinician's request for more flexible hours, and questioned how can clinicians expect their clients to improve when psychologists are "being set up for a painful level of fragmentation?" (p. 80). Other authors agree. In the title of her book, Adams (2014) urged her readers to be wary of the "myth of the untroubled therapist" and stated that psychologists need to be models of personal growth to clients. White (1997) was not a parent clinician but wrote that psychologists are pressured to be neutral experts, which can isolate them from seeking external sources of support. In addition, psychologists are ethically required to protect client confidentiality so most of what we spend our days doing and hearing cannot even be share with our partners and families. Adams (2014) stated this as well which is why she calls for clinicians to have strong support within the field. Based on the stories from the literature and the parent clinicians in this study, being able to access social support

and feel secure about asking for it seems to be crucial for parent clinicians to navigate a difficult transition to parenthood.

Is There Meaning to Be Made?

The final research question was about if the parent clinicians made meaning or experienced growth of their challenges. The answer seems to be “yes.” Each parent clinician cited many benefits to becoming parents as we reflected on our transitions. Allen appreciated the increased depth he felt in his work with clients, appreciated both his wife and his flexible private practice that allowed him to parent the way he wanted to, and increased confidence as a parent. Jessica felt her experience was “corrective” and she was able to heal from her trauma and became “unapologetic” about her boundaries when she advocated for herself. Elizabeth reported that she had the confidence to change her career and advertise herself and felt in a powerful way what a blessing it is to ask for and receive help from others. Rachel felt more secure and confident in herself. I learned to manage my anxiety and extreme emotions and was proud of myself for finding my own identity as a mother instead of unfavorably comparing myself to others. Jessica was explicit that her growth was not just a byproduct of her becoming a parent, but becoming a parent was necessary for her personal growth:

It forces you, I think I felt forced to look at things I never would have, like I said – I would never [have] been forced to look at, if I didn’t have a child. And yeah, I think being a counselor’s one thing because you’re already in that mindset per se, but it’s easy to not go there, it’s easy to not challenge yourself or to grow.

I also indicated that the crisis of my transition to parenthood and doing this study was a catalyst for personal growth that I wanted to make.

Positive identity changes. When thinking over the changes each parent clinician made, themes that spanned multiple narratives appeared to be positive identity change and an increase in confidence about one's identity. This aligns with the hypothesis posited by Nelson et al.'s (2014) study on the mediators and moderators of parent well-being that having multiple social roles is associated with increased mental health and specifically that holding an additional social role as a parent may be advantageous. Three studies in the parent clinician literature also reported that changing identities was a result of new parenthood. Parent clinicians in one study appreciated adding a second identity when becoming parents (Deery, 1994). Parent clinicians in another study reported that their identities evolved when they became mothers (Holm et al., 2015). Parent clinicians in Insko's (2008) dissertation reported that their identities shifted toward their mother role. In thinking about each parent clinician, I chose one word that they themselves had used to describe how they changed their views of themselves. Allen appreciated himself, Jessica advocated for herself, Elizabeth advertised herself, Rachel became more secure in herself, and I grew to be proud of myself.

Cognitive processing as mechanism for growth. Researchers of stress-related growth hypothesize that a key active ingredient in stress-related growth is cognitive processing. Each parent clinician described using cognitive processing in some way in our stories. Allen talked about "reflecting" for a number of years on his upsetting supervisory relationship and wondering if it was something that he did to cause his supervisor to change supervision. He also stated that he went to couples counseling with his wife as they approached making a decision about another child. Jessica and I both

engaged in cognitive processing by engaging in our own therapy. Elizabeth described having conversations with her boss and connecting with friends who understood parenting while working as a clinician. Rachel and I both reported talking in supervision, and Rachel stated that she also talked to her family members. Finally, as previously suggested, it appears that the parent clinicians also used the interviews and thinking about the interview questions as a way they processed their transitions and made meaning out of their stories.

Amie: It's amazing how much having a child pushes us to stretch.

Elizabeth: Yeah. In many, many ways.

Amie: Yeah totally.

Elizabeth: Lots of stretched parts. [both laugh]

CHAPTER VI

IMPLICATIONS AND CONCLUSION

Implications

The findings of this study generate some recommendations for ways to improve parent clinician's transition to parenthood. These recommendations include providing practical support, dismantling the myths of an independent clinician, and a call for more research.

Recommendations for Increasing Social Support

Since social support was cited as important by the parent clinicians in this study and by many in the literature, it may be beneficial for the field of psychology to build more social support at all levels of training and practice. For psychologists in training and those unlicensed, structured supervision is available. Supervision can be helpful as it was for Rachel and I, but it requires a knowledgeable and sensitive supervisor who will demonstrate that bringing "home" into supervision is allowed. In even the best supervisory relationships, there still remains a power differential and evaluative component. Therefore, in addition to supervision, trainees would benefit from peer groups of other parent clinicians or other parents who are graduate students in other disciplines. The graduate students in Holm et al.'s (2015) study suggested creating more campus resources for graduate students who are parents. During the writing of this discussion section I received a survey from my doctoral institution looking to make

improvements for parents that included questions about the importance of lactation rooms (with fridges!), playgrounds, and study spaces for people who need to bring their children to campus. Some of Holm et al.'s parent clinicians even were active change agents on their campuses and started a parent support group.

Once parent clinicians are out of a training environment there is less of an opportunity for structured social support. Some parent clinicians will through luck land in agencies with supportive, like-minded colleagues, but others will not have supportive coworkers or will work in private practice. What kind of social support structure can be built in to all work sites? Psychologists must continue to seek continuing education credits (CE's) throughout their careers and it may be helpful to incorporate support groups that are required throughout one's career; support groups can meet through email listserves, social events, and talks at conferences.

In addition to increasing support at the group level, new parent clinicians need support on an individual basis as well. It is therefore recommended that more senior parent clinicians volunteer to provide mentorship to new parents. I urge potential mentors to volunteer because asking for mentorship can be exceedingly difficult. Many clinicians will become new parents at vulnerable times in their careers either in training or as early-career clinicians. These time points in the career of a psychologist are fraught with inherent job stress such as classes or comprehensive exams, applying for jobs, learning new policies at a new position, building a caseload, or seeking tenure. In addition to these stressors, trainees and early career clinicians frequently feel the pressure to "prove themselves" and asking for help may feel excessively anxiety-provoking. It can be

difficult to know who is a “safe” person or who provide advice and support without judgement or consequences. A parent clinician mentor is someone who has been through their own transition and can be an invaluable source of support. This support can be in the form of advice on how to avoid some pitfalls and for the pitfalls that cannot be avoided, someone to listen to them with a knowing and sympathetic ear. Further, it is necessary to not overlook new fathers. At times it may be more salient to recognize and support a new mother, but new fathers also experience stress in transitioning to parenthood, and may encounter unique challenges, such as coworkers who neglect noticing their new parenthood or who are not as understanding when they take time off.

Recommendations for Addressing the Culture of Psychology and Academia

In addition to providing instrumental help and building in social support, psychology as a field and academia should work to actively challenge the myths of untroubled therapist or the independent academic. Psychology and academia arose from traditional western philosophies and are entrenched in the cultural assumptions. Psychology as a field is traditionally individualist and far too often privileges individualism and even competitiveness over cooperation. In addition, psychology has long been patriarchal which results in prioritizing one’s work identity at the expense of other identities. If the field wants to start embracing other ways of being and other cultural norms, clinicians and faculty in senior positions should resist proudly telling their "horror stories" of how they had it so hard or came back from maternity and paternity leave too soon. Often these stories proliferate the myth that in order to achieve in

psychology or academia, developing clinicians must suffer and place their needs or the needs of their family second after their careers. In addition, the narrative is often whether or not new parenthood impacts a clinician's work. So often I hear new parents, such as Rachel, feel the need to justify their continued value at a position by stating that their new role as a parent will not impact their clinical work or diminish their research productivity. Of course it will! At least temporarily, and perhaps forever. That needs to be acceptable in psychology and academia. Elizabeth commented that she knows she is not doing her "top-tier work" and added, "And I don't know if I'll ever do that top-tier work again" and appeared to accept that possibility. As long as we as a discipline are focusing on what is "lost" when people have children we are failing to see what is gained or how parent clinicians refocus or deepen their work. Let us focus instead on what is added.

Clinicians and faculty are advised to use their stories, both negative and positive, to normalize the difficult transition and model adaptive behaviors. Clinicians and faculty frequently use the term "self-care" to urge clinicians to engage in activities to take care of themselves. Without instructions on how, examples, and time to take self-care, it often becomes another "to-do" item for new clinicians that then becomes another stressor. Self-care as a concept should be presented in coursework and trainings, research provided for its rationale, faculty should model good self-care, and provide time to practice it. Feminist therapist Brown (2016) points out that self-care is required to be an ethical therapist, but that the American Psychological Association (APA) does not spell it out in their code of ethics. She advocates that feminist supervisors therefore should support their supervisee's self-care by modeling it, talk about their own struggles with self-care,

and even going so far as to help their supervisees to schedule time off. Finally, agency directors and department heads may look at the messages that are subtly conveyed to parent clinicians in their policies and practices. Example questions for decision-makers in power include, are children visible? Where in the department or agency can children “hang-out” during a meeting? Are working hours, meeting hours, and social hours flexible and accommodating to parent’s schedules? I have overheard colleagues who were frustrated that work parties and social events often occur after-hours when parents feel like they are forced to chooses between work and their families or pay for (expensive) childcare.

Recommendation for More Research

More research is needed on clinician's lived experiences both in becoming a new parent and in other aspects of clinician’s lives (e.g., marriage, deaths, career transitions, etc.). More qualitative and quantitative research can serve as a guide for supervisors, site directors, and directors of clinical training as they look to provide support and interventions to clinicians through supervision and consultation. In addition, the findings from more research is necessary in developing training guidelines and workplace policies that support parent clinicians. Moreover, increased research will continue to provide social support to future parent clinicians as they see themselves and their experiences represented in the literature.

Limitations

Parent clinicians in this study identify as White, are in heterosexual marriages,

and share parenting responsibilities with their spouses. In addition, all parent clinician's children were healthy (after Allen's son's surgeries). It is easy to imagine that the findings of this study may be vastly different for clinicians with different life circumstances such as those who did not have co-parent support, or who had the additional stress of a chronically ill child. One of the five clinicians in this study was male, and of the 115 parent clinicians in the literature only three were male. In addition, there were very low numbers of parent clinicians in the literature who identified as non-White, single parents, LGBTQ, or who had adopted their children. Therefore, more research is needed studying the transition to parenthood for parents with diverse identities including men, gender diverse parent clinicians, parent clinicians of color, and parent clinicians who identify as lesbian, gay, bisexual, and queer. The concepts of cognitive processing and seeking and receiving social support are likely often experienced differently among different gender identities and cultures.

Conclusions

This narrative study aimed to present the lived experiences of five parent clinicians (the author was included) who became first-time parents while working as mental health clinicians. The study focused on the unique challenges and personal contexts of each clinician to investigate how each clinician navigated the challenge to make their transition a meaningful experience. Parent clinician's narratives were obtained using two semi-structured interviews.

The parent clinicians in this study reported using a number of methods to cope

with the stress of the transition, with using social support being a consistent theme. In addition, the parent clinicians described positive changes in their identities, and used varying methods of cognitive processing to make sense and assign meaning to their transition stories. The findings of the study align with hypotheses that people can grow as a result of stress by using cognitive processing.

This study contributes to the relatively small literature base on the lived experiences of clinicians. I hope that the findings from the study can be used to support parent clinicians by increasing the knowledge base for supervisors, colleagues, and policy-creators in power to make social support more available. Finally, I hope that the study will encourage "cognitive processing" and provide social support for the parent clinicians who read it.

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CURRICULUM VITAE

AMIE L. SMITH

Counseling and Psychological Services
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 206-718-3340

Education

- Ph.D. **Utah State University, Logan, Utah**
 2018 Combined Clinical/Counseling/School Psychology (APA
 Accredited)
 Dissertation: *The transition to parenthood when working as a
 mental health clinician: A narrative study.*
 Chair: Susan L. Crowley, Ph.D., ABPP
- M.S. **Utah State University, Logan, Utah**
 2014 Psychology
 Thesis: *Biopsychosocial variables predict compensation and
 medical costs of radiofrequency neurotomy in Utah workers’
 compensation patients.*
 Chair: M. Scott DeBerard, Ph.D.
- B.S. **Washington State University, Pullman, Washington**
 2010 Psychology
 Summa cum Laude
- B.A. **University of Washington, Seattle, Washington**
 1999 English
 Cum Laude

Clinical Experience

- 07/18 – Present **Faculty Psychology Resident**
 Cougar Health Services
 Washington State University, Pullman, WA
- Provide approximately 26 hours per week of direct service to university students; services include providing brief, focused individual therapy to clients of diverse backgrounds with a

range of presenting concerns (e.g., mood disorders, anxiety, significant suicidality, PTSD and trauma, adjustment concerns, gender dysphoria, interpersonal distress, substance abuse), conducting intake sessions, crisis intervention services, facilitating process groups and workshops, and providing mandated substance abuse counseling sessions

- Provide outreach presentations to groups on campus
- Serve as a liaison to Multicultural Student Services
- Receive two hours per week of individual supervision
- Attended weekly staff meetings, case management staff meetings, and occasional continuing education trainings

Supervisor: Nikki Stypa, Psy.D.

07/17 – 06/18

Doctoral Psychology Intern

Counseling and Psychological Services

Washington State University, Pullman, WA

- Provided approximately 10 hours per week of brief, focused individual therapy to clients of diverse backgrounds with a range of presenting concerns (e.g., mood disorders, anxiety, significant suicidality, PTSD and trauma, adjustment concerns, gender dysphoria, interpersonal distress, substance abuse)
- Conducted intake sessions including assessing for risk of harm to self and others
- Provided crisis intervention services during business hours, after-hours, and on weekends, including short-term interventions with students admitted to the hospital for alcohol intoxication
- Co-facilitated one process group and 2-3 skills-based workshops per semester
- Supervised first-year doctoral students in their intake sessions and workshops
- Provided outreach presentations to groups on campus
- Administered and interpreted assessments for students presenting with ADHD and/or learning disorder concerns
- Served as a liaison to Multicultural Student Services - spent three hours per week holding drop-in hours to meet with students, provided outreach services in student centers, co-taught mentorship class
- Received two hours per week of individual supervision, one hour per week each of group supervision and supervision of supervision, and biweekly group supervision of group counseling and assessment supervision; received continued didactic training on specialty clinical topics and professional development; attended staff meetings

Supervisors: Jane Barga, Ph.D, Michele Larrow, Ph.D., Nikki Stypa, Psy.D.

- 05/16 – 09/16 **Graduate Student Therapist,**
 Student Health and Wellness, Utah State University, Logan, UT
 Utah State University Psychology Community Clinic, Logan, UT
 Provide brief individual psychotherapy and assessment, consult with primary care providers while working within an integrated health services model.
 Supervisor: Scott DeBerard, Ph.D.
- 08/15 – 05/16 **Graduate Student Therapist,**
 Practicum in Clinical Child Psychology
 Center for Persons with Disabilities, Logan, UT
 Provided comprehensive psychological assessment services as a member of a multidisciplinary team. Duties included intake assessments, administering cognitive and achievement assessments (WAIS-IV, WISC-V, WPPSI-IV, KTEA-II, WJ-IV), writing integrative reports, providing feedback to clients, and school observations.
 Supervisor: Martin Toohill, Ph.D.
- 08/14 – 05/15 **Graduate Assistant Therapist**
 Counseling and Psychological Services, Utah State University, Logan, UT
 Provided psychotherapy services to a college population including intake assessments, individual therapy, group therapy, and campus outreach programming. Interventions included cognitive-behavioral therapy, dialectical behavior therapy, existential and humanistic therapy. Supervised undergraduate peer counselor who taught skills (e.g., mindfulness, anxiety management, etc.) to clients. Attended weekly case staffing meetings.
 Supervisors: Amy Kleiner, Ph.D.; Eri Suzuki Bentley, Ph.D.
- 06/13 – 07/14 **Graduate Student Therapist**
 Utah State University Psychology Community Clinic, Logan, UT
 Provided long-term schema therapy to two adult clients
 Supervisor: Susan L. Crowley, Ph.D., ABPP
- 08/13 – 05/14 **Graduate Student Therapist**
 Practicum in Clinical/Counseling Psychology
 Counseling and Psychological Services, Utah State University
 Logan, UT

Provided psychotherapy to a college population (including undergraduate and graduate level students). These services included conducting intake assessments, individual therapy, group therapy, and outreach presentations. Other activities included long-term treatment planning, case conceptualization, and didactic training. Types of interventions included cognitive-behavioral therapy, acceptance and commitment therapy, and interpersonal psychotherapy.

Supervisors: Steven Lucero, Ph.D.; LuAnn Helms, Ph.D.

08/12 – 05/13

Graduate Student Therapist

Integrative Practicum with Adults, Adolescents, and Children
Utah State University Psychology Community Clinic Logan, UT
Provided community-based psychotherapy services to adults, adolescents and children. Services included providing intake assessments, individual psychotherapy, psychoeducation, and LD and ADHD evaluations. Other activities included treatment planning and clinical case presentations. Types of interventions included cognitive-behavioral therapy, behavioral parent training, and schema therapy.

Supervisors: Susan L. Crowley, Ph.D., ABPP; Gretchen Gimpel Peacock, Ph.D.; Kyle Hancock, Ph.D.

Group Therapy and Workshop Experience

01/18 – 05/18

Understanding Self and Others for Graduate Students
Washington State University
Pullman, WA

08/17 – 05/18

Navigating Distress: an ACT skills workshop
Washington State University
Pullman, WA

08/17 – 05/18

Mood Management: a DBT skills workshop
Washington State University
Pullman, WA

10/17 – 11/17

CBT for Anxiety
Washington State University
Pullman, WA

09/14 – 05/15

Understanding Self and Others
Utah State University
Logan, UT

01/15 – 05/15 DBT Skills Group
Utah State University
Logan, UT

01/14 – 05/14 Understanding Self and Others
Utah State University
Logan, UT

Research Experience

06/12 – 09/12 **Research Assistant**
Cache County Study on Memory, Health, and Aging, Logan, UT
Administered brief personality assessments over the phone to caregivers who had or were in the process of caring for someone with dementia. Entered tracking information into study database and performed some filing duties in support of the project.
Supervisor: JoAnn Tschanz, Ph.D.

08/11 – 07/12 **Research Assistant**
Center for Persons with Disabilities, Research and Evaluation, Logan, UT
Performed literature reviews and wrote summaries for senior researchers, tabulated survey results, data entry.
Supervisor: Mark Innocenti, Ph.D.

01/10 – 06/11 **Undergraduate Research Assistant**
Washington State University, Pullman, WA
Assisted with coding and data entry for studies evaluating smart technology to assist adults with mild cognitive aging and dementia. Tasks included coding data into SPSS, coding qualitative data, training other students, and attending lab meetings.
Supervisor: Maureen Schmitter-Edgecombe, Ph.D.

08/09 – 05/10 **Undergraduate Research Assistant**
Washington State University, Pullman, WA
Data collection and for studies on visual attention, action and perception. Duties included guiding participants through experiment protocol and debriefing them, assisting with statistical analysis using Statistica, programming experiments in E-Prime, and attending weekly lab meetings.
Supervisor: Lisa Fournier, Ph.D.

Publications

Smith, A.L. & DeBerard, M.S. (submitted for publication). Presurgical biopsychosocial variables predict compensation and medical costs of radiofrequency neurotomy in Utah workers' compensation patients. *Journal of Occupational and Environmental Medicine*.

Wheeler, A.J., **Smith, A.L.**, Gundy, J.M., Sautter, T., & DeBerard, M.S. (2013). Predicting back pain treatment outcomes among workers' compensation patients: Important information for clinical neuropsychologists. *The Clinical Neuropsychologist*, 27(1), 49-59.

Presentations

Smith, A. (May, 2015). *The impact of existential beliefs on clinicians' sense of hopelessness*. Paper presented at the annual meeting of the Congress of Qualitative Inquiry, Urbana-Champaign, Illinois.

Pratt, K.M., DeBerard, M.S., Julka, D., & **Smith, A.** (April, 2013). *Predicting complementary and alternative medicine (CAM) use in college students using the socio-behavioral model of healthcare utilization*. Poster presented at the annual meeting of the Society of Behavioral Medicine, San Francisco, California.

Christensen, T., Wheeler, A.J., DeBerard, M.S., **Smith, A.**, & Richards, S. (April, 2012). *Using presurgical variables to predict compensation and medical costs of radiofrequency neurotomy patients receiving workers' compensation*. Poster presented at the annual meeting of the Society of Behavioral Medicine, New Orleans, Louisiana.

Seelye, A., **Smith, A.**, Schmitter-Edgecombe, M., & Cook, D. (October, 2010). *Cueing technologies for assisting persons with mild cognitive impairment in instrumental activity of daily living completion in an experimenter-assisted smart apartment environment*. Poster presented at the annual meeting of the National Academy of Neuropsychology, Vancouver, Canada.

Selection of Outreach and Workshops Presented

- | | |
|---------------|--|
| 10/17 – 11/17 | <p>Working with undocumented students
 Washington State University, Pullman, WA
 Developed and co-led two 90-minute trainings on the issues pertinent to working with undocumented students</p> |
| 09/17 – 12/17 | <p>Multicultural Student Services
 Washington State University, Pullman, WA</p> |

Co-led hour-long presentations to undergraduates in their student centers on topics including stress management, self-care, depression and anxiety, how to seek services on campus

08/17

“Booze, Sex, Reality Check”

Washington State University, Pullman, WA

Co-led presentations to incoming freshmen students providing psychoeducation on alcohol and marijuana use, and sexual decision-making

08/17

Stress Management

Washington State University, Pullman, WA

Co-led presentation on stress management and mindfulness during the transition to college for underrepresented freshman students intending to major in STEM disciplines

04/15, 03/15

Stress Management and Wellness Presentation

Counseling and Psychological Services, Logan, UT

Led 90-minute presentation on coping with stress in college and co-led a second. Presentation included didactic training, group discussion, and in-session mindfulness activities

10/14

Coping with Anxiety Workshop

Counseling and Psychological Services, Logan, UT

An all-day workshop designed to provide psychoeducation about anxiety for the university body. Screened college students for anxiety and provided information on treatment and services at the counseling center

12/13

Stress Management Presentation

Counseling and Psychological Services, Logan, UT

Co-led two-hour group presentation to dormitory population on stress management as requested by Housing Services to Counseling and Psychological Services

10/13

Suicide Attempt Debrief

Counseling and Psychological Services, Logan, UT

Co-led two-hour group discussion and debrief to dormitory students who had experienced a fellow resident's suicide attempt. Housing Services requested presentation to Counseling and Psychological Services

Teaching Experience

- 01/18 – 05/18 **Instructor**
 UNIV 497: Multicultural Student Mentor Class
 Washington State University, Pullman, WA
 Lead class discussions to encourage prospective student mentors to engage with material, grade assignments
- 08/15 – 05/16 **Instructor**
 Psychology 5200: Introduction to Counseling and Interviewing
 Utah State University, Logan, UT
 Two semesters; online course
 Created course including selecting readings, developing assignments, and writing quizzes; participating in online discussions to encourage student involvement; grading quizzes and papers
- 05/15 – 08/15,
 01/13 – 05/14 **Teaching Assistant**
 Psychology 1010: General Psychology
 Utah State University, Logan, UT
 Six semesters; on-campus and online sections
 Graded homework, led student lab sections
- 05/14 – 06/14 **Instructor**
 Psychology 1010: General Psychology
 Utah State University, Logan, UT
 One semester; on-campus class
 Created course including writing and delivering lectures; developing written assignments and exams; grading
- 08/13 – 05/14 **Teaching Assistant**
 Psychology 3500: Research Methods
 Utah State University, Logan, UT
 Two semesters; on-campus class
 Graded student research papers and exams; guest lectured on ethics in research
- 01/13 – 05/13 **Teaching Assistant**
 Psychology 3110: Health Psychology
 One semester; on-campus class
 Utah State University, Logan, UT
 Graded student homework and exams; guest lectured on health behaviors and pain

- 08/12 – 12/12 **Teaching Assistant**
 Psychology 6330: Tests and Measurement
 Utah State University, Logan, UT
 One semester; on-campus class
 Graded homework and held regular office hours
- 08/12 – 12/12 **Teaching Assistant**
 Psychology 6310: Intellectual Assessment
 Utah State University, Logan, UT
 One semester; on-campus class
 Graded WAIS-IV and WISC-III protocols and video
 administrations to ensure graduate students were certified for
 administration, led weekly laboratory sessions

Selection of Specialty Trainings Attended

- 09/17 – 05/18 **Courageous Conversations:**
 Monthly discussions on diversity topics
 Jeanne Schmidt, Program Coordinator of Office of Diversity
 Education
 Washington State University, Pullman, WA
- 01/18 **Care of Gender Diverse Individuals**
 Stephanie Fosback, MD and Leslie Robison, PhD
 Washington State University, Pullman, WA
- 07/17 **Safe Zone (LGBTQ) Training**
 Matthew Jefferies, Director of GEISORC
 Washington State University, Pullman, WA
- 05/15 – 06/15 **Feminist Multicultural Counseling; Safe Zone Training**
 Kristy Bartley, Ph.D.
 University of Utah, Salt Lake City, UT
- 04/15 **Mindfulness: Tailoring the Practice to the Person**
 Ronald Siegel, Psy.D.
 Utah State University CAPS Annual Conference, Logan, UT
- 04/14 **Understanding and Treatment of Psychological Trauma –
 “Trauma and the Brain”**
 Bessel van der Kolk, Ph.D.
 Utah State University CAPS Annual Conference, Logan, UT

09/12 **Introduction to Acceptance and Commitment Therapy**
 Michael P. Twohig, Ph.D.
 Utah State University, Logan, UT

Professional Service

05/13 – 05/14 **Combined Program Student Representative**
 Utah State University, Logan, UT
 Elected by my peers as one of two student representatives to liaise between students and faculty in the Combined Clinical/Counseling/School program. Attended faculty meetings, co-ran monthly student meetings, worked with students to address their concerns, organized academic and social functions for the department

Other Work Experiences

05/16 – 06/17 **Graduate Assistant to the Director of Clinical Training**
 Utah State University, Logan, UT
 Provide administrative assistance to the Director of Clinical Training (DCT) and Associate Director of Clinical Training. Duties include creating website for the Combined PhD program, compiling and reporting data for the program self-study and end-of-year program statistics.
 Supervisors: Susan L. Crowley, Ph.D., ABPP ; JoAnn Tschanz, Ph.D.

05/08 – 06/11 **Housing Program Coordinator**
 Community Action Center, Pullman, WA
 Ran federally-funded Housing Choice Voucher Program (formerly Section 8) at social service agency. Relevant duties included working with low-income individuals and families to determine their eligibility, help them apply, and ongoing case management. Reported detailed data to the federal government and maintained extensive paperwork.

10/06 – 02/08 **Project Manager**
 Plexapixel, Seattle, WA
 Managed multiple projects for a design and animation studio including schedules, budgets, client relations. Supervised designers and computer developers.

07/04 – 10/06 **Administrative Assistant**
 Glumac, Seattle, WA

Completed daily and monthly accounting tasks, wrote and edited marketing proposals.

11/00 – 08/03

Program Editor

Headsprout, Seattle, WA

Managed creation of animated reading games, drafted and edited all text for instructional design department including scripts, technical documents, customer correspondence and stories for children

2004; 2005

Camp Counselor

Muscular Dystrophy Association

Worked as camp counselor for week-long camp for children with Muscular Dystrophy. Activities included helping child with activities of daily living (toileting, dressing, eating) and assisting with camp recreation activities.

Awards and Honors

2015, 2012 Department Travel Award, Utah State University, Logan, UT