Portfolio Volume 1: Major Research Project

Navigating Mental Health Difficulties as a Parent-Trainee on the Clinical Psychology Doctorate Programme

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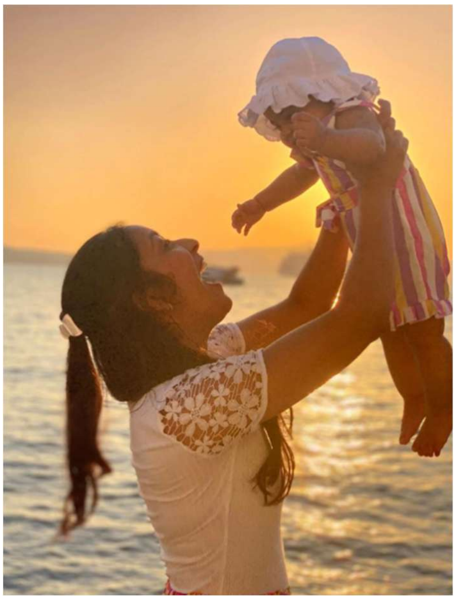
I dedicate this thesis especially to you.



"My daughter has changed me in a way that I could never have planned for, and I could have never envisioned without having a child. And it is not easy to put it in words, but I know that the person I was before was great, but something about having her has made me feel like I'm now exceptional and I've still got so much more room to grow. She has just done something that's made me evolve in a way that I really love who I am."

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Abstract

Background

It is not uncommon for individuals with Lived Experiences of Mental Health Difficulties (LEMHDs) to follow career paths which align with the psychology and mental health profession (APA, 2010; BPS, 2020; Hinshaw, 2008). Existing research indicates that parents in higher education simultaneously juggle the responsibilities of parenting and academic demands, which has detrimental effects on their mental health (Evans, 2024).

This empirical research explored the experiences of parent-trainees with LEMHDs who were enrolled on Clinical Psychology Doctoral programmes (DClinPsy) in the UK. The research aimed to understand how parent-trainees navigate mental health and how they interpret impact and challenges. It aimed to explore how personal and professional demands are balanced and prioritised, and how parent-trainees manage self-care and their mental health.

Method

Semi-structured interviews were conducted with eight Trainee Clinical Psychologists (TCPs) parents enrolled on DClinPsy programmes. Eligibility criteria consisted of participants having legal responsibility for a child or children less than 18 years old, with past or current mental health difficulties. Recruitment was through purposive and snowballing methods. Interviews were analysed using Interpretative Phenomenological Analysis (IPA).

Results

Four main themes were identified along with their respective subthemes. Findings highlighted significant challenges for parent-trainees with being able to navigate mental health whilst engaged with the programme. Both personal and systemic barriers perpetuated distress, resulting in parent-trainees questioning their competencies and ability to balance the demands and responsibilities within their respective roles.

Implications and Conclusion

Findings are presented with the wider literature and research question in mind. There are implications at a systemic and individual level for how parent-trainees with LEMHDs are supported to engage with training. Recommendations for improvements include flexible working, therapeutic support and peer communities, to support current parent-trainees presenting with LEMHDs.

Keywords: *Mental health difficulties, DClinPsy, Parents, Trainee Clinical Psychologists*

Chapter 1: Introduction

Chapter overview

This empirical research used Interpretative Phenomenological Analysis (IPA) to explore how parent-trainees with Lived Experiences of Mental Health Difficulties (LEMHDs) navigated mental health difficulties whilst enrolled on UK Doctorate in Clinical Psychology programmes (DClinPsy)[1]. It explored how participants made sense of their experiences within academic and placement contexts, and the impact that mental health had on wellbeing, their engagement with DClinPsy training and their family life. Recommendations are provided for how parent-trainees with LEMHDS can be supported in clinical training.

The following introductory chapter will situate the research within a personal context whilst reflecting on my relationship with the research, and how my epistemological stance has underpinned my work. Definitions and descriptions of the key terms will be presented, followed by a conclusion including my rationale and aims for my empirical research.

Relationship with the Research Project

Personal significance

In 2021, I reached top five positions on reserved lists for two DClinPsy training programmes. My application was not successful that year, which in hindsight was a blessing as I was expecting my first child, a daughter, born later that year. Having been in the practice of applying for training over several years, I re-submitted my application and participated in pre-selection tests when my daughter was three months old. To my surprise I was offered interviews, but I could not prepare in the same ways as before – after all, I was too busy enjoying my newborn baby, exploring my new identity and adjusting to my new role as a mother.

I was grateful to be offered a place at the University of Hertfordshire, and despite conflicting thoughts about whether to defer or not, I accepted my place and started training in September 2022. My decision was influenced by my wish to improve my daughter’s life, and I was very aware of the upcoming challenges the next three years would hold for me and my

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[1] Doctorate in Clinical Psychology Programme (DClinPsy): interchangeable terms have been used throughout this research; terms include referring to the DClinPsy as training, course, programme and doctorate

family. My transition included selling our first family home, relocating far away from family and friends (thus, reducing our social connections and support), and reluctantly putting my daughter into nursery fulltime so that I could engage with training. Through noticing personal difference to my peers and feeling isolated, I connected with other parent-trainees via social media. It became apparent that like me, parent-trainees were struggling to engage with training (namely the academic and placement demands), particularly those with LEMHDs, and more so than Trainee Clinical Psychologists (TCPs) without children. Sadly, these conversations became focused around mental health worsening and how aspects of DClinPsy training were negatively impacting family relationships/life and parenting abilities. Whilst discussions enabled comfort through shared experiences, anger and frustration persisted for many of us, even when psychological, occupational and institutional support was offered. Consistent change did not appear to be possible when the difficulties were perceived as situational and contextual rather than located with the parent-trainee specifically. This incongruence inspired me to conduct my research in the hope that shining a light on the experiences and challenges for parent-trainees with LEMHDs will lead to positive change and equity in clinical training.

Epistemological position and philosophical approaches

Epistemology explores the question, what is knowledge and how it is obtained? It considers what knowledge is privileged over others (Scheurich & Young, 1997). It is crucial to consider how we arrive at knowledge, particularly in research, because of how the interpretations of data are formed. To explore individuals' experiences of navigating mental health as parent-trainees, a critical realist epistemological lens was chosen for my research.

Critical realism combines two philosophical approaches; Ontological realism, which premises that reality exists outside of human perception, and epistemological relativism, that knowledge about reality is formed and influenced by social and historical contexts (Pilgrim, 2020). Critical realism can be considered as the relationship between reality and how reality has been interpreted through individual perspectives based on social, historical and cultural factors (Losch, 2009). This is different to that of a positivist approach which looks at objective truths and the idea that there is one true reality, where knowledge about reality originates from observable data (Danermark et al., 2002). Knowledge through a critical realism lens can undergo changes and revisions through interpretative processes, and it is constantly changing and never absolute due to the evolving historical and cultural experiences by which it is formed (Fletcher, 2017). The critical realism approach acknowledges that reality exists (e.g., mental health), even if people interpret and experience it differently.

An alternative epistemological lens considered for my research was the social constructionist approach. Social constructionism considers how reality is shaped by social and cultural factors, and influenced by language, communication and shared meanings (Burr, 2015). Ones idea of a reality is constructed rather than discovered through social interactions and language (Schwandt, 2003); knowledge is constantly changing. There is no single truth or an idea of objective knowledge, rather there are subjective perspectives of truth and knowledge which are dependent on time, historical, linguistic and cultural contexts. Thus, the acquisition of knowledge is dynamic. The critical realist approach has been chosen over the social constructionist approach for its ability to explore how social structures affect parent-trainees mental health, and not just how they are spoken about. This approach allows for an exploration into participant's experience and an understanding of how they have made sense of their reality as well as the structures that have contributed to their experience. The critical realist approach aligns with an Interpretative Phenomenological Analysis (IPA) framework, as it helps to explore *why* and not just *how* things are described, whilst considering the deeper meanings of these interpretations.

Harper (2011) states that phenomenologists explore experiences from the perspective of participants and that the researcher is required to focus on understanding and interpreting the deeper meaning of these experiences. Through analysing emotions and cognitions, phenomenologists can seek to comprehend how individuals have made sense of their experiences, and what they understand and consider to be true, subsequently informing others about participant's version of events. It identifies the researcher's role in shaping participants' experiences, bringing their own assumptions, biases and values when interpreting data. Considering my empirical research, participants are invited to share and form meanings of their mental health experiences. The critical realist epistemological lens will allow for the interpretation of individual experiences giving "rise to a new, refreshed, or richer meaning of the phenomenon" (Moon & Blackman, 2014). The experiences of parent-trainees with LEMHDs are subjective in nature and interpretations are considered with a participant's social and cultural context in mind (Larkin et al., 2006). Critical realism is an appropriate approach for my research which used the IPA framework to generate new knowledge.

Self-Reflexivity

Reflexivity requires an interrogation of assumptions, and self-monitoring of biases and experiences as a researcher, influencing the design and implementation of the empirical study (Lazard & McAvoy, 2017). Self-reflexivity informs the analysis and helps to critically engage with the findings of a study. This requires the researcher to demonstrate transparency and authenticity. To begin this process, I will describe my background, motivation for this research topic and my personal biases.

I bring to this research the lens of being a working-class, cis-gendered female. I identify as British Mauritian, a second-generation immigrant whose parents immigrated from Mauritius to the UK, and who worked within the field of mental health both as psychiatric nurses. Within the family home and in social gatherings, conversations surrounding the topic of mental health were not uncommon given the nature of my parent's work. My interest in mental health evolved and I chose to pursue a career as a Clinical Psychologist (CP). Along the way I encountered mental health challenges and sought psychological support. When applying for the DClinPsy programme I became a mother, and I started training when my daughter was eight months old. I juggled the clinical and academic demands of training as well as the demands of parenting to the best of my ability, and with the support of my husband. But very quickly I recognised symptoms of distress exacerbated by inflexible academic structures, which prevented me from reaching my full potential as a TCP. This narrative became uncomfortably familiar through my conversations with others, who also occupied dual roles as parents and trainees. I was directed to information about LEMHDs for trainees, but I noticed that there was no information about the LEMHDs for individuals who hold both intersectional identities. I felt inspired to give a voice to this underrepresented group of trainees, using my research to bring awareness and explore the meaning of these difficulties. I hope that my research creates positive change towards supporting parent-trainees with LEMHDs along their DClinPsy journey.

An insider/outsider researcher

An insider-researcher can be defined as a researcher who identifies with the group being studied (Greene, 2014). As a TCP, a parent and an individual with LEMHDs, I adopted the role of an insider-researcher sharing similar characteristics with my participants (Dwyer & Buckle, 2009). I have experienced challenges related to aspects of DClinPsy training, which has had a negative impact on my wellbeing. I acknowledge that my intersectional identity and experience will have influenced my relationship with the research, my relationship with the participants and my interpretations. Undoubtedly, my positionality will have had an influence in shaping the research which I will now discuss.

Building rapport is essential in qualitative research and has evidence for yielding rich data (Wilde, 1992), crucial for enabling difficult discussions around mental health and parenting. It may be that participants felt more able to voice challenges or concerns with myself as the researcher, perceiving me as holding the same or shared experiences and characteristics (i.e., a parent-trainee with LEMHDs) (Bhopal, 2001). Some participants may have shared their experiences for the first time, and as I might be independent from the participant's affiliated course, there may have been an increased level of trust for participants to share experiences, allowing for an authentic and unfiltered discussion within the confines of ethical research and without the fear of repercussions. Ongoing reflection and discussions with my supervisory team and in IPA research methods workshops allowed me to explore participants' experiences whilst ensuring that I met ethical protocols and standards for any difficulties.

Insider/outsider status can shift and vary amongst participants (Wilkinson & Kitzinger, 2013). As a British Mauritian, I recognise that I may be considered an outsider to other participants; I may have had a different educational background and there may have been cultural differences with raising children that I was not aware of, which could have created biases/assumptions in my interpretations. Discussing the topic of cultural difference is beyond the scope of my thesis, however, I will demonstrate self-awareness and allow a space for humility and learning (Dwyer & Buckle, 2009). Through regular discussions with my supervisory team, I acknowledged my own biases and limitations, whilst being honest about my perspectives and how they influenced my research decisions. For humility, I prioritised the participant's voice, amplifying the meaning of their experiences using direct quotes throughout my analysis.

Some participants may have felt distress and judgment upon seeing a researcher who bears similarity and who appeared able to engage with aspects of the course in ways that they may not have been able to (Chavez, 2008). Given the shared role as TCPs, the participant may have felt some discomfort with sharing mental health challenges, particularly if the challenges related to individual risks or safeguarding. These barriers could have restricted what the participants felt able to share. Being an insider-researcher may have drawn me into participants' experiences emotionally, and I likely felt varied levels of empathy or distress during interviews (Ochieng, 2010). This, along with the power I hold as a researcher, likely affected how I asked questions, what I was drawn to and how I analysed data and developed themes (Råheim et al., 2016). For example, my own experience of guilt, may have led me to resonate with and recognise participant's guilt more readily in my empirical study. To mitigate these biases and ensure reflexivity, I maintained a reflexive research diary and created entries documenting my research journey (examples of these excepts can be found in Appendix A with their corresponding excerpt details) enhancing transparency and credibility in the research process (Lazard & McAvoy, 2017). This was an integral part of recording changes and providing my rationale for decisions. A critical reflection style considered how my personal lens and experiences influenced the research whilst reflecting on the ethical impact on participants and my work (Berger, 2015). This method documented my evolving thoughts and emotions, and my positionality which shaped the study. It enabled me to consider alternative perspectives, facilitate problem-solving, seek guidance, and challenge my assumptions, biases and interpretations, reducing the impact of bias on data interpretation whilst enhancing credibility (Willig, 2013).

I have drawn upon this research topic for its personal resonance, seeking validation and understanding of my own challenges throughout clinical training. My research has been a process of healing and experiencing difficult feelings, all whilst continuing to develop my identity and sense of self as a psychologist. Some of the findings contradicted my experience leading to feelings of discomfort, which I navigated through discussions with my supervisory team, having open conversations with my support network and practising self-care.

Language and terminology

For this research, relevant terminology and key phrases are defined in Table 1 in line with my critical realist epistemological stance demonstrates the existence of a reality, even if people interpret it differently.

Table 1: Terminology and key phrases for empirical study

Phrase	Description of phrase
Mental health And/ or Mental health difficulty/ difficulties And / or Mental health challenges And/ or Mental health distress	According to the World Health Organisation (2003), mental health is a state of wellbeing; individuals recognise their ability and can cope with the normal stresses of life. They can work productively and fruitfully and contribute to their communities. For this study, participants do not require a formal diagnosis of a mental health difficulty by a medical professional. Instead, the difficulties are perceived as burdening, and significantly interfere with the participant's life, emotionally, socially and vocationally. The World Health Organisation (2003) defines a mental health problem as a behavioural or psychological disturbance which is of clinical significance. It is accompanied by distress, and/or a raised risk of death or an important loss of freedom. Mental health difficulties involve an unexpected cultural response to any situation. Examples of mental health difficulties include depression, anxiety, eating disorders, Post-Traumatic Stress Disorder (PTSD), Borderline Personality Disorder (BPD), Schizophrenia, substance misuse disorder, Autism and Attention Deficit/Hyperactivity Disorder (ADHD). *I have chosen to define these terms in a standardised way to allow for a clear understanding of what constitutes as a mental health difficulty. The use of these terms is support as they have been recognised in wider literature.*
Lived Experience of Mental Health Difficulties (LEMHDs)	An individual who has experienced mental health difficulties in the past and/or an individual who is currently experiencing difficulties with their mental health (Haywood et al., 2023). *I have chosen to use this term as it is a recent and well-known term in literature to identify anyone who has or has had a mental health difficulty.*
Parent/parents, including stepparents and guardians	Usually, an individual who adopts the role of mother and/or father of a child or children. This includes biological and adoptive parent(s) and parent(s) with legal rights responsible for a child or children. *This term is a widely used and known construct to describe someone who has responsibility for a child.*
Doctorate in Clinical Psychology (DClinPsy)	A professional doctorate in the UK which prepares one to practice as a Clinical Psychologist. Completing this training programme allows one to apply for Health and Care Professions Council (HCPC) registration. *This term has been used as it is a recognised term used to describe the DClinPsy training programme. Interchangeable terms have been used throughout this research; these include referring to the DClinPsy as training, course, programme and doctorate.*

Trainee Clinical Psychologists (TCPs)	An individual who is actively pursuing a career as a qualified Clinical Psychologist. They are undergoing doctoral level training at a university (usually lasting three years, full-time), gaining the necessary clinical, research and academic skills required to qualify. TCPs are working towards professional registration with the Health and Care Professions Council (HCPC) to practice as a qualified Clinical Psychologist. *This term has been used as it is the only term used to describe someone who is in the process of completing the DClinPsy training programme.*
Clinical Psychologists (CPs)	An individual who has completed the DClinPsy training programme, which is accredited by the British Psychological Society (BPS). Clinical Psychologists can assess and provide evidence-based psychological interventions to support individuals presenting with a range of mental health difficulties. *This term has been used because a Clinical Psychologist is a protected title in the UK; it allows for clarity and understanding of a particular construct.* *Interchangeable terms include referring to the Clinical Psychologists as, Psychologists, Practitioner Psychologists and qualified Psychologists.*
Student-parent(s)	This term describes an individual who adopts the role of mother and/or father of a child or children (including biological and adoptive parent(s) and parent(s)) with legal rights responsible for a child or children AND who is studying a course offered by an academic institute (e.g., college, university etc). *This term was chosen because it aligns with the literature on adult learners in higher education who have parenting responsibilities.*
Parent-Trainee(s)	Refers to a parent, who is currently undertaking the DClinPsy programme AND who adopts the role of a Trainee Clinical Psychology professional. *This term has been chosen as it is the most appropriate and identifiable term to describe a parent enrolled on the DClinPsy training programme.*

Context: situating my empirical research

The following section situates my research and explores the existing literature whilst describing theories related to my research. I will begin by introducing the history of clinical psychology training and present demographics and characteristics relevant to my research. I will then focus on mental health, discussing its development, prevalence and treatment. Next, I will present literature on the LEMHDs in professionals, Clinical Psychologists (CPs) and then Trainee Clinical Psychologists (TCP) in training, drawing on what is currently known and yet to be discovered. I will then consider parents and theories around childcare, exploring how the theories may influence parents' beliefs about their role. Finally, I will conclude with a section on the LEMHDs in parents enrolled on DClinPsy training, highlighting the current literature and the unique challenges faced by this group of individuals.

Doctorate in Clinical Psychology (DClinPsy)

The Doctorate in Clinical Psychology (DClinPsy) is a professional doctoral level training programme in the UK, accredited by the British Psychological Society (BPS). It is pursued by aspiring CPs, and involves high quality education and clinical practice, enabling those who have successfully completed the programme to train as a qualified CP against the BPS's standards and allowing one to register with the Health & Care Professions Council (HCPC). Whilst on the course individuals are known as TCPs and occupy both a student and professional role. In line with the HCPC requirements, TCPs develop research, clinical and academic competencies preparing them to function effectively as CPs within NHS and related settings to understand and support individuals presenting with mental health difficulties. Skills are also developed in leadership, consultation and supervision alongside therapeutic competencies (BPS, 2010).

The professional doctorate was introduced in the early 1990s and reflected the growing role of the profession of CPs in the NHS (Cheshire & Pilgrim, 2004). The programme is usually completed over a period of three years on a full-time basis, including practice on clinical placements. In accordance with the increased demand for psychological services, currently thirty-one universities across the UK offer DClinPsy training with most places funded by the NHS. The programme is considered as highly competitive; in 2024, a total of 5,603 candidates applied for training, with only 1,164 places available - a 21% success rate (Clearing House, n.d). There has been a rise in the growing demand for mental health services necessitating an expansion of the mental health workforce in line with the Government's increased funding associated with the NHS Long Term Plan (NHS England, n.d.).

Through a survey completed by TCPs reflecting their personal perspectives, The BPS Alternative Handbook helps aspiring CPs chose DClinPsy programmes based on factors which might influence their decision on where to apply. Statistics from the 2024-2025 BPS Alternative Handbook can be viewed in Table 2 for gender and Table 3 for age.

Table 2: BPS Alternative handbook responses for gender

Number of respondents	% of respondents	% of female respondents	% of male respondents	% of other response [2]
1,410	41%	85.2%	11,4%	3.3%

Table 3: BPS Alternative handbook responses for age

Number of respondents	20-24 years old	25-29 years old	30-34 years old	40-44 years old
1,410	10.5%	63.7%	18.9%	1.7%

In the last decade approximately 70% of attendees on psychology doctoral programmes were female (Catalano & Radin, 2021; Fowler et al., 2018) with the course coinciding at a time of child-bearing age (Tram et al., 2025). Nearly a fifth (16%) of respondents reported having a caring responsibility, which was the same figure as the previous year (2023-2024). The most frequently reported caring responsibility was primary carer of a child/children under the age of 18 years old (45%), with 39% being a secondary carer (another person carried out the main caring role).

Interestingly, the Alternative Handbook does not specifically report the statistics on LEMHDs, but generally asks respondents about, "Disability, Impairment, Learning Differences and Long-term conditions," and the reasonable adjustments which may have been implemented at various stages of the DClinPsy selection process. Noting this disparity, one independent research study found that 67% of TCPs (*N*=348) across 19 UK DClinPsy programmes reported having a LEMHD (Grice et al., 2018). Another study surveying UK TCPs (*N*=301) found that 44.9% of respondents had a diagnosed mental health condition, and

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[2] Self-described respondents (non-binary/preferred not to say/preferred to self-describe)

45.2% reported having an undiagnosed mental health condition at some point in their life (Bamber, 2024). From the same study, 86.4% of the total number of respondents had a mental health problem prior to training, with 11.2% reporting mental health problems during training.

These figures related to training are significant, as they demonstrate a portion of trainees with childcare responsibilities whose voices and experiences may not be heard, and with needs which may not be considered in training. Understanding these figures allows for programmes to consider their practices, without placing sole responsibility on TCPs to declare their needs. This could reduce challenges where TCP parents might feel isolated in training, particularly if there are fewer or no parent-trainees within their own cohorts, further restricting their ability to be amongst like-minded trainees for informal peer support. These figures imply that there are limited opportunities for TCPs to share their clinical experiences and reflect on aspects of their personal and professional identity. Representing these figures could normalise and reduce stigma amongst professionals and it is hoped that diverse aspiring CPs can apply for training and be valued for their mental health and parenting perspectives. The next section will provide a background around the topic of mental health helping to understand the potential experiences TCPs with LEMHDs might present with whilst engage with training.

Mental health

The World Health Organisation (WHO, n.d.) describes mental health as, "*a state of well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community*." Having good mental health allows for thinking, feeling and reacting in accordance with what one needs and how one should live their life, and poor mental health can interrupt any or all these abilities, making life more challenging to cope with (Mind, n.d.). Mental disorders are a clinically significant disturbance in these areas, associated with distress, impairment in functioning and/or a risk of harm to self (WHO, n.d.). The *Diagnostic and Statistical Manual of Mental Disorders 5th Edition* (DSM-5) can be used by mental health providers to inform diagnosis, alongside the recommendations for treatment provided by the National Institute for Health and Care Excellence guidelines (NICE). Treatment can include medication and/or psychological therapies and specialist intervention (Cleveland Clinic, 2025).

It is reported that approximately 7.8% of people in the UK meet the criteria for a diagnosis of a mental health disorder with mixed anxiety and depression being the most common mental health disorders in Britain (NICE, n.d.). An estimated 4-10% of people in England will experience depression in their lifetime (McManus et al., 2009), although this number is likely underreported due to factors which impact access and engagement with mental health support (discussed later). These figures again are important to consider, and support Bamber and colleagues' (2024) research regarding the likelihood of psychology professionals experiencing mental health difficulties. The Office for National Statistics (ONS, 2024) publish data on the number of registered deaths by suicide in England in the year 2023, totally 5656, an increase of 372 from the previous year, indicating higher levels of distress in society.

It is difficult to clearly understand how mental health disorders develop, but research suggest they are caused by complex interactions between genetic and environmental factors, altering brain structure and functioning (Clark et al., 2017). The diathesis-stress model was developed in the 1960s by Paul Meehl, initially in relation to the development of Schizophrenia. It is a psychological framework that has now been used to explain the development of a range of mental health disorders occurring due to the interaction between genetic vulnerabilities (i.e. the diathesis) and environmental stressors (i.e. the stress) (Colodro-Conde et al., 2017). It describes genetic factors as being latent or exacerbated until activated by environmental stress.

There is evidence of certain genes increasing the risk of developing mental health disorders within families (Burmeister et al., 2008). Personality factors can increase the risk of depression or anxiety (e.g., traits such as perfectionism or low self-esteem) (Brandes & Bienvenu, 2006). Environmental factors (i.e. the stressors) include early life experiences and trauma, for example childhood abuse/neglect, bereavement, social isolation, domestic violence, poverty, war and poor working conditions. To evaluate the diathesis-stress model, not all individuals who have certain genes, and not all individuals who experience the same environmental stressors, will go on to develop a mental health problem. Some individuals are more susceptible than others, for example people exposed to adversities and social inequalities (WHO, 2025), whilst others have different resources enabling them to navigate distress (e.g., better resilience and coping skills, social support). The disruption usually causes a level of distress that negatively impacts functioning, emotional and psychological ability, cognitive ability, relationships, social life, physical health, identity and one's ability to engage with employment and education.

In relation to my empirical study, the diathesis-stress model could consider TCPs having a predisposition to mental health difficulties (e.g., depression or anxiety), and aspects of the DClinPsy programme being an environmental stressor (e.g., assignment deadlines, work pressure, evaluations and assessments and providing psychological support for individuals presenting with complexities). DClinPsy training encompasses aspects of clinical and academic work, meaning that experiencing various levels of distress may impact academic and clinical performance. It will be important to consider the LEMHDs of TCPs, but I will first draw attention to the general topic of LEMHD and its impact on professionals.

Lived Experience of Mental Health Difficulties (LEMHDs)

Professionals

Lived experience is described as having "*personal experience in the past and/or present of mental ill-health (diagnosed or otherwise)"* (Haywood et al., 2023). Research indicates a high prevalence rate of lived experiences in mental health professionals [3] (Harris et al., 2016; Haywood et al., 2023), with some research reporting rates as high as 50-85% (Bike et al., 2009). Some of the reasons that people are attracted to work in the field of mental health is based on personal lived experiences or caring for someone with LEMHDs (Sciberras & Pilkington, 2018). These professionals can add value to the profession through their experiential knowledge and insight which is recognised as valuable in shaping services and care delivery (HCPC, 2017).

There are many benefits associated with having professionals with LEMHDs actively working in the field of mental health. Convincing evidence exists for professionals being able to draw on their individual experiences to promote recovery, enhance therapeutic relationships, empower and advocate for service-users (Adame et al., 2014; Batchelor, 2021; Carr et al., 2014; Harris et al., 2016). They can enrich service practices and influence policies (Sartor, 2023), normalise and reduce stigma and power dynamics between the patient and the professional and promote positive working relationships between colleagues (Henderson et al., 2013). The most common type of lived experience professionals are peer workers, non-

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[3] Mental health professionals (such as Clinical/Counselling Psychologists, Psychiatrists. Occupational Therapists, mental health social workers, Community Psychiatry Nurses and support workers)

clinical staff or volunteers (Hurley et al., 2018), indicating less representation for those who hold more qualified clinical positions.

Other research suggests that mental health problems are common in mental health professionals, potentially due to the nature of their work (APA, 2010; BPS, 2010; Hinshaw, 2008). NHS staff are 50% more likely to feel chronic stress and burnout, leading to consequences like staff shortages, higher caseloads for actively working staff, poorer quality of care and difficulties with staff retention (Deakin, 2022; Wall et al., 1997). Stigma involves negative attitudes, beliefs and stereotypes, either held by the individual or others, which can often worsen the experience of mental health difficulties (Prizeman et al., 2024). The existing research infers that elevated levels of stigma still exist within the mental health profession (Boyd et al., 2016). Individuals may feel embarrassment or fear judgement from friends, family and the systems around them, such as employment or education (Kantor et al., 2017) deterring them from seeking support and engaging in appropriate forms of care (Corrigan, 2004). Furthermore, individuals who perceive elevated levels of stigma are less likely to seek or engage in treatment (Greene-Shortridge, 2007) exacerbating levels of distress. Disclosing mental health difficulties may not always promote an inclusive working environment or practices. Making a disclosure might risk repercussions, for example, employers/line managers and colleagues might perceive that the professional cannot perform their duties in line with ethical standards, or that they lack the necessary skills/knowledge needed to support service-users experiencing distress (Boyd et al., 2016; Brohan et al., 2013).

As CPs assess and provide psychological interventions to individuals presenting with mental health difficulties, it will be important to review the existing literature around their LEMHDs.

Clinical Psychologists

The role of a CP is demanding in nature; CPs are regularly exposed to distress, risks of safety in relation to themselves and service-users and they work in environments where there is high pressure to meet clinical and ethical standards (Vivolo et al., 2024). A study conducted in the USA by Kelly and colleagues (1978) found that 195 newly qualified CPs were stressed, unhappy with their working conditions and one third stated that they would not enter clinical training again despite the rewards (e.g., helping others, generous salary). In the UK, a study by Crowley and Advi (1999) described how CPs felt stuck, overwhelmed and lacked in confidence in their work, whilst Berkowitz (1987) identified strong experiences of self-doubt. These factors likely perpetuate difficulties, especially for CPs with LEMHDs.

A study by Cushway and Tyler (1994) found that 29.4% of CPs (*N*=101) had symptoms within the moderate to severe ranges on the General Health Questionnaires (GHQ-28). Concerningly, nearly half of the CPs who struggle with severe mental health difficulties, including suicidal ideation, reported that they did not feel able to talk about their difficulties or seek help (APA, 2010). Research conducted by Tay and colleagues (2018) found through an online survey (recruited through the British Psychological Society's Division of Clinical Psychology's mailing list) that two thirds of UK-based CPs (*N*=678) experienced mental health problems, with 84% seeking professional support (mostly private psychology professionals) for common presentations like depression and anxiety, despite them having a less than positive response towards seeking help. Like the experiences of mental health professionals, the research also found elevated levels of perceived stigma for CPs, more so within the work settings (with negative experiences commonly received from the employers) than social relationships.

As mentioned above, CPs are less likely to seek psychological support, particularly for severe forms of mental health difficulties, such as schizophrenia (Griffiths et al., 2006), and fear repercussions and/or judgement from colleagues (Aina, 2015; Walsh & Cormack, 1994). They may suppress their own difficulties believing that they should be exempt and resilient from being vulnerable to distress whilst in a 'caring' and 'helping' role (Hinshaw, 2008), exacerbating difficulties when personal and professional values are not aligned (Turner et al., 1987). Concerningly, fitness to practice may be questioned with many CPs continuing to work under significant levels of distress, impacting the quality of care given to service-users (Pope et al., 1987), further highlighting the need for CPs to receive support.

Stigma remains a key factor for perpetuating mental health difficulties and serves as a significant barrier to receiving support (Walsh & Cormack, 1994). The findings from the above studies corroborate with the existing literature on mental health professionals and CPs with LEMHDs, how they seek/receive support and their experiences overall. There are implications for more open approaches when discussing LEMHDs within the Clinical Psychology profession. However, empirical research on CPs with LEMHDs in the UK context specifically remains limited, and there is little information available regarding the institutional culture and support systems. It will be important now to consider TCPs and their engagement with Clinical Psychology training where academic and clinical expectations are high. The DClinPsy programme is considered as rigorous, with intense workloads, clinical responsibility and personal and emotional challenges (Pakenham & Stafford-Brown, 2012), likely to impact wellbeing for TCPs with LEMHDs.

Trainee Clinical Psychologists

Pereira and colleagues (2020) found that 26.6% of undergraduate students in UK universities reported having a current mental health diagnosis before the Covid-19 pandemic. In higher education settings, poor mental health was common with one study finding depression as the most common mental health disorder amongst university students (Lyubomirsky et al., 2003). One systematic review utilising 24 articles reported prevalence rates from 10-85% indicating that university students experience rates of depression much higher than the general population (Ibrahim et al., 2013). With more students declaring pre-existing mental health difficulties, UK HE providers have reported an increase in the demand for student counselling services (All Party Parliamentary Group on Students, 2020), necessitating academic organisations to provide sufficient and timely psychological support for students with LEMHDs.

TCPs are immersed in clinical work and academic teaching surrounding the topic of mental health. They are often required to provide support to both patients, colleagues and multidisciplinary teams, helping systems to think psychologically and as reflective scientist practitioners. Understandably, TCPs may not want to be exposed as being vulnerable or to have their clinical/academic abilities questioned because of mental health difficulties, similarly to the qualified CPs in the study by Tay and colleagues (2018). The course follows accreditation standards regulated by the BPS and HCPC; it is laborious and requires TCPs to draw on their resources and skills to complete and engage with multiple tasks simultaneously. This can limit time opportunities for self-care and seeking/engaging with psychological support.

TCPs adopt the role of student, researcher, therapist, and clinical professional simultaneously. DClinPsy programmes often encourage aspiring CPs with LEMHDs to apply, understanding the value in their unique experiences, and valuing the contribution made in their roles and post-qualification (Alsop et al., 2008; CPC, 2017). However as with mental health professionals, there remains a culture of nondisclosure and poor organisational support when disclosures are made (Cleary & Armour, 2022). With silencing practices, isolation, stigma, and prejudice are maintained rather than strengthened or promoted (Hinshaw, 2008). For example, Haywood and colleagues (2023) found that Australian psychology students with LEMHDs face stigma, poor support and incongruence between the course material and their personal experience. With TCPs being more likely to experience mental health difficulties (Brooks et al., 2002), they can struggle with aspects of disclosure, such as what information to share and who to (Turner et al., 2020; Valley, 2018). Turner and colleagues (2020) conducted semi-structured interviews with 12 TCPs engaged with UK DClinPsy programmes exploring their experience of self-disclosure during training. Using grounded theory, six main themes emerged which included[4], motivations, enablers, barriers, features of disclosure, responses and impact. Results suggested that there were incidences of disclosure providing relief and enabling personal and professional congruence, thus allowing TCPs to bring their authentic selves to training. Training environments which were non-stigmatising, and which had trusting supervisory relationships permitted safe disclosure. Additionally, empathy and positive connection with colleagues was possible post-disclosure, supporting LEMHDs being of value. Conversely, existing literature has found that in a profession where service-users are encouraged to speak about their challenges, TCPs feel unable to seek support or speak themselves (Turner et al., 2020).

CP students in training (total sample, *N*=462; sample from Argentina, *N*=121; England= *N*=211; USA= *N*=130), perceived high levels of stigma, with UK students having fewer positive attitudes towards seeking therapy (Digiuni et al., 2013). This has implications for training programmes needing to address stigma, provide a safe and supportive space for TCPs, essential training for all programme staff members and adaptions to policies and procedures. The research also recommends accessible mental health support, tailored specifically to TCPs. Of note, TCPs are not required to engage in personal therapy as part of their training, despite research suggesting that it could enhance skills of resilience and managing countertransference (Cleary & Amour, 2022), furthering implicating benefits to enhance practice and encourage recovery for the professional.

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[4] Main themes and subthemes (Turner et al., 2020)
motivations (struggling and needing support, being understood, value and duty, influencing others)
enablers (trusting relationships, feeling safe, having an ‘in-road’)
barriers (worrying about the impact on training, voicing the unspoken, internalising stigma)
features of disclosure (being selective, spilling out versus controlled disclosures, testing the waters)
responses (listening versus jumping to fix, exploring versus lack of curiosity)
impact (making it easier to be open, growing connections, integrating different parts of the self, finding the right support, clarifying positions).

Other challenges which intensify mental health difficulties includes TCPs managing time and high caseloads, where difficulties lead to increased pressure and feelings of inadequacy whilst under evaluation (Jones & Thompson, 2017). Research by Cushway (1992) described that 59% of TCPs (*N*=287) felt moderately to severely stressed whilst engaging with the programme, with many challenges related to being able to meet the demands of multiple roles as a student and trainee. Follow-up studies concluded that TCPs (and CPs) continued to experience significant levels of distress citing too much work, too many different things to do, insufficient resources and poor management (Cushway & Tyler, 1996). Cushway's studies further highlighted the benefits of self-care and the need for additional support from staff and the wider organisation. DClinPsy training emphasises the importance of emotional resilience, but TCPs fear discrimination and judgment from others involved in clinical training that they may not be suitable or competent professionals (Turner et al., 2020).

Parent and parenting

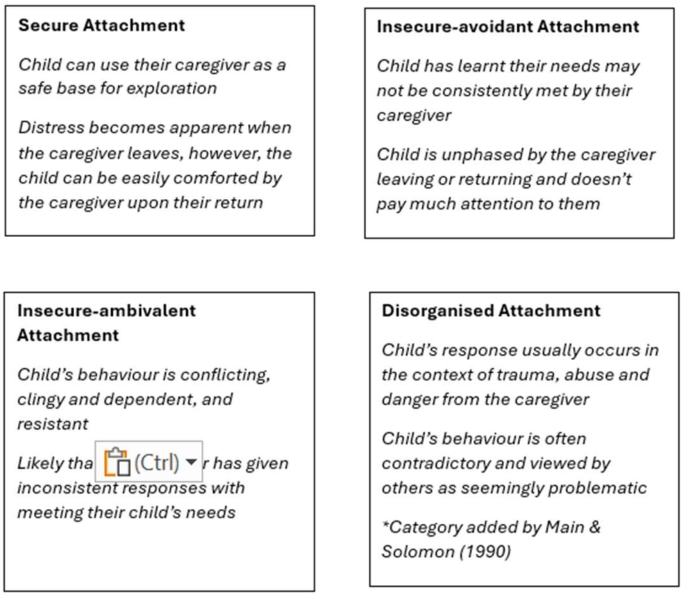
The meaning of being a parent

In addition to how I have chosen to define parents under my key terms and phrases (Table 1), parents are children's primary interactive partners, and they help to support their child's regulation and communication by responding to cues, helping to build the child-parent relationship and the child's development (Campi et al., 2024). Parents protect and provide a home and financial support for children, whilst being responsible for discipline, supporting their education and medical needs (UK Government, n.d.). Parenting is generally a long-term commitment with the parent intended to raise a child, adequately meet conditions to nurture (offer love, affection and security), guide (teach knowledge and values) and support them (financially, food, shelter, clothing etc). Parenting requires parents to evolve and adapt to their children's needs as they grow and progress developmentally. Parenting is not limited to parents being biologically or gestationally tied, it accounts for all social dimensions of parenting (Hill, 2017), such as stepparents and adoptive parents. I will now consider two key psychological theories around childcare, Attachment Theory and Good Enough Parenting.

1. *Attachment theory*

Attachment theory, developed by Bowlby (1969), describes the emotional bond between the child and their parent, with the attachment enabling an infant's survival and protection. Older research describes the primary attachment figure as usually the mother, providing an internal working model of relationships and sense of self. Research has also demonstrated the importance of a father's involvement from early on, usually shown through physical contact (Klause et al., 1995). The theory suggests that challenges during the infant's early life can disrupt the development of a secure attachment style. It also suggests that when attachment figures are unreliable, unavailable and unsupportive, emotional and behavioural difficulties (e.g., inability to relieve distress) may become apparent in later life (Mikulincer & Shaver, 2012). Ainsworth and colleagues (1978) and Main and Solomon (1990), added to the literature on attachment styles, categorising four main attachment styles presented in Figure 1.

Figure 1: Attachment Styles



Secure Attachment

Child can use their caregiver as a safe base for exploration

Distress becomes apparent when the caregiver leaves, however, the child can be easily comforted by the caregiver upon their return

Insecure-avoidant Attachment

Child has learnt their needs may not be consistently met by their caregiver

Child is unphased by the caregiver leaving or returning and doesn't pay much attention to them

Insecure-ambivalent Attachment

Child's behaviour is conflicting, clingy and dependent, and resistant

Likely tha (Ctrl) *r has given inconsistent responses with meeting their child's needs*

Disorganised Attachment

Child's response usually occurs in the context of trauma, abuse and danger from the caregiver

Child's behaviour is often contradictory and viewed by others as seemingly problematic

**Category added by Main & Solomon (1990)*

Research has demonstrated that insecure attachment styles are associated with a higher risk of developing a wide variety of mental health disorders, such as depression, anxiety and personality disorders (Mikulincer & Shaver, 2012). It is said that when there are disruptions with an attachment figure, children struggle to form secure attachments with others and react in a rejecting and hostile manner (Pickover, 2002).

Attachment theory has been recognised for its generalisability and application across various fields including psychology, education and health. It has been relevant for informing childcare policies and practice (Rutter & O'Conner, 1999), particularly in the field of social care (e.g., court rulings, adoption and fostering). It demonstrates the influence of early caregiver bonds on emotion regulation, social skills, mental health and resilience (Slater, 2007). Attachment theory is also considered as a reputable framework for understanding crucial risk and protective factors in social and emotional development (Zeanah, 1996).

However, it has also been criticised for its reductionist and deterministic view of how attachment styles are formed during early childhood, whilst placing high importance on parents, and mostly the mother (Field, 2012), but not other key relationships e.g., fathers, siblings or grandparents (Fegran et al., 2008; Harris, 1998). It infers that parents are solely responsible and accountable if a child behaves in a way that is deemed as inappropriate and it also does not consider attachment styles as fluid or changeable through new relationships, therapy or life experiences (Belsky, 2002; Weinfield et al., 2000). It also does not account for cultural difference or child-rearing practices that are different to westernised, traditional methods (Thompson et al., 2022).

2. *'Good enough' parenting*

Attachment theory explains the feelings associated with separation, fear and anxiety because of the disruption with an early caregiver (Slater, 2007). In the 1960s Donald Winnicott proposed another theory, commonly known as the 'good enough parenting' approach. It speaks to 'good enough' care (where research describes the care as usually being provided by the mother) being given to an infant where the parent is highly attuned to support the child's development in the first months of their life, and where responsiveness naturally reduces. This suggests that parenting does not have to be perfect but adequately meets the child's emotional and physical needs most of the time (Winnicott, 1953). It understands that parents cannot realistically be always attuned; small and manageable mistakes are unavoidable (and acceptable for children to experience frustration and imperfection to foster resilience and self-soothing), with the approach allowing for compassion towards parents, and fostering the child's resilience, independence and adaptability, which are necessary components for later life (Winnicott, 1965). This approach has strengths in promoting empathy, particularly towards modern day parents who occupy non-traditional roles, such as mothers in education and mothers as the breadwinner (Sidebotham, 2017). The 'good enough' parenting approach supports the focus on the quality of relationships, rather than parents meeting all demands, demonstrating longer-term benefits for children in their adult life. An additional strength for this approach includes reducing perfectionism and normalises healthy parenting. However, the good enough concept has been criticised for its subjectivity and vague definition.

There are different parenting styles, where parenting styles involves the attitudes, behaviours and emotions displayed by the parent in relation to child-rearing practices (Coplan et al., 2002; Darling & Steinberg, 1993). Three parenting styles proposed by Baumrind (1966) (as cited by Vasiou et al., 2023) can be viewed in Table 4, with implications on how this might impact TCPs. These styles describe demandingness and responsiveness dimensions, but the approach has received criticism for the rigidity of the styles.

Table 4: Parenting Styles

Parenting style	Description of style	Implications for TCPs
Authoritarian ***High structure, low warmth***	High levels of parental control and maturity demands, low levels of nurturance/responsiveness, poorer clarity of communication	Problematic for parents who are limited with time or stressed, this approach has short-term effects, but more challenging in the long-term related to the quality of relationships
Permissive ***Low structure, high warmth***	High levels of nurturance, high levels of clarity of communication, low levels of control, low levels of demands	Parents may become overwhelmed with managing boundaries, behaviours and the emotions of the child, impacting on their ability to engage with training
Authoritative ***High structure, high warmth***	High levels of responsiveness and control, nurturance, clarity of communication, and high levels of maturity demands	Requires time, emotional availability and consistent approaches, which may not be realistically possible for TCPs engaged with training

Attachment theory shapes parents' beliefs about their role with parents believing that their primary job is to be emotionally available, close, responsive and prompt in their ability to regulate and soothe their child (Foster et al., 2025). Baumrind's parenting styles promotes the authoritative style as the best for a child's outcomes, whilst Winnicott's approach suggests parents do not need to maintain perfect standards of care. Together, these theories are relevant for considering the roles of parent-trainees and their engagement with DClinPsy training and the context of LEMHDs.

However, there are some key criticisms, such as their limited consideration for the context in which parents are living in (e.g., work situations, forms of relational and financial support), their cultural bias towards western norms, and their sample bias with mostly White, heterosexual female parents, living in nuclear traditional families and not engaged in education. Whilst there is growing literature related to student-parents in education, current literature is minimal with capturing their lived experiences.

Bringing it all together

Parents in clinical training

There is limited published research available to explore the experiences of parents who also occupy the role of TCPs. However, what is available shows that parents engaged with DClinPsy training experience challenges with juggling the demands of both parenting and the course requirements. A doctoral thesis which aimed to highlight the challenges faced by mothers (N=18) engaged with DClinPsy training using reflexive thematic analysis found that mothers viewed the course as relentless, inflexible and rigid in nature, with the course not being designed or suitable for those with parenting responsibilities (Comerford, 2025). Results found conflict with the concept of self-care, with self-care being near impossible in the context of training and parenting, and limited opportunities for engaging and connecting with others who occupy similar characteristics of parents. Another doctoral thesis aimed to understand the experiences of parents who have completed clinical training and found through thematic analysis methodology that CPs who were parents during training (N=12) were vulnerable to high cognitive loads, guilt and exhaustion (Johnson, 2024). Findings also reported institutions with rigid systems, where applied support such as flexibility, reasonable adjustments and support from others, enabled them to engage with training.

DClinPsy programmes encourage a healthy work-life balance, i.e., the ability to fulfil work roles without sacrificing personal life. Research shows that a healthy work-life balance not only improves well-being but also allows for the effective prioritisation and production of work and management of home demands (Lee et al., 2009). A healthy work-life balance also helps to reduce life demands and ensure successful implementation of self-care strategies, coping skills, hobbies, and positive social engagement (Burke et al., 2003; Rupert & Kent, 2007). Navigating different personal and professional roles can make balancing work and life a challenge (Matheson & Rosen, 2012) and research indicates that parent-trainees cannot juggle multiple roles or comprehend their personal and professional identities with competing demands and loyalties. An emphasis is placed on the individual to engage in self-carer rather than changes being made at a systemic level (Burke et al., 2003), but due to the demand of both roles, engaging in self-care practices is not always feasible, and likely will be more challenging for TCP parents who present with the intersect of having LEMHDs.

Parent-Trainees with LEMHDs

The biopsychosocial framework (Engel, 1980) can highlight the unique challenges face by parent-trainees with LEMHDs and help to consider the ways that the intersectional identities of being a parent and a TCP with LEMHDs can interact and influence wellbeing and resilience. The framework has been considered for its ability to incorporate biological, psychological and social aspects together, to understand how these interact and influence wellbeing. Usefully, the biopsychosocial framework can provide an overarching context which can be combined with the principles of the diathesis-stress model to consider the development, maintenance and treatment of mental health conditions.

Biological changes have been observed in parents, for example, during pregnancy and postnatally. It is not uncommon for parents with new babies and younger children to experience sleep deprivation affecting their physical and mental wellbeing, emotion regulation and cognitive functioning (Goyal et al., 2007). Considering TCPs and their need to balance the demands of training (clinical, research and academic work), this might involve working long hours, which again limit time for sleep and restoration, and may lead to symptoms such as fatigue and headaches, demonstrating possible impacts of stress. Combined, the symptoms that a parent-trainee experiences could impair their ability to engage with doctoral training tasks, such as reflection, which seeks to deepen trainee's self-awareness and empathy towards client's challenges.

Psychological factors may create or exacerbate mental health difficulties. It is not uncommon for TCPs to report both perfectionism and imposter syndrome, the phenomenon where an individual is viewed as objectively successful and accomplished by others, but cannot internalise this for themselves, seeing themselves as incompetent and fearing failure (Clance & Imes, 1978). This can have implications for the development of a reflective-practitioner and identity formation (Clark et al., 2025). For parents, especially those pursuing doctorates, common experiences include feelings of guilt, shame, and thoughts about not doing enough whilst juggling parenting and professional/academic roles (Catalano & Radin, 2021). These complexities could influence how TCPs respond to stress but also might be perpetuating and re-triggering when demands are perceived as high. Ongoing negotiation may be required when prioritising needs within these three intersectional identities.

Finally, social factors, such as access to support systems, has relevance to all three intersectional identities, where adequate support can positively affect mood and coping, whilst a lack of support can lead to experiences of isolation. Societal expectations of roles can create pressure, for example, being an ‘ideal parent’ or a functional psychology professional. Whilst inequalities and the experience of adversity may influence TCPs access to resources such as childcare provisions and private therapy. These factors require policies within DClinPsy programmes to be inclusive and equitable for diverse TCPs with differing needs.

To date, there is no existing literature from the UK of parents with LEMHDs who also occupy the role of TCPs. Through combining the existing literature, TCP parents with mental health difficulties, are likely to experience distress, burnout, and difficulties with work life balance, due to them having to navigate the demands of multiple roles. Competing demands including employment, engagement in education or family life commitments, might take precedence and prevent an individual from seeking psychological support (Roy et al., 2018). Furthermore, one’s intersectional identity may also change the experience of seeking and receiving support, e.g., gender, age and ability (Singh et al., 2007). With regards to literature on stigma, it is understandable why TCPs might delay or abstain from making disclosures for fear of the impact that it has on their clinical and academic performance.

The BPS (n.d). has produced guidance on how to support and value LEMHDs in DClinPsy training. It aims to challenge the stigma and shame that often silences professionals with mental health difficulties, despite the profession being one that emphasises compassion and kindness towards others. Given that NHS mental health services often have high demands and limited resources (Dent & Golding, 2006), one might wonder how these types of stressors might further affect professionals with LEMHDs, particularly those in training and those who have additional demands related to childcare responsibilities. There is an absence of the student-parents voice in informing policies and procedures, including the challenges that HE institutes have with supporting students who experience mental distress (Universities UK, 2015). When the course demands are coupled with the responsibilities of parenting along with navigating mental health, maintaining healthy work-life balance and wellbeing or engaging in self-care seems challenging and there is limited research to explore these experiences.

Conclusion

What is known about the LEMHDs in TCPs is limited and concerning when there is no empirical research on the mental health experiences of TCPs who are parents. The current literature focuses on one or two aspects of intersection identities, e.g., psychologists with LEMHDs, but not parents. Discussing the LEMHDs in parent-trainees begins to contribute to normalising conversations about mental health experiences in psychology training and parenting practices. Bringing to light these three intersecting identities will help to understand the unique experiences and perspectives of parent-trainees with LEMHDs, which is generally underrepresented due to stigma and shame, and the fear that disclosure can cause professional consequences. Bringing this to light helps to contribute to the academic and clinical literature, which is currently relatively small.

First it will be important to explore what is currently known about the mental health experiences of student-parents in UK Higher Education (HE) settings as well as the experiences of support. It will be important to consider this first before moving on to the specific experiences of TCPs. The information gathered from my Systematic Literature Review (SLR), will help to identify gaps within the literature whilst considering recommendations and areas for research development.

Chapter 2: Systematic review of relevant literature

Chapter Overview

The following chapter outlines the process of my Systematic Literature Review (SLR), and the findings related to the review question and aims. SLRs aim to identify, critically evaluate, and synthesise existing research studies drawing theoretical conclusions about what the literature means and what remains to be explored for future research (Baumeister, 2013). They are considered comprehensive searches that aim to explore and review all relevant literature to address a research question about what is currently known about a topic (Siddaway et al., 2019). They also ensure transparency by documenting replicable methodology informed by theory and pragmatism. A SLR was chosen for its ability to systematically search for, appraise and synthesise research (Grant & Booth, 2009).

I believed it was of value to narrow and focus my searches and to explore student-parents who are completing Higher Education (HE) courses at UK universities as this was most like my own doctoral programme. I also believed there would be less variation in the HE experiences in the UK than if I were to include courses across different countries, which might employ different processes for student-parents. Preliminary scoping searches were conducted in April 2025 to explore the breadth and type of literature available (Levac et al., 2010) whilst identifying any gaps in the literature (Boland et al., 2017). Qualitative studies were also chosen because of their ability to explore the lived experiences of individuals (Milner et al., 2020), and to understand themes, experiences, meanings, insights and interpretations in my topic area. Mixed-method studies could be considered, but only with a focus on the qualitative findings presented and reported by myself. The initial searches produced a snapshot of results from three databases (Scopus, Google Scholar, and Education Research Complete), which included at least six potential studies, indicating the potential for available literature to review and synthesise. PROSPERO indicated that no existing SLRs were being undertaken for the proposed research question. Based on the results of the preliminary scoping search, to review and synthesise current research, an SLR was conducted to answer the following question:

"What are the mental health experiences of student-parents in UK Higher Education (HE) settings?"

I believe by asking this question, I will be able to gain insight into the current challenges faced by student-parents with mental health difficulties, as well as the methods of support offered by HE institutions. The following section will outline the methodology and processes of undertaking the SLR. Following this, there will be a summary and synthesis of studies with a critical appraisal of the research. Appendix B describes the review protocol, which summarises the methods taken to follow the review process (Boland et al, 2017), allowing for replication. Throughout the process, I have maintained a reflexive research diary (Appendix A) which ensured transparency by providing an accurate account of my plans, actions and methodological decisions, whilst also being able to reflect on my research activities (Boland et al., 2017). Appendix C provides a sample of my research activity logs monitoring my progress.

Terminology and key phrases for the Systematic Literature Review

To fulfil this review, relevant terminology/phrases applied in this SLR have been defined in Table 5.

Table 5: Terminology/phrases for SLR

Term/keywords	Definition	Other relevant information
Mental health	Any mental health experience, including wellness, psychological well-being, And/or Any mental health experience, including difficulty/ distress/diagnosis/challenge, which can be a disturbance that is psychological or behavioural. E.g., depression, anxiety/mood disorders, eating disorders, Post-Traumatic Stress Disorder (PTSD), Borderline Personality Disorder (BPD), Schizophrenia, substance misuse disorder, Autism and Attention Deficit/Hyperactivity Disorder (ADHD).	For this review, no formal diagnosis was required. Individuals could self-identify as having a mental health difficulty without the involvement of a professional. Mental health disorders such as anxiety, mood disorders, OCD, eating disorders, ADHD, bipolar, manic depressive disorder, personality disorder, schizophrenia, PTSD, generalised stress, sleep disorders, psychosis, substance disorders.
Students-parent	An individual who is formally engaged in a period of learning, And An individual who adopts the role of mother and/or father of a child or children.	Including parents who are biological/adoptive/stepparents and who are responsible for the care of a child/children.

Higher Education (HE)[5]	A level of education which is post-secondary and post-further education, leading to post-graduate awards/diplomas, Usually in settings such as universities, specialist institutes or colleges.	Course could be of any length/duration, studied in either part-time or full time capacity. For this review, Open University courses were not included due to the nature of these courses being delivered in a flexible capacity.
United Kingdom (UK)	England Scotland Wales Northern island	

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[5] The UK Government Department for Education, which regulates the education system in the UK, HE courses as "Education at a higher level than secondary school, usually provided in distinct institutions, such as universities." It is generally non-compulsory to attend, and they are of a standard that is higher than The General Certificate of Secondary Education Advanced Level (GCE A Level). Three main levels of HE courses include, Postgraduate courses leading to higher degrees, diplomas and certificates (including Doctorate, Masters (research and taught); Undergraduate courses which include first degrees (honours and ordinary) and other undergraduate courses (such as SVQ or NVQ and Diplomas in HE).

Methodology

The following review was conducted to explore and synthesise the current literature on the mental health experiences of student-parents in UK HE settings.

This SLR was original, corroborated by the International Prospective Register of Systematic Reviews (PROSPERO; registration number: CRD420251011372 see Appendix D). Ethical approval for the SLR was not necessary; I ensured that existing research articles followed ethical procedures and did not report any personal, confidential or sensitive information.

Although there were three current and ongoing reviews which looked at the mental health experiences of students in HE settings, Prospero revealed no similar reviews which looked at the experiences of student-parents specifically. This indicated that there was a gap in the research evidence that my SLR could fill. Therefore, I did not contact any researchers undertaking similar SLRs to investigate the mental health experiences of parents in HE.

Search strategy and limits

The main search was informed by the preliminary scoping searches with the main search being conducted between April-May 2025 and with final searches being repeated in June 2025 to account for any new published articles and materials.

Six databases were systematically searched[6], which had the potential to include literature relevant to education, mental health and parenting: Scopus, Education Research Complete, CINAHL Ultimate, PsychArticles, University of Hertfordshire online library system and Google Scholar. These databases were chosen after thoughtful discussion with my supervisory team and the university Library Information Manager, who advised on the best specialist databases for Psychology research relevant to answer my SLR question and which could produce a vast number of materials to appraise (See Appendix E for the rationale for the included and excluded databases).

Research has shown that since the DfES Widening Participation Strategy in 2003 (DfES, 2003), employed by the UK's Labour government, more mature students with parenting responsibilities have enrolled and engaged in UK HE courses (Brooks, 2011). I included studies from the years 2000-2025, to capture as much existing data as possible since

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[6] See Appendix A, Excerpt H for Reflexive research diary entry on SLR screening phase

this programme was initiated. Search alerts were created through registering accounts on the databases with the rationale to inform me of any new relevant studies. These search alerts were stopped in July 2025, after the data had been synthesised. In addition, reference lists from included papers were hand-searched to explore and include any potential publications that may have been missed from initial searches. Google Scholar and the University Library System were explored with results ordered by relevance. Searches were stopped when I felt confident that I had identified, retrieved and reviewed all studies completely or within a 15-page range (restriction were in place for pragmatic and time-limited reasons), which were no longer producing any more relevant materials. One additional page was searched and checked to ensure no other studies were missed. The searches were limited to studies available in full-text and which were accessible through university licences; studies were limited to English Language only due to the research article inclusion criteria and the resource limitations with conducting this SLR. Geographical restrictions were in place to only view articles with courses based in UK institutes.

Searches revealed that some, but not all key concepts featured in the titles, and therefore it was necessary to explore abstracts, keywords and sometimes the studies more broadly to identify the study's relevance. Keywords and key terms were noted from all relevant articles in the scoping and main searches, with the rationale of developing appropriate search terms for the main searches (See Appendix F for search planning form), and this was corroborated with my supervisory team. Search terms were revised and included if they appeared in the preliminary searches, whilst noting if they also appeared in the main searches. Phrase searching (using quotation marks) was used to help retrieve relevant articles rather than searching for each word in a phrase individually. Boolean operators ('AND/OR') were combined with search terms, whilst truncation (using '*') was used to broaden searches and included variations on word endings to generate relevant papers.

Table 6 describes the search terms used for the SLR which were inputted into the databases. Due to the limited nature of Google Scholar and the University of Hertfordshire online library system, it was decided with the university Library Information Manager to limit the number of search terms to the most important search term within each concept to produce potential results ("mental health" AND "student parent" AND "higher education").

Table 6: SLR Search terms

Concept 1 **Mental Health**	**Concept 2** **Students**	**Concept 3** **Parents**	**Concept 4** **Higher Education**
“Mental health*” OR “Mental ill*” OR Wellbeing OR “Psychological health” OR “Emotional health” OR “Mental wellness” OR Distress OR hardship	“Mature student*” OR “Graduate student*” OR “Postgraduate student*” OR “Undergraduate student*” OR “Adult learner*” OR “Non-traditional student*” OR Student*	Parent* OR “Student-mother*” OR “Student mother*” OR “Student-father*” OR “Student father*” OR “Student parent*” OR “Student-parent*” OR “Parent student*” OR “Parent-student* OR Mother* OR Mum* OR Father* OR Dad* OR Carer* OR caregiv*	“Higher education” OR “Universit*” OR “Advanced education” OR “Advanced learning” “Higher learn*” OR “College education” OR “College learn*” OR “Graduate stud*” OR “Undergraduate stud*” OR Academi* OR “Postgraduate training” OR “Postgraduate learning” OR “Tertiary education” OR “Tertiary learn*” OR “Doctora*” OR “Course” OR “PHD”

AND **AND** **AND**

The mnemonic PICO stands for **P**opulation, **I**ntervention, **C**omparator and **O**utcome, and can be used to define inclusion and exclusion criteria (Boland et al., 2017). However, using this approach risked excluding potentially relevant papers due to its criteria which might not have been relevant for qualitative SLRs. Therefore, I decided to use the mnemonic PICo, (Joanna Briggs Institute, 2014) to inform my search strategy; this mnemonic stands for **P**opulation, Phenomena of **I**nterest and **Co**ntext. Referring to 'context' rather than 'comparator' and 'outcome' has benefits in being able to plan the studies to include whilst avoiding the exclusion of relevant articles. It also provides others with enough information about the focus, scope and applicability of the review. The inclusion and exclusion criteria are listed in Table 7.

Table 7: Inclusion and exclusion criteria for SLR

Inclusion criteria	Exclusion criteria
English language	Non-English language
Qualitative studies	Quantitative studies
Mixed-method studies where it is clear to differentiate the qualitative studies, focusing on student-parents' mental health experiences	Mixed-method studies where it is not clear to differentiate the qualitative analysis, focusing on student-parents' mental health experiences
Focused on the experiences of student-parents in higher education	People who are not parents, and people who are not students or who have not been student-parents in higher education settings
UK higher education courses (part-time or full-time)	People who had caring responsibilities for children > 18 years old
Focused on mental health experiences (including mental health diagnoses of depression, anxiety, PTSD, Psychosis, Eating Disorders, etc)	Higher education courses which are not in the UK
Can include those currently engaging in HE or those who have qualified/left the course due to difficulties	No mention of mental health experiences/student-parents without mental health conditions
Courses including PHD, Doctorate, graduate, undergraduate, post-graduate	Further education e.g., colleges
Empirical research published in peer-reviewed journal articles	Individuals between the ages of 16-18 years old
Individuals >18 years old	Open university courses
Individuals with children <18 years old	Dissertations, book chapters, review of books, government papers, grey literature, qualitative self-study,
Journal articles	Conference proceedings, unpublished clinical files, theses, dissertations, and working papers, grey literature

Criteria rationale

I decided to exclude grey literature and only include peer-reviewed studies, aligning with my epistemological stance, specifically the critical realist lens. This included conference proceedings, unpublished clinical files, dissertations and government papers.

A decision was also made to exclude Open University courses on the basis that they typically have different teaching methods and accessibility options. They tend to prioritise distant learning and flexible study, whilst ensuring more availability of online resources and fewer social assessment methods. The full review protocol and search strategy process can be found in Appendix B.

Screening and data extraction

Covidence is an online software system that can streamline the processes involved in conducting systematic reviews. It is considered a standardised approach for reporting how many studies were included in a review, including removing duplicate studies (Babineau, 2014). The process includes importing the references of relevant studies and screening and extracting the data from articles. Covidence had the benefit of allowing additional members of my supervisory team to cross-check and help me to navigate disputes and queries, thus ensuring high-quality systematic reviews and attempts to reduce bias (Boland et al., 2017). Covidence can also produce an accurate flowchart that follows the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) framework (Liberati et al., 2009; Moher et al., 2009), which is favourable for demonstrating the quality of the review, assessing its strengths and weaknesses, and allowing for replication. Figure 2 describes the study selection, screening and data extraction process[7] for my SLR.

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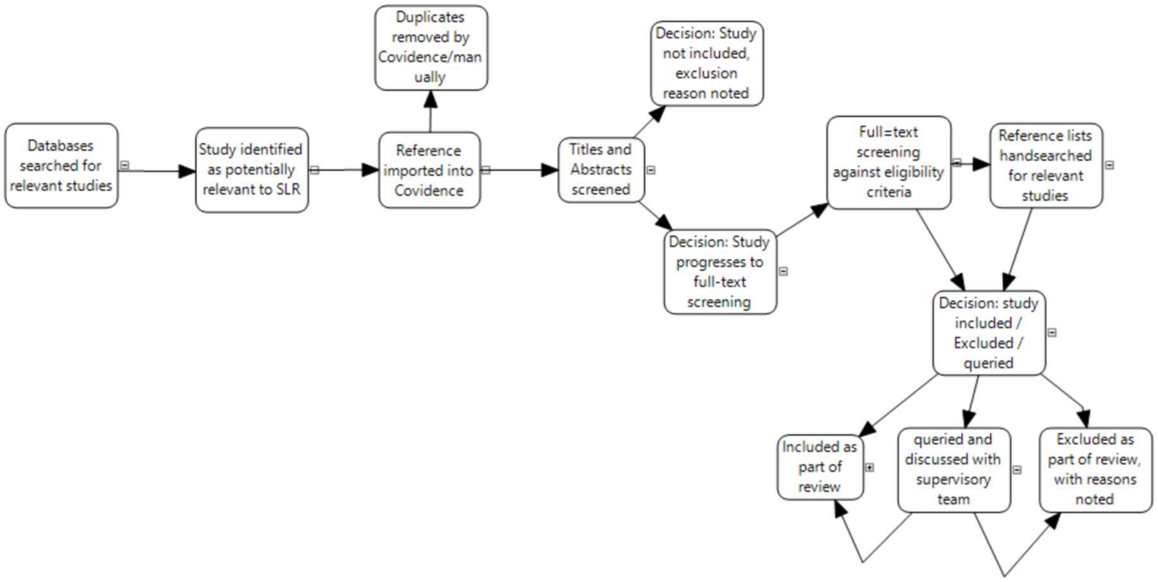
[7] See Appendix A, Excerpt I for Reflexive research diary entry on extraction and narrative synthesis

Figure 2: SLR process, selection, screening and data extraction

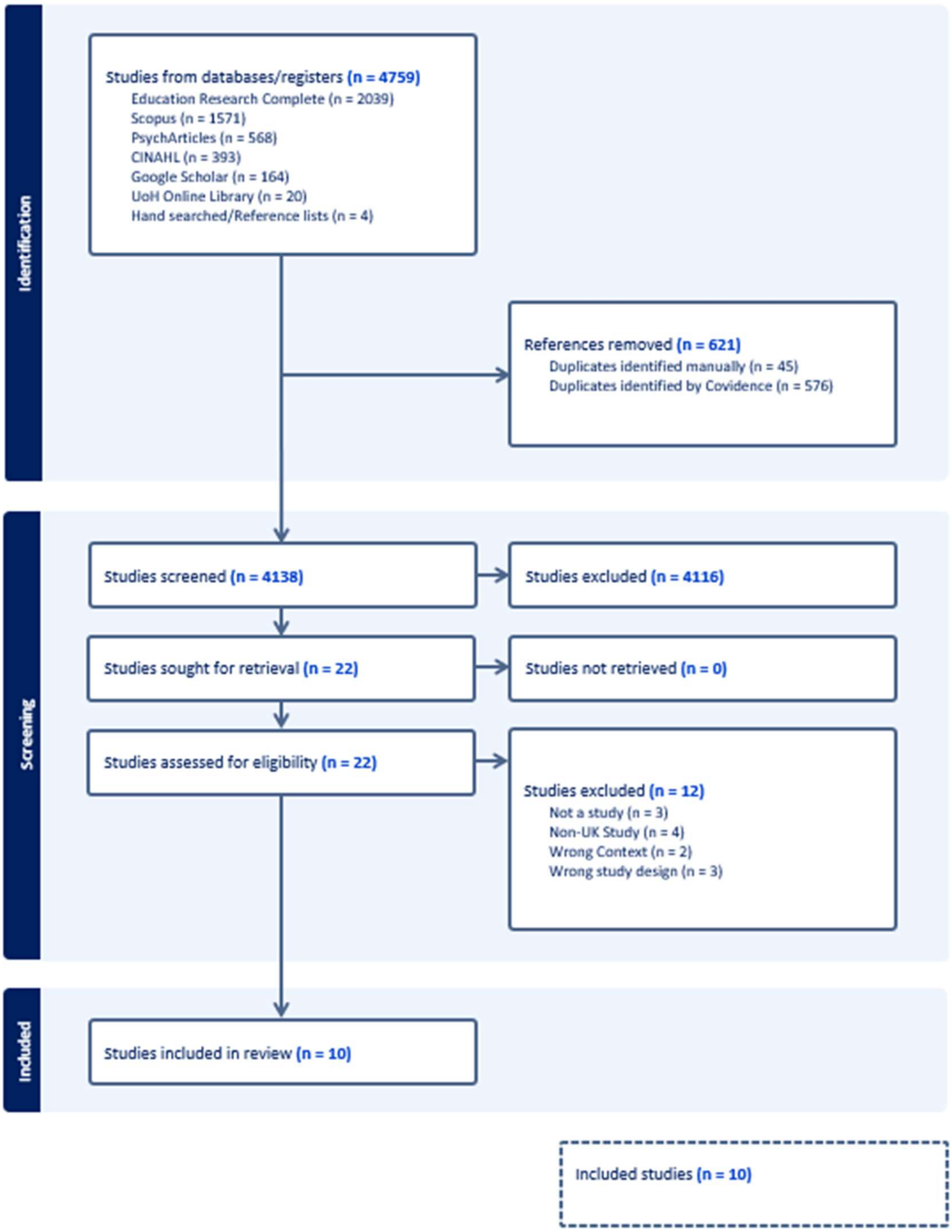


I screened study titles, abstracts and full texts which met the inclusion criteria using Covidence. A random sample of five studies were selected for review against the inclusion criteria by another current DClinPsy peer, also completing a SLR as part of their own thesis. Studies selected for full-text review, were cross-checked by at least one other reviewer, to ensure consistency, reduce bias and increase validity. My supervisory team were involved to support and help me navigate any disputes or queries surrounding the article's eligibility against the inclusion and exclusion criteria before the full-text review and extraction stage.

Results

The SLR produced 4759 studies in total with 10 being considered as appropriate for review against the inclusion and exclusion criteria. Figure 3 displays the PRISMA flow chart, detailing duplication, included and excluded articles.

Figure 3: PRISMA flow chart



Critical evaluation of the quality of the studies

The Critical Appraisal Skills Programme (CASP, 2018) Checklist for Qualitative Studies includes 10 questions used to assess the quality, relevance and risk of bias for each study. It considers the areas of importance, appropriateness and scientific rigour, and provides a rating of ‘yes’ ‘no’ or ‘can’t tell’ against each of the 10 questions. For studies of a mixed methods approach, qualitative information around student-parents’ mental health experiences were synthesised only if there was enough relevant information provided to answer the research question. Upon evaluation, only limited quantitative information was provided, and this was mostly in the form of YES/NO questions, or to provide information about the participant’s demographic profile. The CASP checklist (Table 8) was deemed as suitable for answering my SLR research question and chosen for its consistent appraisal approaches and ease of use, discussed and agreed with my supervisory team, thus enhancing credibility and reducing bias.

Table 8: *CASP Checklist for Qualitative Studies*

Title, Author, Year of Study	**Clear statement of research aims?**	**Appropriate qualitative methodology?**	**Appropriate research design?**	**Appropriate recruitment strategy?**	**Appropriate data collection ?**	**Relationship between researcher and participant considered?**	**Consideration of ethical issues ?**	**Data analysed sufficiently rigorously?**	**Clear statement of findings?**	**Is the research valuable?**
Accessing and experiencing higher education: young	Y	Y	Y	Y, some participants were not in higher education, but there	Y	Y, mentions reflexivity	Y, very well documented in this study	Y	Y	Y, original, relevant to student male parents, ability to influence policies and

fathers in the UK **Clayton et al., (2024)**				was enough qualitative info from the ones who were						those who look to enter higher education in the future
Outside looking in: Gendered roles and the wellbeing of working student mothers studying for a part-time PhD **Cronshaw et al., (2023)**	Y	Y	Y	Y	Y	Y, mentions that one researcher is an insider-researcher	?, not clearly mentioned, in terms of how parents might have been supported in the interview/post-interview, but otherwise ethical approval /committee mentioned	Y	Y	Y, very relevant for mothers undertaking further studies in higher education settings
Parenting by day, studying by night: challenges faced by student-	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y, highlighting underrepresented voices

parents in the COVID-19 pandemic **Evans (2024)**										
Student parents, hardship and debt: a qualitative study **Gerrard & Roberts (2006)**	Y	Y	Y	Y	Y	N, not discussed, only one interviewer conducted interviews	N, apart from mentioning that ethical approval was obtained	Y	Y	Y
Invisible experiences: understanding the choices and needs of university students with dependent children **Marandet & Wainwright (2010)**	Y	Y	Y	Y, ensuring that different departments asked different students questions	Y, mixed methods design, but thematic analysis for the interviews	Y as this was insider researcher, steps were taking to ensure confidentiality at the point of recruitment, interview and analysis	Y	Y	Y	Y
Navigating the Same Storm but Not	Y	Y	Y	Y	Y, but more qualitative	N, not mentioned	Y	Y	Y	Y, covid study, but has relevance

in the Same Boat: Mental Health Vulnerability and Coping in Women University Students During the First COVID-19 Lockdown in the UK **Misca & Thornton (2021)**					information would have allowed for a deeper analysis on relevant topics					for post pandemic
Care in academia: an exploration of student parents' experiences **Moreau & Kerner (2013)**	Y	Y	Y	Y	Y	N, not mentioned	N, no ethics committee / approval information mentioned in the main body of the text	Y	Y	Y, speaks to more inclusive practices for diverse student-parents
'Little islands': challenges and opportunities	Y	Y	Y	Y, but out of 10 carer participants, only	Y	Y	Y	Y	Y	Y

for student carers in higher education **Rawlinson (2024)**				three were parents						
Student-parents’ experiences of personal and academic support in UK higher education: barriers and challenges to equality of opportunity and policy and practice recommendations to mitigate them **Todd (2024)**	Y	Y	Y	Y	Y	N, not mentioned	Y	Y	Y	Y
it has been an uphill battle from the get go’: The experiences	Y	Y	Y	Y	Y	N, not mentioned	Y	Y	Y	Y

of single parents studying at university in the UK during the COVID-19 pandemic **Trotter (2023)**										

The overall quality of the papers was deemed as sufficient to synthesise the main findings/themes and implications related to the mental health experiences of student-parents in HE. Good methodological approaches were utilised in all studies, and a sufficient snapshot of experiences were found. Small sample sizes could reflect challenges with recruitment and could reflect the limited time that student-parents had available to participate in research.

Synthesis of findings

The final 10 studies were synthesised using the narrative synthesis approach (Popay et al., 2006)[8], where key themes and findings across studies were collated to 'tell the story' of the findings and conclusions. The narrative synthesis approach was discussed within my supervisory team and deemed as the most suitable and appropriate method to address the SLR research question, which looked to explore the mental health experiences of student-parents in UK HE settings. My rationale for selecting a narrative analysis is recommended by research; it related to the approaches ability to understand more nuanced and complex phenomena to generate new insights, mostly focusing on qualitative studies (but can consider mixed methods designs) and identifying gaps within the literature (Popay et al., 2006). Alternative syntheses were explored and rejected; these can be viewed in Table 9.

Table 9: Alternative syntheses methods

Synthesis approach	Rationale for rejection
Thematic synthesis	*Useful for coding qualitative data and developing analytical themes.* My SLR was not aimed at generating new hypotheses or looking for recuring patterns or themes across studies. Instead, I sought more descriptions without in-depth themes with a goal to summarize existing literature rather than building theories.
Meta-ethnography	*Useful for qualitative studies which seek to form new interpretations of a phenomena.* I sought more descriptive rather than interpretive information from studies for my SLR.

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[8] See Appendix A, Excerpt I for Reflexive research diary entry on extraction and narrative synthesis

The studies gathered were published between 2006-2024, with a total of eight studies being published within the last 10 years. All studies were published after the inception of the DfES Widening Participation Strategy (DfES, 2003) and should capture the effect and impact of these changes. All extraction was completed by me as the lead researcher and Table 10 summarises this information.

Table 10: Data extraction

Title, Author and Year of Study	Study Aims	Participants / Recruitment	Methods / Design	Main findings	Strengths / limitations	Implications / Future research suggestions
Accessing and experiencing higher education: young fathers in the UK **Clayton et al., (2024)**	Explore the gap in existing research by sharing insights into young fathers' HE viewpoints. How young men view HE and why some may choose this pathway whilst others do not. How do fathers navigate the decision-making process when seeking to enrol and study at HE institutions. What are the challenges they face and the perceived	22 fathers who had children up to age 15 and before the fathers were 25 years old. fathers were aged between 17-32. All white-British except one. 11 young fathers were classified as EET (in Employment, Education, or Training). 9 fathers were not in EET 7 of these participants were welfare recipients. 7 young fathers were engaged with professional support services for families; 1 participant identified as a care leaver. 5 young men had direct experiences of HE-of which, 1 participant became a father during	22 qualitative semi-structured interviews (f2f /telephone), with young fathers with and without HE experiences. Reflexive thematic analysis.	Mental health concerns were raised by the HE fathers often due to the tensions associated with studying and balancing educational priorities with family time. The decision to return to education and 'putting life on hold,' was said to create additional pressures. There were obligatory feelings of having to do well for some of the HE young fathers, which could then create anxieties around 'falling behind' or 'failing.' Worries about securing employment after	<u>Strengths</u>: originality to address a gap in the current literature directly relates and can influence policies and procedures in HE for academia and support services. <u>Limitations</u>: Small sample size for parent-fathers in HE and lack of generalisability of results.	<u>Implications</u>: Importance of acknowledging and supporting young fathers throughout the HE process, and the significant role professional services and effective policymaking can have on young men's outcomes. Missed opportunities for supporting young fathers, making support visibly and inclusive. Future research:

	benefits of becoming a student.	his studies and 4 were parents when applying for HE. 4 participants had considered enrolling on HE courses but decided not to apply. 11 young fathers did not see the benefits of HE. 5 young fathers reflected on their undergraduate HE experiences during the interviews. Email adverts shared by family support services, social media adverts, (10) former research participants were contacted directly with an email advert and research invite.		HE could also exacerbate mental health issues. Other concerns, e.g., managing finances/housing difficulties as a student were also mentioned. The young fathers had little knowledge of what help was available to them with HEI support services and what support they were entitled to. Some young fathers were aware of student-mother support (such as student-led social groups and breastfeeding friendly areas on campus), but not any awareness of support for young fathers. Young fathers suggested that HE providers should advertise what support is available		non-western, broader demographic of young fathers, longitudinal analysis for those who remain in HE – exploring intervention efficacy and evaluation, with an aim to gather more insights into the prevalence and nature of challenges faced by young fathers in HE.

				for students in a more visible and inclusive manner. student support should be more holistic in nature and not just academically driven. stigma attached to the use of professional services, particularly as a male and as a young father, would need to be considered and addressed in the planning of HE student support. young fathers aspired to enter HE to improve their personal circumstances, their future earning potential, and to increase the number of career opportunities. Young fathers who went on to study at HEIs, experienced		

				difficulties in identifying and using necessary and tailored support. Feelings of being 'burnt out' were reported due to managing and juggling parenthood alongside studying. Young fathers may feel reluctant to engage with formal support services due to stigma, feelings of being judged, previous negative experiences of working with professionals, and traditional ideas around masculinity and help-seeking behaviours being associated with weakness		
Outside looking in: Gendered roles and the wellbeing of working student mothers	To explore how the wellbeing of working doctoral student mothers is affected when	35 Working mothers who were part-time doctoral students Recruitment advertised in a newsletter	Qualitative semi-structured interviews, interpretivist approach using thematic narrative	The role that provoked the most conflict was that of 'mother'. The women in this study all discussed the	Strengths: This study contributes to current debates around well-being in the	Implications: For developing support systems, wellbeing initiatives

studying for a part-time PhD. **Cronshaw et al., (2023)**	undertaking part-time PhDs. There is a growing literature on the research student experience and an increased awareness of mental health issues in doctoral study. “What is the experience of working mothers undertaking part- time doctorates and how does that experience impact on their well-being?”		analysis to identify themes.	difficulties of the PhD in terms of reconciliation of conflicting ‘mothering’ competing demands, responsibilities, whereby the woman takes responsibility for the child's welfare, leaving them with feelings of guilt and anxiety when they must leave the child for their own employment or study demands. Students usually choose part-time study because of competing demands on their time which means they are likely to be in a constant state of negotiating between professional, student and personal identities. Marginalisation: women feeling excluded as they	postgraduate student community. An under researched groups voices being heard Limitations: no experiences of fathers	Improving relationships between students and staff, mentoring, forums Future research: explore the phenomenon of mothers undertaking part-time PhDs in different countries, exploring approaches to doctoral education/ institutional framework.

				lacked the opportunities, involvement and knowledge required to participate. Lack of support: The feelings of loneliness came from the lack of understanding of what they were going through. There was no reassurance that what they were thinking, feeling and experiencing was a normal part of the PhD process and this resulted in the women feeling they were on their own. PSYCHOLOGICAL WELLBEING: women in this study wanted to feel competent and autonomous in their achievements but experienced conflict due to the pressure to fulfil their gendered ‘obligations’ as mothers, resulting in		

				feelings of guilt. Many of the women in the study felt that things had just got too much to deal with and questioned their motivation to continue with the doctorate. PHYSICAL WELLBEING: health affected and neglected. SOCIAL WELLBEING: lack of socialisation can have a negative impact on retention as students have little interaction with faculty members and fellow students resulting in their feeling marginalised. CONFIDENCE, COMPETENCE, SELF-BELIEF: The women considered themselves as ‘novices’ in terms of the PhD. They lacked confidence in their knowledge and		

				ability partly due to their exclusion from the available institution and postgraduate research activities and associated communities of practice. Their position remained peripheral, preventing them from identifying themselves as students. They felt they were not intelligent enough or not capable of completing the PhD, they suffered from a lack of self-belief or 'Imposter Syndrome		
Parenting by day, studying by night: challenges faced by student-parents in the COVID-19 pandemic **Evans (2024)**	To what extent did the pandemic emphasise the importance of the student-parent voice informing HE policies and procedures	23 female and 4 male participants who adopted the role of student-parents. 14 female undergraduates, 9 female postgraduates, 3 male undergraduates, 1 male postgraduate	Qualitative semi-structured interviews	The pandemic and associated restrictions served to magnify existing inequalities experienced by student-parents as well as creating significant additional barriers.	Strengths: highlighted underrepresented voices limitations: self-selection bias of participants, only a snapshot	Implication: HE policies are necessary to recognise the intersecting identities that characterise a non-homogenous student

	To examine the pandemic's impact on pre-existing challenges of being a student-parent. - To explore any additional barriers created by the pandemic- To identify issues for further research	Study was posted on the HE electronic noticeboards, and snowballing techniques were used to allow additional interviewees to contribute to the study.		Consequently, this problematise the lack of institutional awareness of the unique circumstances faced by student-parents made evident by the lack of data collected on the diversity of the student population. Gendered nature of care: more mothers taking the load to provide academic support for their child and more domestic responsibilities- economic impact/HE structures/Financial impact/learning environment: Emotional toil= guilt, regret	of experiences and not longitudinal tracking of experiences	population. HE policy should incorporate targeted support mechanisms that address the unique challenges faced by different subgroups within the student-parent population Future research: consider the HEIs' discourse on international students who are assumed to be independent and unencumbered
Student parents, hardship and debt: a	To gain an insight into student-parents' concerns and	12 female undergraduate student-parents at Kingston University age range 29-45 years. All	Qualitative design, using structured (yes/no) and open-ended questions in an interview. IPA	Parents reported that their own stress adversely affected their children. Financial adversity	Strengths: use of piloting Limitations: low numbers	Implications: imperative that policy makers do not rely on data that come

qualitative study. **Gerrard & Roberts (2006)**	illuminate issues which may have far reaching consequences not only for the mental and physical health of student-parents but also for their children.	participants were mature students who returned to education with the intention of using their degree to either return to work or as a career move. 10 mothers had two children, 1 had three children and 1 had one child. Eight were married or with a partner and four were single/divorced/separated. Purposeful sample through snowballing	method used for analysis.	affected their psychological well-being. 7 participants (58.33%) reported suffering depression, with a majority also indicating that they were under considerable stress. 3 participants (25%) reported receiving counselling for depression. Almost all participants (11/12, 91.66%) felt that financial pressures had adversely affected their mood. In addition to depression, many of the women drew attention to anxiety and feelings of guilt (9/12) that emanated from feelings of not contributing enough financially or of perceived inadequacy as a parent.	of participants, non-diverse sample (from one London university) have not explored all areas of personal and family life, not an adequate measure of distress used.	only from students from higher socio-economic groups. Future research: further investigation regarding the diets of student-parents and their children is needed.

				Lack of resources was expressed in several ways, associated with making personal sacrifices on spending, having to work and socializing, which for some resulted in feeling isolated and alienated. Widespread emotional strain, depression, guilt, exhaustion and lack of sleep were reported. The strain of juggling work with studies and childcare could lead to poor parental support, which in turn may lead to developmental lack of emotional support early in life may lead to depression and chronic conditions in adulthood		

Invisible experiences: understanding the choices and needs of university students with dependent children **Marandet & Wainwright (2010)**	aimed to begin to fill this gap by exploring the learning needs and experiences of university students with children (aged 16 and under) and to develop recommendations and guidelines to better support and retain them.	18 participants, 12 female and 6 males, aged >18+, 10 parents in relationships, 8 lone parents, 11 parents not in employment, 4 in parttime work, 3 in full time work, 14 undergraduate parents, 4 postgraduate parents, 3 in part-time studies, 15 in full-time studies. Surveys were sent electronically to all subject areas; researchers visited lectures and enlisted the help of administrators to raise the profile of the research. a sample of 18 students was selected for interview in such a way that it included at least one person from each university school and where, possible, reflected the characteristics of the	18 Semi-structured interviews for university services and academic staff, and a questionnaire survey amongst students with dependents (analysed using SPSS) with follow-up interviews for 18 of these students with dependents thematic analysis for interviews Mixed methods design over all	time constraints and stress, financial pressures, sense of isolation, confidence and self-efficacy.	Strengths: Analysis focusing on under representative groups, attempts to ensure that the interview participant was reflective of the respondent in the survey limitations: conducted in one university setting, small sample size	Implications: better support services, community inclusion and flexible learning options. despite the government's lifelong learning and widening participation policies, students who have children still face several barriers to studying at university. changes have been concentrated on getting new inclusive space Future research: longitudinal studies, more

		wider pool of questionnaire respondents in terms of gender, family and employment status and level of study				diverse samples,
Navigating the Same Storm but Not in the Same Boat: Mental Health Vulnerability and Coping in Women University Students During the First COVID-19 Lockdown in the UK **Misca & Thornton (2021)**	to increase understanding of individual mental health vulnerabilities, behaviours and feelings during the COVID-19 pandemic.	36 student women (18-64 years) with and without reported pre-existing mental health diagnoses, enrolled in HE institutions in the UK. 39% of students reported a pre-existing mental health diagnosis. Data extracted from a larger dataset from a large-scale study. Recruited through opportunity sampling through social media and snowball techniques.	Mixed-methods approach. Anonymous online survey relating to demographics, relationships & families, coping, health and wellbeing (participant's retrospective self-reports). Two qualitative open-ended questions which asked participants to report what their personal strengths and difficulties/challenges has been.	Students with a pre-existing mental health diagnosis reported higher levels of loneliness compared to a matched sample of non-students, and more avoidant coping and negative emotional coping than students without a diagnosis. Qualitative data illustrate how parenting intersects with well-being and stress as both a protective and risk factor for women university students Students with no mental health diagnoses reported more positive coping behaviour and	Strengths: newly designed items from a survey, ability to hear first-hand accounts from under researched group of participants limitations: small sample size, retrospective reporting post covid-19 lockdown (recall bias). No longitudinal data to track changes overtime. Non-	Implications: provide opportunities for targeted support, while distinguishing effective coping strategies which have the potential to inform interventions Engagement with university mental health services was reported to be low and such barriers need to be examined and addressed by universities in the future.

				specified details related to positive coping in response to the open question about strengths.	standardised measure used	Future research: diverse larger sample, longitudinal designs, evaluation of the support systems for students and exploring resilience factors. Further research into vulnerable student groups is needed to understand how this complex picture can be used by HE institutions to provide targeted support and to inform both preventative and targeted interventions.
Care in academia: an	to shed light on the experiences	40 interviews with student-parents enrolled	qualitative semi-structured	Student-parents often describe their	Strengths:	Implication:

exploration of student parents' experiences **Moreau & Kerner (2013)**	of student-parents, with a view to contribute to the theorisation of the relationship between care and HE. To explore the issues they face when navigating the conflicting demands of care and academia	on (10) university programmes across England. Had children under the age of 11 years old. 1/2 were undergraduate students, 29 were studying full-time, two male student-parents were recruited average age of 25 years old. 26, White British, 5 White other, 5 Black British/African/Caribbean, 1 Arab, 1 Asian, 1 Egyptian and mixed race. 9 were single parents, 12 were international students. 1/3 had at least one child aged <5 years old, with a max of 6 children.	interviews, Thematic analysis	experience of navigating academia as a struggle, in which time-related, financial, health and emotional problems prevail. high levels of sleep deprivation, and a high occurrence of depression among this group. Yet some did not feel that their mental health issues were taken seriously. Many felt that they did not dedicate enough time to their children and partner or studies, nor with the default image of the childfree student, fully available for their studies. This was often associated with feelings of guilt, and because caring for children is often presented as a purely enjoyable experience. feelings of 'missing out' and	Presents evaluation of policies, good theory frameworks, attempt at a large recruitment of participant across the UK limitations: the sample is not representative of the HE sector in England as more extensive provisions were provided for student-parents at particular universities. The level of provision available for student-parents varies significantly across the	the need for higher education institutions to recognize and accommodate the unique challenges faced by student-parents. The research advocates for a more inclusive understanding of student identities that encompasses caregiving roles opens avenues for additional research into the experiences of diverse student-parent populations, including single fathers, LGBTQ+ parents, and those from various cultural backgrounds

				‘not fitting in’ also emerged from these narratives. the lack of time for activities other than parenting and studying (e.g. leisure or community activities) emerged students also expressed concerns about not being seen as fitting within the ideal of the academically excellent student. Some students complained that their parental status was interpreted by university staff as a lack of commitment. Student-parents experience a range of issues related to their dual status, leading many to describe their experience as a ‘struggle’ and some to consider dropping out	sample, ranging from very little to an array of initiatives. Admin in each uni were involved in putting the researchers in touch with staff and student-parents- potential for bias in terms of selection and inconsistencies with procedures of recruitment. they were not directly asked about physical and mental health problems. only 10 universities snapshot in time	Future research: Evaluating the effectiveness of current policies and developing recommendations for inclusive practice Exploring the types of support mechanism that are most effective for student-parents e.g., peer support, flexible schedules.

‘Little islands’: challenges and opportunities for student carers in higher education **Rawlinson (2024)**	To explore what challenges are faced by students with caring responsibilities and how can they best be addressed.	10 carers. (3 were parents/guardians) participant numbers 1,4,10 Students were contacted via several institutional channels, including an internal communications newsletter, Instagram social media post, and the university’s bespoke forum for gathering student voice. purposive sampling.	10 semi-structured 1:1 qualitative interviews using IPA	Disclose caring role, but on a need-to-know basis (childcare), consider giving up because of the pressure. not being able to go out with friends/classmates or celebrate events. feeling ‘overwhelmed’ or feeling guilty for not making the ‘sacrifice’ to care for a child and instead prioritising studying, leading to a self-perception that they are a ‘bad’ parent, determination to succeed, and be successful for themselves and their child. Theme of isolation and highlighted the need for increased awareness of counselling and mental health services early.	Strengths: inclusive of student-parents to gain their experiences, qualitative, in-depth limitations: students representing different carer roles. Very small sample size	Implications: diverse needs and experiences for students with varied caring responsibilities. Not knowing the demographic of participants, inability to understand how different factors can affect or influence the experience of a student-parent. Temporal constraint a snapshot in time. Future research: quantitative investigation of the academic and well-being impact of caring responsibilities

				Extensions, but tailored to individual needs. support with the transition back into education. limited opportunity for self-care. student-parents are highly organised and plan their time with limited time. anxieties about missing key bits of information; meeting assessment deadlines and the interplay of these with the unpredictability at times of caring demands; absence of adjustments (i.e. extra time) taking into account caring responsibilities; and, relatedly, the perceived rigidness and one-size-fits-all approach to extenuating/unexpected circumstances claims which left students feeling as		for student-parents/guardians and sibling careers would be a welcome addition.

				though they had to 'sacrifice' pieces of coursework; as well as general feelings of overwork and lack of time		
Student-parents' experiences of personal and academic support in UK higher education: barriers and challenges to equality of opportunity and policy and practice recommendations to mitigate them **Todd (2024)**	to explore the participants experiences of pastoral and academic support during their university journey 1. To expand the evidence base relating to the experiences, perceptions and needs of student-parents by gathering data from undergraduate student-parents across the UK. 2. To gather first-hand experiences from a wide range of	41 undergraduate students across the UK (from 14 universities), in education or who had completed the course within the previous three years. 35 reported studying in England and 6 in Scotland. 36 females 5 males, and almost two-thirds of participants fall within the 30–39 age bracket. Most respondents reported having one or two children, some having completed just one year of study and some having the benefit of the entire undergraduate journey to reflect upon the survey was shared via email with the	open and closed questions to gather quantitative and qualitative feedback on undergraduate student-parents' perceptions of their university experiences. Thematic analysis mixed methods approach	systemic failures in pastoral and academic support for student-parents across the sector, which pose a considerable risk to their retention, progression and success. Student-parents are currently being let down by failings in pastoral and academic support. There is a need for investment, recognising parental responsibility and a need for tailored interventions.	Strengths: providing an up-to-date representation of the difficulties and challenges faced by undergraduate student-parents in the UK, painting this picture via the voices of student-parents themselves larger sample size limitations: All survey respondents and focus group participants are current	Implication: Recommended changes in institutional policy to encourage the retention and progression of student-parents Institutions need to invest in establishing and maintaining effective pastoral and academic support for student-parents national policy drivers encouraging student-parent support have the potential to flow down

	student-parents to inform two guides (one for student-parents and another for personal tutors) to complement the evidence-based institutional guide to supporting student-parents	author's network of student-parents and was emailed to HE academic and support staff contacts within the author's network across the UK, with an accompanying request to share amongst their student cohorts. The author also posted a link to the survey on LinkedIn 5 student-parents attended an online focus group to review two guides			student-parents or graduates. The sample does not contain student-parents who may have withdrawn from their studies, therefore the experiences recorded do not necessarily reflect the full range of student-parent experiences. This was a small-scale study, and a targeted approach to the survey. It is not possible to know what percentage of the national cohort of student-parents the research	through institutions via academic and support departments, individual members of staff and finally to students future research: researching the lived experiences of postgraduate students and of those undertaking work placements as part of their course, as well as considering the pre-entry decision-making process of those with parental responsibility evaluating the student-parent guides

					participants represent. the issues raised were not new	
it has been an uphill battle from the get go': The experiences of single parents studying at university in the UK during the COVID-19 **Trotter (2023)**	to explore the meanings of being a single parent studying at a UK university in the context of the covid 19 pandemic. What impact has COVID-19 had on the experiences of being a single-parent student studying at university in the UK? What support is currently available for single-parent students studying at university in the UK? How	single-parent students, studying undergraduate or postgraduate degrees. AND who had children <18 years old. The questionnaire was distributed by contacting (via email) staff members at UK universities with responsibility for equality and diversity, and it was also shared via social media. A separate email was sent to participants who agreed in the surveys to be contacted about an interview, inviting them to an interview. During the interviews, participants were invited to participate in focus groups.	mixed-methods research online questionnaires. 18 online interviews and 3 online focus groups were conducted.	single-parent students occupied a simultaneous position of agency and mastery in the context of HE. personal demands related to childcare, time, and money have a negative impact on the mental and physical health of single-parent students, which has further implications on their studies. Issues of support, such as personal, academic, and peer support were found the be particularly striking in the context of the mental and physical health challenges identified by single-parent	Strengths: Drawing out key issues of demands and support. uses lessons learnt from the pandemic to explore how to meet the needs of students. Used interviews and focus groups to collect data. Limitations: the issues raised were not new Focusrd on single-parent experience only Attended to some issues	Implications: Universities should collect data on student-parents and use this data to enable tailored support via student support services; (2) Universities should work with Student Unions to ensure parent-friendly freshers activities and ongoing social/support groups for student-parents; and (3) Universities should make concrete

	do single-student-parents who study at university in the UK navigate childcare and timetabling concerns? What are the positive or rewarding elements of being a single-parent student who studies at university in the UK?			students. They occupied a position of submission and mastery within the university system.	specific to the context of the pandemic e.g., closure of childcare facilities	changes to campus space, including the introduction of accessible, flexible, discounted childcare on campus, parent and baby rooms, and baby-changing facilities. Future research: Longitudinal impact, comparing with those who have partners, evaluating and investigating the effectiveness of university based counselling and mental health services.

Table 10 has been used to inform the process of narrative synthesis, which involves theory development, a preliminary synthesis of findings from the included studies, explorations of the relationships in the data and an assessment of the robustness of the synthesis. All studies were read fully, with key concepts and relevant quotes around the mental health experiences of student-parents being highlighted. Appendix G shows the explorations for the relationships in the SLR data (i.e. themes), which were collated and coloured according to their representing theme.

Review findings

The SLR aimed to explore the mental health experiences of student-parents in UK HE settings, obtaining an insight into the challenges, barriers and methods of support offered by HE institutes. The studies focused on student-parents engaging in undergraduate, post-graduate and PhD courses, who had at least one child <18 years old. Table 11 displays the themes that will be discussed in the review findings.

Table 11: SLR table of themes

Theme	Description of theme
Theme 1	High expectations leading to feelings of guilt
Theme 2	Isolation
Theme 3	Identity conflict
Theme 4	Navigating demands and time pressures
Theme 5	Forms of institutional support

Overall, the complex interaction between engaging in HE and parenting directly affected the mental health of student-parents, who described a range of difficulties including sleep, high levels of worry, stress and regret (Evans, 2024; Gerrard & Roberts, 2006; Moreau et al., 2013). Financial adversity featured as a contributing factor to mental health distress, particularly with regards to the cost of childcare provisions, where UK costs are amongst the highest in the world (Clayton et al., 2024; Gerrard & Roberts, 2006; Moreau et al., 2013). Others described their time in HE as though they were in ‘survival mode,’ being ‘pushed to the limits,’ nearly ‘breaking’ them and being incredibly ‘overwhelmed’ (Rawlinson, 2024; Todd, 2024).

"I do wake up in the middle of the night and lay awake wondering how I am going to cope so it probably makes me feel anxious and tired (L119, Case 4) (Gerrard & Roberts, 2006)."

"I have suffered depression and yes I feel anxious and tired a lot of time, and sometimes I have to work really hard not to let it affect me deeply (L129, Case 4) (Gerrard & Roberts, 2006)."

The following themes describe the reported experiences, and considerations have been made for the similarities and differences found within studies.

Theme 1: High expectations leading to feelings of guilt

Five studies discussed how student-parents reported a strong desire to prove themselves (including to others), create better opportunities and be viewed as role models for their children (Marandet & Wainwright, 2010; Moreau et al., 2013; Rawlinson, 2024; Todd, 2024). It was important for them to do well; however, performance was significantly impacted by mental health difficulties. In most studies, student-parents experienced anxiety (fear of failure, falling behind, missing key information), increased distress and emotional pressure with wanting to be both a 'good student' and a 'good parent.' Societal narratives were particularly apparent for student-mothers. These expectations led to exacerbated feelings of guilt, which featured as a key concept in most studies. Three studies described how student-parents wanted to feel competent, but instead they felt they lacked confidence and knowledge as if like 'novices' and 'imposters' compared to their peers, who were being viewed by academic staff as academically excellent students (Cronshaw et al., 2024; Marandet & Wainwright, 2010; Rawlinson, 2024). This lack of self-belief and doubt was evident despite student-parents having previous successful careers and in the context of being accepted into HE programmes (Cronshaw et al., 2024). Some student-parents considered further studies but decided against this as they were concerned about the possibility of further affecting the relationship with their child/children and perceiving themselves as a 'bad parent' for engaging in more study (Rawlinson, 2024).

"The guilt that I'm not doing what I should be doing it hangs over you all the time (Grace) (Cronshaw et al., 2024)."

"I felt very guilty that I wasn't doing the best I could in my work and felt guilty I wasn't doing enough for my PhD. I felt guilty that I wasn't doing enough as a mum (PG3) (Evans, 2024)."

"I think maybe I partly didn't feel I was worthy of doing it. I think I felt that I wasn't intelligent enough, which is something I still feel (Denise) (Cronshaw et al., 2024)."

"You're anxious about everything, it's a really complicated mix of guilt and anxiety (Joan) (Cronshaw et al., 2024)."

In addition, student-parents mental health difficulties impacted on their parenting, where changes in behaviour and emotional responses were noticed by the children. Student-parents did not feel they were always attentive to their children's needs and reported stress and irritability with them for seemingly trivial matters (Evans, 2024; Gerrard & Roberts, 2006). By contrast, in two studies, student-parents described their children as a source of strength and motivation to continue through the challenges of the HE courses and considered them as a welcomed distraction from their studies (Misca & Thornton, 2021; Todd, 2024).

"They pick up on my emotions and also my behaviour is more negative and less patient (L94, Case 5) (Gerrard & Roberts, 2006)."

Theme 2: Isolation

In all studies, student-parents reported negative impacts on their psychological wellbeing a result of feeling marginalised, isolated and excluded from being able to engage fully as student. Family commitments often took precedence (e.g., childcare arrangements, child illness), which limited student-parents ability to partake in academic activities and social events (Clayton et al., 2024; Misca & Thornton, 2021). In some circumstances, limited interaction with faculty staff and other peers from their course left student-parents feeling on the peripheral of the HE community (Cronshaw et al., 2024). In a third of the studies, motivation was discussed as being negatively impacted, with student-parents questioning their desire to complete the course and having thoughts to end the course or take a break from it.

"The sacrifice you are making in your family, your personal life, your wellbeing – it's not worth it (L294, Case1) (Gerrard & Roberts, 2006)."

"At times, I have felt like giving up, because I have been struggling for the money to pay for the childcare. I have struggled for the time for myself to do the work that I needed to do (Stephanie) (Moreau et al., 2013)."

> *"I don't think I felt part of anything, I was too isolated. And I didn't get to talk about my research until I sat down with a supervisor, so I didn't get to share it with other people (Patricia) (Cronshaw et al., 2024)."*

Alternatively, some student-parents did not experience the same sense of isolation, especially for HE courses where more student-parents were present (e.g., nursing or education) and where there were usually more diverse students undertaking these courses. In these situations, student-parents were able to give and receive support on practical and emotional levels, and they were in much better positions to request for flexibility and reasonable adaptions with how they engaged with academic tasks (Moreau et al., 2013). Consequently, these requests were upheld by course tutors.

Theme 3: Identity conflict

Most studies described, student-parents struggle to navigate the interaction between different roles (parent, professional and student) creating a sense of conflict and 'fractured' identities (Cronshaw et al., 2024; Marandet & Wainwright, 2010). There was also a sense of student-parents occupying a position of submission (Trotter, 2023) and having to just 'get on with' academic demands. Attempts to 'fit in' with the university life tended to be at the expense of students' wellbeing (Marandet & Wainwright, 2010) and even when student-parents participated in academic activities or events, they did not feel knowledgeable or confident to engage amongst their peers. On the other hand, some spoke about how engaging in HE courses enabled them to reconnect with themselves and find meaning to their life, other than being a parent.

> *"When you have a child, as a mother, you lose your identity…you suddenly become just that mum over there. People don't see you for being anything other than that, but [the course] gives you just a little piece of you back (Lisa) (Moreau et al., 2013)."*

> *"I find it very difficult sometimes changing the hats to meet different situations, you were never a great mum because you didn't go to all the mummies classes and you're not a great colleague because you don't go to the pub with other people from work, so everything you're doing, you're not quite doing as well as everybody else... (Jan) (Cronshaw et al., 2024)."*

Theme 4: Navigating demands and time pressures

All student-parents, regardless of gender, spoke about the challenges of engaging with academic demands (e.g., assignments) and parenting responsibilities, which affected their mental and physical health as well as their emotional capacity. This constant negotiating and prioritising of tasks occurred in the context of all student-parents having very little time worsening mental health with some describing it as ‘spinning multiple plates’ and making important sacrifices (Clayton et al., 2024; Cronshaw et al., 2024; Todd, 2024). Consequences of too many demands and little time involved neglecting wellbeing needs, including the attendance of peer support groups, spending time with friends, and not engaging in self-care or restorative practices, such as sleeping and eating well, necessary for promoting mental wellbeing (Clayton et al., 2024; Evans, 2024; Gerrard & Roberts, 2006; Misca & Thornton, 2021; Moreau et al., 2013). Participants spoke about time poverty and were sacrificing their sleep to engage with necessary academic and parenting responsibilities leaving them more exhausted and sleep deprived (Marandet & Wainwright, 2010, Moreau et al., 2013).

“Restricted, alienated if you can’t go out with friends (L41, Case 6) (Gerrard & Roberts, 2006).”

“I don’t do anything apart from my children, uni and the house…there is no time to myself. There is absolutely none (Kelly) (Moreau et al., 2013).”

“Anxiety because deadlines are piling up but you barely have time to do anything and when you do, you’re too exhausted (Respondent 36) (Todd, 2024).”

“I find it very difficult sometimes changing the hats to meet different situations, you were never a great mum because you didn’t go to all the mummies classes and you’re not a great colleague because you don’t go to the pub with the other people from work, so everything you’re doing, you’re not quite doing as well as everybody else but trying to keep up (Jan) (Cronshaw et al., 2024).”

“It’s a constant balancing act and you can’t ever win. If I dedicate as much time to my studies as I wanted to, I would be neglecting my child. If I dedicated as much time to my child as I wanted to, I would be neglecting my studies (Katherine) (Moreau et al., 2013).”

Concepts which enabled psychological wellbeing included knowing what is good enough and being able to organise time and manage both academic and parenting demands.

"I think I've had to learn what is a good enough point for me, what is a good enough amount of parenting and what is a good enough amount of studying and how I am going to make that balance. (Nesha) (Moreau et al., 2013)."

"It's all about time management really, you know, and being able to work around [my child's] time, not just mine (Student carer 1) (Rawlinson., 2024)."

In addition to children being in childcare provisions (which was cited in three studies as something helpful to enable student-parents to engage with their academic requirements), many student-parents studied when the children were asleep or distracted with an activity, although this was not successful when being interrupted. Taking up opportunities to complete work also came with a consequence of severe burnout (Clayton et al., 2024; Moreau et al., 2013) with student-parents already experiencing exhaustion and a lack of motivation and poor concentration (Misca & Thornton, 2021).

"It is really difficult, because obviously the kids don't go to bed until half seven, eight o'clock, which is the time I basically get to do my work (Stephanie) (Moreau et al., 2013)."

"Mental health, mental stability. There are some days you're clinging on by your fingernails. Because it's just immense carrying the full workload and all the commitments that come with our job, then doing a PhD, then organising a family (Cronshaw et al., 2024) (June)."

Theme 5: Forms of institutional support

Only one study directly referenced student-parents accessing counselling support within the wider institution (Gerrard & Roberts, 2006), whilst two studies stated difficulties with the visibility of the support on offer (Clayton et al., 2024; Rawlinson, 2024). Clayton and colleagues (2024) described support as unclear and potentially inaccessible for young fathers, referencing stigma and poor experiences of accessing similar mental health services outside of the institute. Marandet and Wainwright (2010) noticed that there seemed to be a reluctance to seek counselling support with some student-parents minimising distressing. In the same study, some students associated accessing counselling as suitable for those with more serious issues. Todd (2024) stated that pastoral and departmental support was considered as the most used and most helpful in addressing various difficulties for non-traditional student-parents over psychological support. Facilitators for support included an understanding of diverse students, being knowledgeable about the mental health challenges and priorities outside of HE and genuinely being interested in student-parents' families and lives (Todd, 2024).

Student-parents felt that their challenges were not understood, and they did not feel that their parental status was considered by peers or the institute (e.g., with organising events and the release of timetables). This invisibility and one-size-fits-all approach allowed for mental health problems to go unnoticed and in some cases worsen (Clayton et al., 2024; Marandet & Wainwright, 2010; Moreau et al., 2013; Todd, 2024).

"The university doesn't time events well for parents, doesn't have facilities for children or breastfeeding and generally likes to pretend that every student is 18 or 19 with no caring responsibilities. The timetables kept changing and I found it extremely difficult to arrange childcare and for it to change again. It affected my mental health. (Todd, 2024)."

Student-parents did not report positive experiences of requesting support within the institution. As a result, they often questioned their ability and commitment to finish the course.

"Either I take a week off sick or I work from home, because if I don't I'm either going to kill someone or kill myself (June) (Cronshaw et al., 2024)."

It seemed that mental health difficulties were not being taken seriously by faculty staff. Some student-parents felt that their commitment to studies was being questioned, even in unprecedented circumstances (e.g., unwell child). Students also expressed concerns about not being seen as the 'academically excellent student' by course staff and felt as though they were not fitting in with their peers (Moreau et al., 2013).

"I've been suffering a bit with depression recently, which is a bit of a pain…the university counsellor seemed to be of the opinion that I just needed to manage my time better and there was nothing really wrong with me and kind of sent me packing. (Natalie) (Moreau et al., 2013)."

Student-parents made suggestions for support, including better support services for mental health, support which is visible and inclusive in nature, earlier releases of timetables and flexible options (such as attending online lectures/seminars) to engage with academia and fit in family life (Clayton et al., 2024; Marandet & Wainwright, 2010, Misca & Thornton, 2021; Todd, 2024). However, two studies described concerns around the level of engagement and contribution for online classes and declined flexible studying options when studying in unconducive environments (Rawlinson, 2024; Todd, 2024). Another suggestion was made around peer support and being amongst others who share similar parenting/mental health circumstances, helping to develop a sense of belonging at emotional and intellectual levels (Marandet & Wainwright, 2010).

Implications, recommendations and conclusions

This SLR presents and synthesises the findings from ten studies to explore the mental health experiences of student-parents in UK HE settings. This SLR combined information about the mental health experiences, facilitators and barriers to accessing support. The following provides a summary of the findings. It considers strengths and weaknesses of the SLR findings, and it provides recommendations for future research, which could have valuable implications for policies and processes in UK HE settings.

Overall, the studies concluded that student-parents experience significant mental health difficulties as a direct result of engaging in HE courses whilst simultaneously managing the necessary requirements of parenting or caregiving. Mental health impacted student-parents' academic abilities, and despite having high expectations and desires to perform well, not only for themselves but for others and their children, student-parents exhibited such distress that it impacted the perception of their capabilities. Guilt was mentioned in all studies, with student-parents reporting challenges with balancing both academic and parenting demands. With sacrifices being made frequently, student-parents felt isolated and excluded from HE communities, further exacerbating distress. There was a lack of flexibility in approaches for these students, meaning less opportunity for self-care and family time. Student-parents feel guilty, isolated and excluded, and often experienced a loss of their sense of self and identity. Whilst mental health needs may be attended to by faculty staff on a practical level (e.g., being able to offer and provide extensions as they are more likely to be in frequent contact with student-parents) findings suggested that the wider institute does not appear to offer personalised support to meet individual student-parents' needs. Consideration needs to be made for how student-parents can access mental support given their report of having limited time for anything other than catching up on and completing their work and parenting. Despite student-parents being considered as highly organised individuals, this SLR highlighted the need for more tailored support in the context of mental health.

This SLR is considered as unique, highlighting the voices of student-parents in HE who voices are underrepresented in research related to mental health. Whilst my research question hoped to consider both positive and negative experiences of accessing support, challenges dominated as the central focus. With studies being published between 2006-2024, this SLR captures the relevant qualitative experiences of the inception of the DfES Widening Participation Strategy (DfES, 2003). Importantly, the studies appear to highlight a need for consistent and equitable structures of support across all institutions. Additionally, less was known about the type of support being offered to student-parents (e.g., counselling or psychological intervention), other than that of pastoral care. To date, no other review has focused on these experiences, and so this SLR can be considered as a step towards making changes to improve access to mental health support and evaluating the effectiveness of any future changes.

Small sample sizes tend to exist within qualitative studies and within my SLR sample sizes ranged from 3-41 participants. Whilst there was a mixture of female and male student-parents, females participants dominated. Societally, mothers take on more of the household duties and responsibilities (Cronshaw et al., 2023; Evans 2024), and therefore it could be that this group of individuals may struggle more with their mental health whilst balancing both a student and parenting role.

My SLR findings cannot be generalised to all individuals as they might be less relevant to other non-traditional students. For example, only a few studies described the ethnicities of student-parents, therefore another weakness of this SLR is that there is no clear information on the mental health experiences of student-parents from diverse ethnic backgrounds or marginalised communities. Considering the lens of culture/ethnicity could provide alternative insights into the diverse experiences and needs within different populations, such as the cultural influences of understanding mental health, disparities, help-seeking behaviours and responses to institutional support.

Grey literature, such as doctoral level dissertations, blogs and research by specialist organisations, were not included in this review to align with my epistemological stance. This may mean that potentially relevant and recent data have been excluded, which may have highlighted other mental health experiences of student-parents in HE. Grey literature could be useful to explore in future research. It is possible that experiences may differ in terms of accessing and receiving support for both mental health, engagement with studying and family support when considered in the context of intersectional identities. Future research could also look to investigate these experiences.

Collectively, studies described difficulties with student-parents being able to navigate the academic tasks and more pressing parenting demands, leading to negative consequences on their mental health. Few recommendations are offered for how these complex demands are navigated, other than reasonable adjustments being made which suits the needs of individual student-parents. This indicates a need for student-parents to be involved in designing policies and informing processes, so that their perspectives of what helps and what hinders their engagement and mental health is considered. Findings published in peer-reviewed journals have implications for how information and recommendations are disseminated and implemented across HE settings. Effective dissemination strategies are required beyond traditional academic publications with HE settings implementing comprehensive guidelines and consulting with public government bodies for evaluation purposes.

It is possible that some student-parents could not share their experiences within studies due to lack of time and too many demands. Additionally, whilst no study appeared to exclude participants on the basis of mental health conditions, the voices of student-parents with severe mental health difficulties may not have been included in the SLR studies, if they had temporarily disengaged from studying and missed the recruitment phase (e.g., due to a period of mental health sickness), or from those who have chosen to leave the course prematurely due to their mental health. Future research could consider student-parents who have had to leave HE courses or pause their studies due to experiencing a severe mental health difficulty.

This SLR obtained studies from UK HE institutes and so future research might want to consider exploring mental health experiences of student-parents engaged in HE courses internationally. Given that more barriers with accessing support was reported, there could be an opportunity for international research to highlight the potential benefits and facilitators with accessing support.

Three out of ten of these studies reported mental health difficulties in the context of the Covid-19 pandemic (Evans, 2024; Misca & Thornton 2021; Trotter, 2023), which coincided at a time where parents had to adjust to a new way of living in heightened uncertainty, some with a lack of resources to support their children’s education. It is possible that mental health difficulties and distress was confounded by these factors.

The SLR findings can inform policy, practice and future research. The findings suggest that changes can be made to institutional policies, where there are opportunities to develop and provide appropriate support and interventions that facilitate mental wellbeing. Findings suggest facilitating connections with peers, parenting initiatives across departments and offering more visible mental health support. These forms of support should be presented early in the course and not when student-parents are experiencing distress, as this might alleviate the challenges associated with student-parents' reports of time poverty, isolation and guilt.

There is a need for clear consistent approaches, and this requires consideration as to who is responsible for providing and ensuring mental health assessment and support. More collaborative working between student-parents, department faculty staff and the wider institute can help facilitate communication and inform policy and processes whilst additionally collecting data on student-parents' mental health needs. More awareness of mental health difficulties could be provided through training to help academic professionals recognise the challenges student-parents face and to enable them to respond compassionately and flexibly. This also has the potential to reduce stigma highlighting a culture that normalises health-seeking behaviours among student-parents.

More research is needed into vulnerable student groups and addressing the needs of non-traditional students-parents. These have implications for equitable practices and developing policies and processes which are inclusive. SLR studies recommend longitudinal designs, which evaluate the effectiveness of mental health intervention for student-parents and to evaluate the any proposed changes.

Rationale for the current empirical study

The findings from my SLR referred to student-parents in HE settings only, with no studies including those who were engaged in DClinPsy training. Taken together with the literature explored in my introduction chapter, the findings from my SLR highlighted a gap in the current knowledge of how mental health difficulties are navigated by parent-trainees enrolled on DClinPsy programmes in the UK. There is limited research on the experiences of trainees with LEMHDs who are fulfilling parenting roles. This research gap is novel, yet crucial in contributing to a deeper understanding of how those involved in the design and implementation of clinical training can act to support parent-trainees with LEMHDs. The implications of conducting this research include uncovering potentially unknown sources of support for current trainees. There may be benefits for helping to inform future applicants who are parents with LEMHDs of the challenges and responses to these challenges, and how to navigate aspects of the programme, such as academic tasks, clinical placements and employment. It may also identify how trainee peers can respond to parent-trainees with LEMHDs.

Empirical research aims and questions

Main research question

- How do parent-trainees navigate mental health whilst on the DClinPsy programme?

Exploratory questions

- What is the impact of navigating mental health and the role of a parent-trainee with LEMHDs?
- Are there any challenges and how do trainees make sense of these challenges?
- How are personal and professional demands balanced and prioritised in training?
- How do parent-trainees manage self-care, wellbeing and their mental health?
- What sources of support are available for parent-trainees with LEMHDs?

Chapter 3: Methodology

Overview

The following chapter outlines the process of my empirical research, with the research question focusing on how parent-trainees navigate mental health difficulties when enrolled on DClinPsy programmes. It will consider the rationale for a qualitative design and the rationale for using Interpretative Phenomenological Analysis (IPA). Details of recruitment, data collection, and ethical considerations will also be presented.

Design

My research question aimed to explore how parent-trainees navigate mental health challenges on DClinPsy programmes. A qualitative design was chosen as the most suitable and appropriate method to answer my research question, instead of a quantitative design, which uses pre-determined variables and quantifiable or measurable data. Qualitative designs are concerned with meaning and seek understanding about how people make sense of the world and how they experience it (Willig, 2013). Analysing complex phenomena in an under-researched area with an under-researched group through qualitative methodology is advantageous, as my research sought to gather a rich and in-depth understanding of the LEMHDs in parent-trainees. Qualitative designs followed the principles of my epistemological stance with how reality is interpreted through individual perspectives based on social, historical and cultural factors (Fletcher, 2017; Losch, 2009). Findings from my SLR supported the use of a qualitative approach which was a commonly used methodology for exploring the experience of student-parents in HE settings.

Methodology

Rationale for Interpretative Phenomenological Analysis

After careful consideration, Interpretative Phenomenological Analysis (IPA) was chosen to answer my research question. IPA seeks to understand how people make sense of what is happening to them (Smith et al., 2022) whilst exploring the meaning that people give to their subjective lived experiences (Alase, 2017; Smith et al., 2009). IPA research questions "*explore in detail how participants are making sense of their personal and social world…the meanings particular experiences, events, and states hold for participants*" (Smith & Osborn,

2015. IPA has three primary theoretical underpinnings; Phenomenology (a philosophical approach of how one experiences and interprets the world), double hermeneutics (a two-way, second-order interpretation made by both the participant and the researcher) and idiographic (the use of an inductive approach by examining the detailed experience of each participant in turn) (Smith & Osborn, 2015). For my research I explored and analysed how parent-trainees made sense of navigating mental health challenges in clinical training. This was the double hermeneutics approach. The critical realist lens was suitable for IPA analysis; I was aware that each participant brought their own subjective experiences to interviews, and I recognised that an external reality existed which shaped their experiences. Through the IPA framework I added a further layer of interpretation, interpreting participant's accounts of their experiences (Harper, 2011).

The IPA methodology can be time-intensive particularly for researchers who are not familiar with the process. As with most qualitative studies, data is subjective and has limited generalisability, as does idiographic studies with small sample sizes, leaving results at risk of being impressionistic (Malim et al., 1992), with findings only contributing to theory at a lower level (Pringle et al., 2011). There is a risk of researcher bias which can influence the data if proper measures are not in place to mitigate this (e.g., bracketing interviews, reflexive research diaries). IPA involves an iterative process, but it can be challenging to disregard knowledge from older interviews influencing newer ones (Finlay, 2008). Some existing literature questions IPA and its ability to show scientific rigour, especially if methodological steps for replication purposes are unclear. Thus, document decision-making processes through reflexive research diary entries was essential (Koch, 2006).

Despite the limitations, IPA was considered the best approach for my research, which combined both the researcher (my own) and the participants knowledge. IPA has methodological quality with a clear framework provided. Participants construct knowledge based on their lived experiences whilst the researcher constructs knowledge based on their analysis and interpretation of the meaning of the data (Karnieli-Miller et al., 2009). IPA benefits from smaller sample sizes allowing for in-depth analysis of personal accounts (Smith et al., 2009), ensuring rich data, firmly grounded in what the participant has said before interpretation. It is a useful methodology for examining complex, ambiguous and emotionally laden topics (Smith & Osborn, 2015). To mitigate the risk of researcher bias, I used a reductionist approach where I used purely descriptive verbatim to delay any assumptions forming. To address findings that contributed only at a lower level, theoretical transferability was considered rather than empirical generalisability (Smith et al., 2009). And to assess the rigour and validity of qualitative studies, Yardley's validity framework (Yardley, 2000) was used to enhance the validity of qualitative research using four main principles: 1) sensitivity to context, 2) commitment and rigour, 3) transparency and coherence, and 4) impact and importance. This will be discussed in my reliability and validity section.

Consideration for alternative methodologies

Table 12 presents alternative methodologies considered for my research and my rationale for rejecting them.

Table 12: alternative methodologies for empirical research

Qualitative methodology	Rationale for rejecting this methodology
Thematic analysis (Braun & Clarke, 2006; Braun & Clarke, 2019).	*The thematic analysis approaches seek to explore, interpret and report patterned meanings within data (*Braun & Clarke, 2022*)).* Thematic analysis was originally considered for its ability to focus on the broader, general themes across participants. It involves a rigorous process of data familiarisation, coding, developing and revising themes, which together can help address the research question. Reflexive thematic analysis was considered for its theoretical flexibility and its use with different theoretical frameworks, which can explore people's experiences. Thematic analysis is more theory-driven and less interested in the phenomenology or personal meaning of experience. It was rejected as it does not provide a rich, in-depth focus on the personal and subjective lived experiences of participants (i.e. parent-trainees with LEMHDs), or the meanings that participants make of their experiences (how challenges with mental health were navigated). It also does not utilise the researcher's reflexivity or own interpretations in co-constructing meanings of experiences.
Narrative analysis (Bamberg, 2012).	*Narrative Analysis is interested in how people narrate stories about their reality to make sense of their life experiences. This approach focuses more on the storytelling process rather than the experiential context.* Narrative analysis was considered as an option to explore how people tell their stories of navigating the DClinPsy training as a parent-trainee with LEMHDs. However, it was not chosen, because the aims of the research were to explore what the experiences mean to participants, more than how stories are told. Narrative analysis does not include an interpretative process, and the researcher does not have an active role in understanding the meaning that participants make of their experiences.

Ethical considerations

Throughout my research I have engaged with the process of maintaining an ethical approach[9] to all aspects of my research. I defined ethical considerations as the rules of conduct when carrying out research, informed by the BPS Code of Ethics and Conduct (BPS, 2021). As a researcher, I have a duty to protect research participants from forms of harm, respecting their rights and dignity. The following will discuss key practices that I engaged in to maintain ethical standards. This includes obtaining ethical approval, consent and confidentiality, responding to distress, and upholding wellbeing for both the participant and me.

Ethical approval

All UK research requires ethical approval to assess if the benefits of conducting research outweigh the risk of any possible harm. The Health, Science, Engineering and Technology Ethics Committee at the University of Hertfordshire granted my research ethical approval, with the notification of approval received on the 18th of June 2024 (protocol number LMS/PGR/UH/05677) (See Appendix H for ethical approval).

Informed consent

Informed consent relates to participants being fully aware of the purpose of the research, what it entails and any potential risks that might arise, before giving consent to participate (BPS, 2021). This information was provided in the participant information sheet (See Appendix J), and included details of the eligibility criteria, confidentiality, recording and storing of data, the right to withdraw and any reasonable adjustment requests. All participants were encouraged to ask any questions before commencing the interview. They were recruited on a voluntary basis, with no incentives or coercive methods used to encourage participation. To allow for altruistic motivations for taking part in my research (Surmiak, 2020) participants were not remunerated nor given any monetary incentives for their participation. No deception was involved in my research.

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[9] See Appendix A, Excerpt C for Reflexive research diary entry on ethical approval, participant interest

Confidentiality and privacy

Online interviews required participants to be in a private and confidential setting, such as a private room in their home or workplace office, and without their children present. Confidentiality was discussed before the interview due to the sensitive nature of the topic of LEMHDs and parenting.

In line with The BPS Code of Ethics and Conduct (BPS, 2021), participants were assigned pseudonyms with excerpts from the interview being anonymised. Any identifiable information, (e.g., university location, child's name and geographical location) was removed from transcripts. As part of the analysis, anonymised transcripts were shared in research methods workshops, and with my supervisory team. The research was considered General Data Protection Regulation (GDPR) compliant with all participant's data forms and recordings being stored in separate folders on the encrypted university drive (no hard copies were held). As the lead researcher I recorded and transcribed all interviews, and no personal data was shared. Participants could withdraw at any time during the interview and request for their data to be removed for up to one week past their interview date. I destroyed all personal data including recorded interviews after successful completion and submission of my thesis.

Responding to risks

Managing participant's wellbeing

There were no known risks associated with my research. However, the sensitive nature of the topic concerning personal mental health experiences and parenting could have led to some discomfort. Participants were informed of this via the participant information sheet, and just before the interview to mitigate any potential risks. Participants were able to request to see the themes of the questions in advance of the interview[10]. Participants were reminded before the interview that they had choice over what they shared and what questions to answer, they could stop the interview at any time, and they could withdraw their data for up to one week past the interview. Drawing on years of experience working with people in distress, if I noticed that discussing mental health or parenting caused distress, I offered participants a break, encouraging them to return when ready and if they wanted to continue. I conducted regular check-ins during the interview to ensure participant's wellbeing, maintaining ethical considerations.

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[10] See Appendix A, Excerpt D for Reflexive research diary entry on viewing interview themes

At the end of the interview, participants were given a debrief form (see Appendix K) which stated the aims and hopes of the study. This form included relevant information about my research for if the participant wanted to discuss anything in more detail, as well as the researcher's details and information related to sources of support. With these options in mind, appropriate measures were in place to mitigate any potential risk of harm to participants ensuring their wellbeing. The risk of harm was considered as minimal and no greater than what would be encountered in everyday life, particularly when the participant had control over what they shared.

Managing the researcher's wellbeing

As an insider-researcher, it was important for me to reflect on how participant's accounts affected my own wellbeing. Hearing experiences which may be different to my own may make me feel discomfort. I shared matters of personal resonance with my supervisory team, which allowed me to seek advice and support maintaining my research and ethical conduct. Engaging in continuous reflection through a reflexive research diary helped me notice personal resonances and gave me an awareness of my emotions which could have influenced my interpretations. To maintain a healthy work-life balance I engaged in self-care practices (see Appendix L), such as listening to music and using my mindful colouring book to help regulate my emotions post-interview and during the research process. I found immersing myself in self-care extremely therapeutic and stress-reducing, especially for interview which had personal resonance. This stress reduction is corroborated by research which has documented the associated benefits of mindful colouring in reducing levels of anxiety and stress (Anderson et al., 2007; Shapiro et al., 2005). I allowed myself to engage in this activity for at least 30 minutes after each participant's interview. I found it especially beneficial for the interviews which brought up intense emotions, such as sadness, anger and shame, as it allowed me to process feelings, reflect, gather and formulate my thoughts coherently to include in my reflexive research diary. This process helped me to separate my emotions from my interpretations and analysis, minimising the risk of bias.

Consultation with Experts by Experience (EbEs)

Experts by Experience (EbEs) are essential as they bring valuable perspectives and insights based on their own personal experiences, improving the understanding of human behaviour (Ahuja & Williams, 2005). EbEs are beneficial for research as it can increase critical thinking and research practice (navigating validity, ethical sensitivity, dissemination). In addition to empowering EbEs, their insights can help researchers mitigate the risk of biases, leading to more accurate findings (Domecq et al., 2014; Thompson et al., 2009). My research involved drawing on the expertise of a consultant with similar characteristics to my target population, helping to inform and support the decision-making process for the design of my research. My consultant was identified and recommended by my supervisory team. They were deemed as suitable for my research with having similar characteristics to my participants (a mother who was a parent-trainee on the DClinPsy programme) and who recently engaged in doctoral-level, qualitative research exploring how mothers experienced DClinPsy training.

My consultant provided feedback at multiple stages of the research process. This included the design and piloting of the interview questions (see Appendix I for interview guide), recruitment poster[11], consent, debrief form and participant information sheet. My consultant was also involved in analysing excerpts (see Appendix M) sharing reflections and ideas for possible themes along with members of the supervisor team. To maintain research transparency, I documented feedback and changes recommended by my consultant in my reflexive research diary. When developing the interview questions, I conducted a bracketing interview[12] with my consultant[13] and a fellow TCP, revising the wording and ordering of questions. This helped me to consider what the interview questions brought up for me and allowed for questions on the interview guide to be refined, helping to answer the research questions. Bracketing is an important part of the double hermeneutic process in IPA research. I have decided to include my reflections related to the bracketing interview in the appendices within my reflexive research diary entries (Appendix A, Excerpt B) rather than the main body of the text for readability purposes and stylistic preferences.

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[11] See Appendix A, Excerpt A for Reflexive research diary entry on producing the poster

[12] See Appendix A, Excerpt B for Reflexive research diary entry on bracketing interview and practice

[13] My consultant was thanked, acknowledged and made aware of the impact of their contributions. In line with maintaining ethical considerations, my consultant was asked if they would like to be renumerated for their involvement with my research, but they declined and wished to be named in the acknowledgements only.

Participants

Sampling

In IPA, the use of a homogenous sample is recommended as participants can offer insight from a position of shared knowledge of their lived experiences. IPA tends to use a small, homogenous sample, though an actual sample size recommendation is not usually provided (Smith et al., 2009). Through discussion with my supervisory team and with IPA workshop facilitators, my research aimed to recruit between 4-10 participants, deemed as beneficial for allowing an in-depth exploration into individual experiences and sufficient to answer my research question at a doctoral level (Clark, 2010). Purposive sampling was used to identify and recruit participants who offered a meaningful perspective of my research topic. It was chosen as participants were selected based on specific characteristics relevant for answering my research question. Snowballing sampling techniques were also used asking participants who completed the interview to share the research poster with others who also met the eligibility criteria. To be eligible for my research, participants needed to meet the inclusion and exclusion criteria listed in Table 13.

Eight female TCPs enrolled on UK DClinPsy programmes participated in my research, and all identified as parents of a child/children under the age of 18 years. Their ages ranged from 30 to 40 years old.

Table 13: Inclusion and Exclusion Criteria for empirical research

Inclusion Criteria	Exclusion Criteria
Current CP trainee and parent on a UK DClinPsy programme	Individuals who are not enrolled on a UK DClinPsy programme
Parent-trainee ≥18 years old	Individuals who are <18 year olds
Parent-trainee of a child/children ≤18 years old	Parent-trainee of a child/children ≥18 years old
Parent-trainee must be the legal/adopted parent of the child/children	Individuals who are not parents
Parent-trainee must experience current/ongoing mental health difficulty/difficulties whilst enrolled on the DClinPsy programme	Severe mental health difficulty where the participant is not currently working or attending aspects of the DClinPsy programme (e.g., training has been suspended) and where participation in the

	study may be detrimental to their recovery/treatment And Trainees who do not present with mental health difficulties
Parent-trainee fluent in English	Any other spoken language, other than English

Recruitment process

After ethical approval participants were recruited between June 2024 and August 2024 via three Social Media platforms which had an active following of TCPs and which I was familiar with (See Appendix N for recruitment and social media adverts). The research poster[14] (see Appendix O) was advertised on Instagram, X and the DClinPsy parent group on Facebook (specific social media accounts were made for advertising) to help reach eligible participants. In addition, an email was sent in June 2024 with the recruitment poster and participant information sheet attached to all universities in the UK which offered the DClinPsy programme. The email asked for the administrators to circulate the email to current TCPs. If a TCP was interested and believed that they met the eligibility criteria, they were advised to email to express interest. I then emailed the participant information sheet, the participant consent form (see Appendix P) and the pre-interview demographics questionnaire (see Appendix Q). Once forms were signed and returned, interview dates were confirmed via an online meeting link sent to the participant's email address.

Recruitment and interviews lasted just under three months[15]. The recruitment advert was posted only three times on Social Media platforms (once a week). No reminder emails needed to be sent to universities as a total of twelve individuals expressed their interest, with eight individuals returning signed forms and participating in the interviews. Figure 4 documents the recruitment process flowchart.

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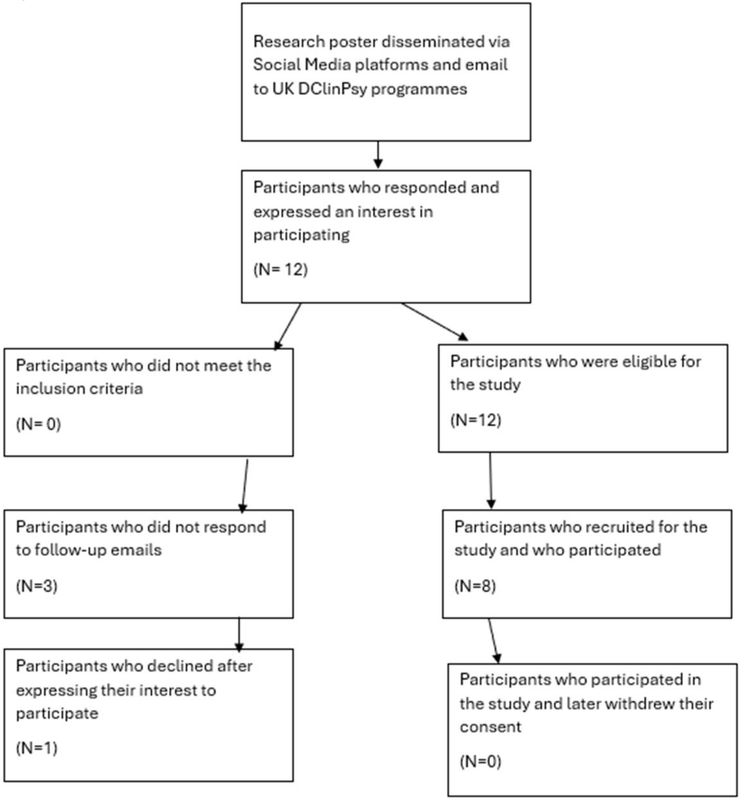
[14] See Appendix A, Excerpt A for Reflexive research diary entry on producing the poster

[15] See Appendix A, Excerpt E for Reflexive research diary entry on the interviews

Figure 4: Recruitment Process Flowchart



Recruitment and interview challenges

The current study recruited eight eligible participants, with 4-10 participants deemed as appropriate for the desired sample size by my supervisory team and facilitators of the IPA workshop[16]. A decision was made to end recruitment when no more expressions of interest was received, this was after posting on social media three times, and when eight participants returned their signed forms. Minor challenges were present with recruitment and interviews, which can be viewed in table 14.

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[16] See Appendix A, Excerpt F for Reflexive research diary entry on sharing excerpts for analysis

Table 14: Recruitment/interview challenges and adjustments

Participant[17]	Detail of challenge	Action	Outcome
1	Recruitment stage: This individual expressed their interest to participate, but forms were not received after two weeks.	I discussed this with my supervisory team and agreed to send a follow-up email.	The individual no longer felt able to participate due to their current mental health difficulties. I thanked them for expressing their interest and for sharing that they were experiencing difficulties. I shared information from the debrief form signposting them to sources of support.
2	Recruitment stage: Three individuals expressed their interest to participate in the study but did not return any forms.	Discussed with my supervisory team to send a follow-up email asking them if they wished to partake in the study and to return the forms if so.	No responses were received, nor were forms returned. No further action was needed.
3	Recruitment and interview stage: This participant who returned forms was concerned about the visual recording and the risk of being recognised by others during the analysis stage	Referred to my ethics protocol and participant information sheet to share the appropriate information with the participant, to help them consider if they wish to continue partaking in the research. Discussed the option of just an audio recording as being sufficient with my supervisory team.	I sent an email sharing that only anonymised excerpts from transcripts would be shared for the development of themes, and no visual or audio recordings would be shared. I agreed that the participant could turn their camera off during the interview with only their audio being recorded for transcription purposes. The participant agreed with this adjustment and continued to participate with the interview. This adjustment was discussed again before the interview.
4	Recruitment stage:	Explanation provided via email of what would be helpful in the pre-	I sent an email to explain that a general description of their mental health difficulties would suffice, and

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[17] These participant numbers do not correspond with the participants pseudonyms

	This participant felt unsure about what details to include around their mental health difficulties on the pre-interview demographic questionnaire.	interview demographic questionnaire. No additional action needed.	that the information provided would only be used to gather information about participant characteristics. The participant understood and continued to participate with the study.
5	Interview stage: This participant had difficulties with joining the link and 25 minutes had passed.	Due to the limited time that both the myself and the participant had, we agreed to reschedule the interview for another day. No additional action needed.	Interview was rescheduled for another day and time when both the participant and I could attend. The interview was completed later.
6	Interview stage: Two participants requested for reasonable adjustments to their interview.	Via email I discussed what reasonable adjustments each participant wanted, which would support them to engage with the interview.	Both participants asked for interview questions to be typed within the chat function on the online meeting. I shared that I had an interview guide, but there may be follow-up questions, which I would need some time to write. Both participants understood and consented to this, and both continued to participate in the research.
7	Interview stage: Two participants requested for themes around interview questions to be sent beforehand to help reduce feelings of anxiety and uncertainty.	Themes sent, consent reconfirmed. No additional action needed.	Themes were sent before the interview, participants had already agreed to participate in the study, but I ensured that I asked the question again in my email which included the themes.[18] They understood and gave their consent. I also reconfirmed this with them at the beginning of their interview.

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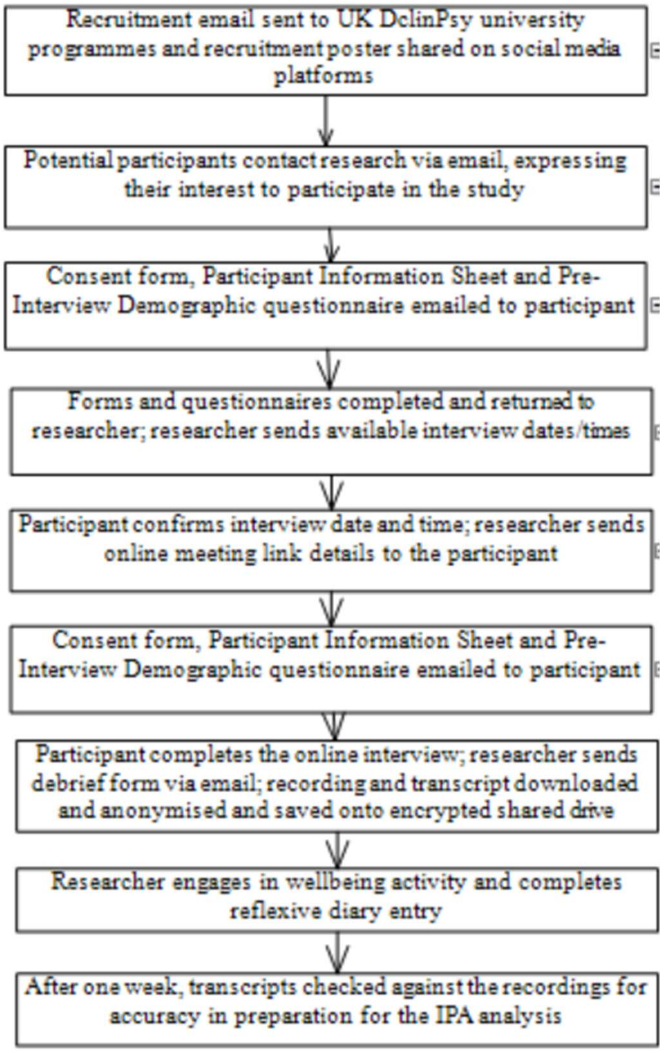
[18] See Appendix X, Excerpt X for reflexive research diary entry

Procedures

After ethical approval was granted, research recruitment emails were sent to all UK DClinPsy training programmes (participant information sheet and research poster, included), and the recruitment poster was shared on Social Media platforms. Specific social media accounts were made for the purpose of advertising the study. Upon expressing an interest in the study, prospective participants were provided with an information sheet, a consent form, and a demographic questionnaire to complete, sign and return to the researcher. Potential dates and times were offered for the interview which the participant selected depending on their availability. Following confirmation, a meeting link was sent to the participant for the online interview. Participants were reminded of confidentiality, consent, voluntary participation, risks and the right to withdraw before the interview started. If they wished to proceed, the participants answered questions using the semi-structured interview schedule as a guide. All interviews were conducted online and recorded for transcription purposes. Interviews lasted between 45 minutes to 1 hour (mean average 52.5 minutes). At the end of the interview, participants were emailed the Participant Debrief Sheet and offered an opportunity to discuss the study. Interviews were anonymised and saved securely on the encrypted university drive. Consent forms and pre-interview demographic questionnaires were saved in different folders also on the encrypted university drive. Figure 5 describes the interview process.

Figure 5: Interview Process Flowchart



Data collection

Basic demographic information about the participants was collected to gather a range of perspectives and provide a contextual understanding of potential influences on individual experiences.

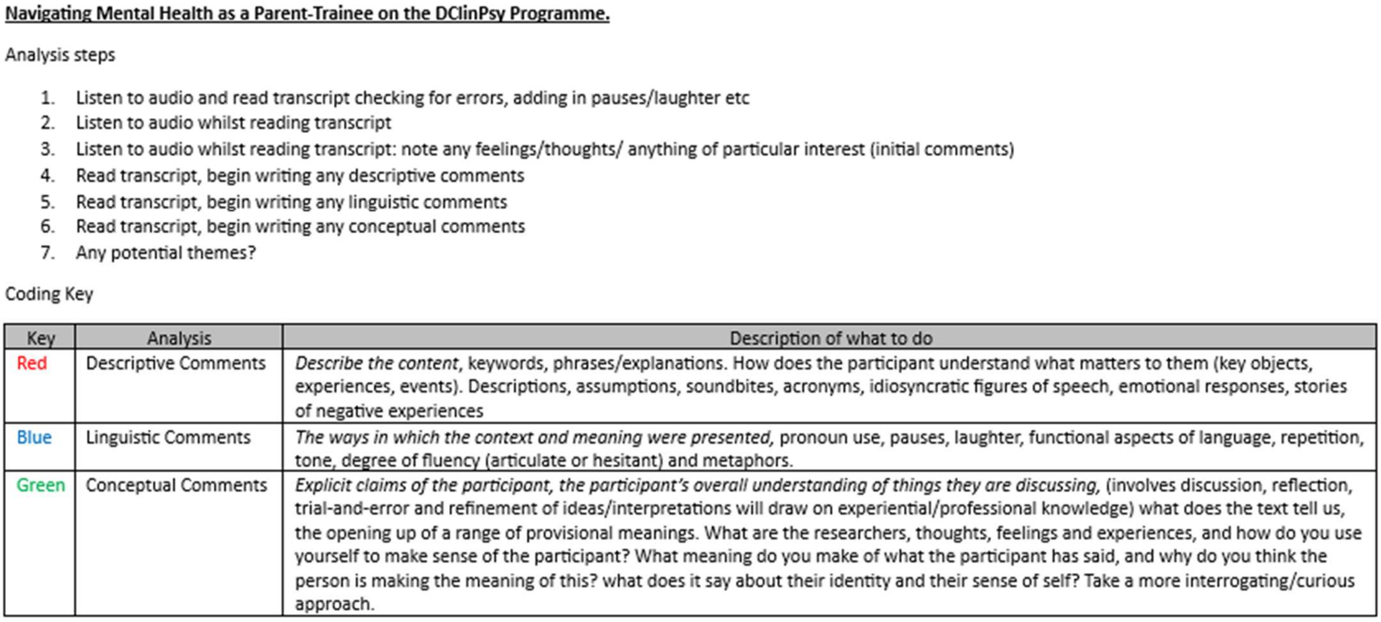
The semi-structured interview guide was designed by me with the research question in mind. Questions explored topics such as challenges of DClinPsy training, resources drawn upon and how parent-trainees balance and prioritise demands. The first draft of questions was shared with the consultant for review and feedback was discussed with relevant changes being made. For example, the wording on one question assumed that parent-trainees had difficulties obtaining support rather than the question taking an explorative approach and asking whether parent-trainees had experienced any difficulties with obtaining support. Following this a pilot interview was conducted to identify any issues, explore the length of the interview and to refine any of the interview questions. Second, a bracketing interview was also conducted with the rational to identify and eliminate bias, be attuned to any preconceived ideas and enhance objectivity.

Analysis

Research has shown the benefit of online interviews in gathering rich details about complex phenomena (Archibald et al., 2019; Oliffe et al., 2021). Individual online interviews were chosen to allow for more inclusive practices and consideration of the cost-of-living crisis, financial difficulties, childcare needs, confidential spaces for interviews, recording and transcription purposes. The topic of LEMHDs and parenting is considered sensitive and emotional; interviews conducted in this manner allowed me to engage in rapport-building, ensuring the participant's perspectives were heard and could be gathered in rich detail.

Interviews were analysed following the Interpretative Phenomenological Analysis (IPA) framework (Smith et al., 2022), which explored how participants understood their experiences and the meaning of their experiences in a historical and socio-cultural context (Karnieli-Millier et al., 2009). The steps in Figure 6 display how I analysed and coded individual transcripts. I often repeated steps to ensure my familiarisation with the transcripts (e.g., Step 3, listening to the audio recordings more than three times, and Step 6, writing conceptual comments), and for the development of key concepts (descriptive, linguistic and conceptual concepts), which were formed and organised using the coloured coding key. An example of the IPA analysis template suggested by Smith et al. (2022) can be found in Appendix R.

Figure 6: Analysis steps and coding key



Navigating Mental Health as a Parent-Trainee on the DClinPsy Programme.

Analysis steps

1. Listen to audio and read transcript checking for errors, adding in pauses/laughter etc
2. Listen to audio whilst reading transcript
3. Listen to audio whilst reading transcript: note any feelings/thoughts/ anything of particular interest (initial comments)
4. Read transcript, begin writing any descriptive comments
5. Read transcript, begin writing any linguistic comments
6. Read transcript, begin writing any conceptual comments
7. Any potential themes?

Coding Key

Key	Analysis	Description of what to do
Red	Descriptive Comments	*Describe the content*, keywords, phrases/explanations. How does the participant understand what matters to them (key objects, experiences, events). Descriptions, assumptions, soundbites, acronyms, idiosyncratic figures of speech, emotional responses, stories of negative experiences
Blue	Linguistic Comments	*The ways in which the context and meaning were presented,* pronoun use, pauses, laughter, functional aspects of language, repetition, tone, degree of fluency (articulate or hesitant) and metaphors.
Green	Conceptual Comments	*Explicit claims of the participant, the participant's overall understanding of things they are discussing,* (involves discussion, reflection, trial-and-error and refinement of ideas/interpretations will draw on experiential/professional knowledge) what does the text tell us, the opening up of a range of provisional meanings. What are the researchers, thoughts, feelings and experiences, and how do you use yourself to make sense of the participant? What meaning do you make of what the participant has said, and why do you think the person is making the meaning of this? what does it say about their identity and their sense of self? Take a more interrogating/curious approach.

I adopted the guidance for analysis as proposed by Smith et al., (2022). This involved immersing and familiarising myself with the transcripts, followed by an exploration and interpretation of participants lived experiences. It required focused attention and ensuring self-reflexivity and awareness of biases and assumptions. It begins with an analysis at an individual level, understanding individual perspectives, followed by an overarching broader-level analysis of participant's lived experiences. Table 15 describes my IPA process.

Table 15: IPA process

Stage	Description
Familiarisation	The first step of IPA involved familiarisation with an individual transcript; each transcript went through a process of reading and re-reading the data to understand the participant's lived experiences, whilst also checking for any inaccuracies between the audio and written transcript. Notes were taken around the rapport and any personal reflections I held. Thoughts, feelings, significant comments, theoretical models/approaches and potential themes/patterns in the data were also documented.
Exploratory noting	The next step of the IPA analysis involved the initial exploratory noting of the key descriptive and linguistic concepts from individual transcripts and highlighting any key phrases or words. I noted how the participant used language to describe their lived experiences (e.g., metaphors, laughter, pause, tone and repetition).
Development of experiential statements	Following this I began developing experiential statements (conceptual concepts) approaching transcripts with curiosity about how participants have made sense of their lived experiences and the meaning of them. These are my initial interpretations of what a participant is saying about their experience. This process drew upon my analytic and interpretation skills to make sense of the meaning of the participant's experiences in addition to my own interpretations.
Connecting statements	I then developed connections across statements, grouping similar themes and statements together to uncover shared patterns and experiences and any similarities and differences between how the participant conveyed the meaning of their experiences.
Personal Experiential Themes (PETs)[19]	Personal Experiential Themes (PETs) were then developed, which looked at grouping statements together and making sense of the data at a higher level of abstraction.
Repeating the process	These steps were repeated for all interview transcripts, with interviews being analysed without consideration of any prior transcripts to allow for the analysis of participants own unique experience (eliminating prior knowledge to the best of my ability).
Group Experiential Themes (GETs)[20]	Once all transcripts were individually analysed, I began to look for Group Experiential Themes (GETs) across transcripts using PETs to capture the essence and importance of the participant's experiences. I looked for connections between the themes, organising them into categories which helped me to make sense of participants collective experiences.

The analysis concluded when themes were repeated, when the interpretation of experiences were no longer providing new insights or learning and when theoretical

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[19] Definition of PETs: in IPA, Personal Experiential Themes emerge from an individual participant's experience. These relate to the meaning that participant's attach to their experience, through grouping experiential statements, which represent the participants understanding of a particular part of their experience (Smith et al., 2022).

[20] Definition of GETs: in IPA, Group Experiential Themes are the overarching patterns of meanings across multiple participants. They draw upon the commonalities in PETs, offering a broader understanding of the collective experiences (Smith et al., 2022).

saturation occurred. During this process, I engaged in supervision and maintained a reflexive research diary to inform self-awareness and conscious attentiveness (Finlay, 2006).

Reliability and validity

As mentioned previously, qualitative studies risk bias and subjectivity and its generalisability is limited, particularly with small sample sizes. The current study utilised Yardley's validity framework for good qualitative research (Yardley, 2000). My rationale for choosing this framework relates to its robustness with ensuring trustworthiness and quality of my work. This is essential because it helps to provide a structured approach to quality and helps to demonstrate that my findings are based on the data rather than just my subjective interpretations. Four main principles were considered to enhance validity and reliability as suggested by Smith and colleagues (2022). This is presented in Table 16.

Table 16: Yardley's validity framework for qualitative research

Yardley's principle	Description
Sensitivity to context	I engaged with my supervisory team and consultant and considered my research from the critical realist epistemological lens whilst drawing on the relevant literature surrounding LEMHDs and parenting. As an insider-researcher I reflected on the ideographic nature of participant's interviews with my supervisory team. Through my analysis I remained sensitive to the participant's stories, enhancing the meaning they made of their experiences through my IPA workshops and with my supervisory team. I considered reasonable adjustments ensuring I could recruit as many diverse participants as possible, ensuring that varied experiences were shared.
Commitment and rigour	I attended training and research methods workshops[21] to acquire the necessary skills for the current research. I ensured a thorough and detailed methodological protocol through my data collection and analysis, following the suggested IPA framework by Smith and colleagues (2022). Having multiple sources share their perspectives on transcripts throughout the analysis stage, enhanced credibility and reliability when uncovering key conceptual meanings and themes. Throughout my study, I have maintained a detailed reflexive research diary demonstrating my decision-making and any corresponding changes. This approach aimed to ensure credibility and depth in my research.
Transparency and coherence	This has been well-documented through my reflexive research diary entries for which I have remained truthful and authentic as a researcher. The research process and findings have been presented clearly and in a manner that I hope will be accessible to all. The use of direct and unchanged quotations from participant's transcripts helped to provide a rich authentic account of their experiences, followed by my interpretations of the meanings. Themes were reviewed with my supervisory team, mitigating the risk of researcher bias.
Impact and importance	Impact and importance have been considered: to date, no current research has been conducted on the mental health experiences of parent-trainees on UK DClinPsy programmes. The findings from my SLR suggest that student-parents experience challenges with their mental health whilst engaging in Higher Education and balancing the demands of parenting. This provides a rationale for my empirical research. This study can add valuable insights to doctoral level practice and have relevance for Clinical Psychology training. Potential benefits of implementing recommendations could make programmes look more desirable by reducing challenges faced by parent-trainees with LEMHDs and reducing the stigma surrounding mental health for parent TCPs. It will be presented at a research conference, and I aim to publish this study in an open-access, peer-reviewed journal. Through dissemination a summary of the findings, implications and recommendations it is hoped that DClinPsy programmes will find the research suggestions valuable in providing support to current parent-trainees with LEMHDs and future applicants for the DClinPsy programmes. It will also validate and give a voice to a group of individuals who are considered as marginalised and underrepresented in research.

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[21] Training and learning around aspects of conducting SLRs, such as entering search terms; using Covidence and writing for publication.

To mitigate the challenges posed by the current research around reliability, several measures were put in place. Reviewing anonymised excerpts with the supervisory team and in research methods workshops allowed for alternative perspectives to be considered and the opportunity to challenge my assumptions, reducing the risk of researcher bias and to enhance objectivity (See Appendix S). The bracketing interview helped to identify any biases and preconceptions, allowing for the focus to be around the participant's experiences, thus, ensuring validity. Reflections and any changes were noted in my reflexive research diary to ensure transparency and credibility (Lazard & McAvoy, 2017). It also allowed me to document my evolving thoughts and emotions and draw upon aspects of my intersectional identity that might shape and influence the study.

Chapter 4: Analysis and results

Chapter overview

This chapter presents the findings of my research. Guided by the IPA framework, participants' individual experiences were reviewed to explore how parent-trainees navigate mental health difficulties. Experiential themes within the individual transcripts were collated to form Personal Experiential Themes (PETs), which represented the unique emotions, personal meanings and interpretations specific to the individual and which may not be shared by others, thus ensuring the idiographic nature of the IPA framework. Following this, all transcripts were cross compared as part of the process of creating Group Experiential Themes (GETs), which represented the shared experiences, interpretations and meanings. These broader shared GETs reoccured across multiple participants to form a higher-level understanding of how parent-trainees navigate mental health difficulties on the DClinPsy programme. As an insider-researcher, personal accounts of my emotional experiences[22] and thoughts have been shared in my reflective diary entries[23]. Due to the limitations of this project, it has not been possible to use all relevant quotes in my analysis, however, I believe that the quotes which have been used convey participants experience in the richest and conceptually accurate way.

Participant characteristics and demographics

Eight female TCPs were recruited from across England and Wales and across all three DClinPsy training cohorts, with ages ranging from 30-45 years. Their ethnicity was Black British, White European, White British and White Other. All participants had either one or two children aged between 1-6 years old, and one participant was pregnant with their second child at the time of their interviews. Some participants were married, or co-habiting and one was a single mother. A range of mental health difficulties[24] were reported with the onset of difficulties from pre-school/early childhood to early 30s. Current engagement with therapy included private 1:1 therapy, Psychodynamic therapy, self-management strategies and medication, for three participants including one who was on a waiting list for therapy. Past psychological support included an inpatient admission, 1:1 counselling and group therapy,

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[22] See Appendix A, Excerpt G for Reflexive research diary entry on personal challenges

[23] See Appendix A, Excerpt A for Reflexive research diary entry on analysis and discussion

[24] Post Traumatic Stress Disorder, Depression, Anxiety, Panic Disorder, Attachment-Related difficulties, Health Anxiety, Social Anxiety, Obsessive-Compulsive Disorder, and Eating Disorders (e.g., Anorexia Nervosa).

Cognitive Behavioural Therapy, Perinatal Compassion-Focused therapy, Eye Movement Desensitization and Reprocessing, Mindfulness-Based therapy, Internal Family Systems Therapy, Radically Open Dialectical Behaviour Therapy and medication.

Table 17 presents GETs and subthemes derived from my data. These GETs have been selected for their richness and relevance to the research aims and questions. They have repeatedly emerged from cross-case analysis within individual PETs, reoccurring across multiple participants which provided insight into the collective experience of how parent-trainees navigate mental health difficulties on the DClinPsy programme.

Table 17: GETs and subthemes

GETs	Subthemes	Description of subtheme	Relevance to research aims/questions
1.“*A dark cloud and a negative spiral.*” **The emotional impact of an intersectional identity**	1.1 Distress 1.2 Experiencing difference	The impact of difficult experiences, describing how participants endured and navigated a range of difficult emotions The concepts of difference and having to navigate the journey alone, without being understood by others.	Explore the impact of navigating mental health Explore wellbeing and mental health
2.“I found it easier to talk about parenting and Neurodiversity, but not mental health.” **The impact of stigma on the parent-trainee**	2.1 Talking about mental health 2.2 Valuing lived experiences	Participants spoke about their mental health experiences with course tutors and with placement supervisors, describing the barriers and facilitators and forms of support when talking about their experiences. How were LEMHDs valued? Did participants feel represented and feel as though they belonged in the psychology profession?	Explore the impact of navigating mental health Understand the challenges Explore wellbeing and mental health
3.“Everything takes pre-planning.” **The ability to balance personal and**	3.1 Time 3.2 Prioritising and boundaries	How did participants implement strategies to help with prioritising, balancing demands and time constraints? What were the experiences of juggling demands and navigating role responsibilities?	Explore the impact of navigating mental health Understand the challenges Explore abilities to balance and prioritise

professional demands			Explore self-care and wellbeing
4.“Well, if I went to therapy, what would I talk about?” **Implementing coping strategies**	4.1 Relational support 4.2 Making requests for reasonable adjustments 4.3 Self-care	Relational support (mentors, buddies, peer groups, wider professionals e.g., therapy and wellbeing, validation and understanding reasonable adjustments (advocating for yourself, flexibility/rigidity self-care (good enough competencies)	Explore the impact of navigating mental health Understand the challenges Explore abilities to balance and prioritise Explore self-care, wellbeing and mental health

[25] See footnote for how quotes have been presented within the text

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[25] “*Direct quotes*” in italics and quotation marks

[…] represented omitted words

(ADDED) words to improve coherence of participants comments

[DESCRIPTION] includes non-verbal communication/behaviours, pauses, laughter, sigh etc

Underlined word to represent a word or phrase which has been emphasised

1. GET 1*: "A dark cloud and a negative spiral"* - The emotional impact of an intersectional identity[26]

1.1 Distress

All participants reported an array of mental health challenges, likening them to a "*dark cloud and a negative spiral (Arianna),*" with "*no joy (Maya),*" and no enjoyment for life (Kirsty), experiencing *"suicidal thoughts (Ria),"* OCD flare ups (Leila) and eating disorder relapses (Belle) whilst having "*full on breakdowns [...] crying for a whole weekend from upset (Maya).*" Triggers for distress included changes, especially those at short notice, transitions and having to regularly adjust to things, such as new placements and supervisors, locations, and different types of academic demands (Arianna, Maya, Leila and Belle).

> "*Nothing about that transition was easy. I think sometimes that you're constantly changing placement and with every new placement, things might completely change. And you might be held to different standards of hours, or you might have to go in or work from home more. And there's always a flux and you never get a guarantee, and you don't get an awful lot of information in advance either. (Maya)."*

Arianna, Maya, Kirsty, Leila and Belle discussed physical symptoms of mental health problems such as poor appetite and sleep, which were usually related to the challenges associated with both academic demands and parenting, and with both being experienced as essential to promote wellbeing, but which were often neglected or sacrificed. Kayleigh described her first year on the course with the following statement: "*I ended up becoming really unwell physical health wise, so all the stress and anxiety that I've been holding in came out physically in my body."* Participants made sense of the course challenges as relentless in nature (Serena, Ria and Kayleigh) with continuous demands and evaluations creating stress and fatigue and no place for processing:

> *"(It's like) a never-ending marathon [...] with no breathing space (Serena).*"

> "*This is how I have felt sometimes…spinning (a lot of) plates. And it's been forever! (Kayleigh).*"

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[26] The concepts captured by this GET demonstrates intense emotional pain that parent-trainees have felt whilst engaging in training, all whilst feeling alone and different in their experiences.

Participants seemingly endured distress to benefit their own future and their families. A quarter of the participants felt that they needed to hide the extent of their emotional and mental health difficulties to others through putting on a "*mask (Maya and Serena),"* and "*being someone you're not (Serena).*" Behaviourally, these participants hid, minimised and stopped talking to others about their challenges with feeling distress, with one participant feeling burdened and "*so overwhelmed with trying to hold everything together to protect my family from seeing me so low (Ria).*" As the researcher, I wondered if it could be that participants hid their emotion due to feelings of shame and embarrassment. Desensitisation and dissociating experiences were also mentioned by some participants: *"I just wanted to be present with my kids and I can find myself dissociating (Ria)."* Arianna, Ria and Belle experienced such high levels of distress that they needed to take time out from the course for recovery to be a "*better parent (Arianna and Ria).*" Serena likened her mental health experience to a traumatic event:

> "*It's like a scar that not going to go away [...] it's always going to bring me back to that time when I was so low and I was so anxious. I can't erase that from my memory. My body knows it. My mind knows it. It's forever in my memory. And to be honest, there are memories I wish I wouldn't have, but I will carry them with me forever (Serena)."*

I considered the high levels of psychological stress as triggering physiological responses, like that of trauma. I wondered if Serena framed her experiences as feeling intense fear or threat to her wellbeing, helplessness for trying to improve their situation and struggling deeply with being able to cope with her experiences. I also wondered about the length of time to complete the DClinPsy training programme (three years) and whether Serena experienced such profound distress over this time, to the point of her safety being compromised, and the memory of these left lasting emotional impacts.

Worry featured as a great concern to half of the parent-trainees, particularly worrying about their mental health deteriorating throughout the remainder of the course: "*I'm not as well as I thought I was. If these thoughts and these feelings are coming up to this intensity at this point in first year, how am I going to deal with the rest of the course? (Belle).*" Regret and hopelessness also featured for Maya, Serena, Ria and Kayleigh, who were considering leaving the course to protect their own wellbeing and protect their children:

> "*I just thought I'd made a large mistake (Kayleigh)."*

" I just don't want to be in this process anymore [...] I just wanted everything to stop (Serena)."

"I just can't be bothered trying anymore (Ria)."

Nearly all participants (Arianna, Maya, Serena, Ria, Kirsty and Kayleigh) mentioned feeling guilty with being unable to effectively perform the duties relevant for their intersectional roles due to the immensity of demands. This was understood as a perpetuation of their mental difficulties, worsening their experience of clinical training:

"I felt so guilty because I didn't enjoy spending time with my daughter. I didn't enjoy spending time with my family [...] And yes, I was happy that I got on the course. But it was massively dampened by that grey cloud over everything (Maya)."

Participants also worried about the consequence of their mental health difficulties on their children (*"I do not want my daughter to suffer (Maya)")* with little compassion or understanding of personal resilience in their own attempts to navigate their difficulties:

"I thought if I had kids and I worked hard and I tried to do other therapy [...] You know, nothing like that would happen again. But it was the fact I felt suicidal [crying] I just felt so guilty! (Ria)."

This above statement describes the participant's experience of their mental health difficulties as a risk of possible detrimental effects on their child, which may have been in relation to participant's ability to address their child's needs whilst experiencing distress. And despite participants doing all the necessary things to ensure their wellbeing, they continued to struggle. Participants seemed to understand that not being able to cope equated to failing as a parent. Participants (Serena, Belle, Kayleigh and Ria) seemed to blame the course for the deterioration in their mental health:

"I know my mental health. There's definitely a fault with the course (Ria)."

"*We felt kind of really guilt ridden in terms of how much time the course takes from you and how much time it takes in your family (Kayleigh)."*

Participants felt strongly that the nature of the course led to an exacerbation of difficulties and an experience of negative emotions. This might relate to the heavy workload and course-related stress, social challenges (e.g., isolation, social and organisational support) the fast and necessary adjustments between roles (e.g., student, parent, TCP) and the need for competence in all these roles, but with distress hindering performance. I wondered if externalising the cause of their difficulties served as a function to avoid considering any personal failings and feelings of shame. Blaming the course seemed to be a form of coping, protecting participant's self-worth and self-esteem.

1.2 Experiencing difference

Most participants spoke about themselves and their experiences as being "*completely different (Arianna)*" to that of their peers in training, and it was interpreted as not being understood by others, which contributing to the maintenance of mental health difficulties.

"Why am I different? (Leila)."

"Other trainees are in different stages of life. And you know, training could be just their everything. And that's all they focus on. And that's stressful and hard in itself, but it's very different from our [parent] experience. And so there is a sense of being isolated around that (Arianna)."

"We're light years apart in terms of our experiences. It's hard being the different one (Kirsty)."

Other trainees were viewed by participants as having such different life contexts and responsibilities (possibly viewed as minimal or less important responsibilities), which did not appear to impact or interfere with their ability to engage in the course like it did for parent-trainees.

"...That's what I see in all the other trainees that they've got endless time and they're moaning that they don't know how to use it (Belle)."

This perceived difference could be related to the unique challenges that parent-trainees face. For example, time management and balancing childcare and academic work, internal conflict and wondering whether sacrificing aspects of their life through engagement with the course was a worthy decision in relation to time with their children. The theme of difference was accounted for by all participants, demonstrating its need to be included as a subtheme.

"I kept questioning whether psychology was for people like me. I wondered whether like...whether, how people with lived experience or any of neurodiversity, or even someone with kids... I don't think the DClin is built for anybody that has any sort of diversity difference at all. (Ria)."

"I felt incredibly isolated for lots of different reasons, partly mental health, partly being a parent and partly some other things as well (Kayleigh)."

My interpretation of participant's experience of difference was related to isolation; participants felt like the challenges associated with their intersectional identities were invalidated, misunderstood and unheard by those associated with the course (namely peers and academic staff).

"If I speak to any of the trainees who don't…who aren't parents, I think some of them will probably be like ' yeah it must be hard,' but I don't think that they would really grasp the kind of the toll on your mental health (Arianna)."

"I felt I couldn't really share it with anybody in the course. I don't think anybody really knew or understood what I was going through (Kayleigh)."

"When you return from maternity leave and you got a toddler at home or a young child at home, no one really knows what the last 24 hours was like for you (Arianna)."

And for those who were understanding or validating (for example, clinical placement supervisors), participants continued to feel frustration that no changes could be made, and this still meant that they had to navigate challenges on their own.

2. GET 2*: "I found it easier to talk about parenting and Neurodiversity, but not mental health."* - The impact of stigma on the parent-trainee[27]

2.1 Talking about mental health

With participants sharing mental health difficulties with professionals, it seemed to be done with an intention to help others to understand them (course or clinical placement supervisors), and their competencies and performance, to seek support and receive care, and to provide justification for why they might be struggling with the course. Varying degrees of pressure was felt when telling placement and course supervisors about mental health challenges, with some revealing it in a preventative nature and as a type of safety net (*"If I didn't tell her the truth, I figured she'd know something was off, but she wouldn't be able to*

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[27] The concepts captured by this GET describes how parent-trainees experience sharing their difficulties and the responses and behaviours received by others through the process of sharing.

put a finger on it, and that would have felt worse (Maya)"), and others disclosing because they were in need of support after hiding their distress for a period of time and possible feeling like they had no other choice ("*I've raised the parenting. I've had an ongoing, like, battle with them. [...] I asked for flexible working. And they just don't want to give it. And I kept saying to them I cannot regulate myself. I find it hard. I can't regulate myself anymore! (Ria)")*. Participants spoke about their challenges more so in relation to LEMHDs when sharing it with placement and the course team, which I wondered may have been a more likely way to get their needs met compared to if they were to request for changes based on childcare needs.

Arianna, Maya, Ria and Belle spoke about being selective with the content of what they shared:

> *"It's a really delicate line, between wanting people to know enough that they understand kind of my context and where I'm coming from and why I might have a more emotional reaction to things that people might say. But not wanting to overshare. Or kind of affect how this brand new supervisor who's never met me before or who knows nothing about me, affects how they see me or their opinions of my competence or my kind of...Ability to be a psychologist (Belle)."*

It seemed that if a precedent was set for having a safe space to talk about mental health, participants seemed more likely to talk about it in clinical supervision or a 1:1 meeting with their course tutors. Containment was felt when supervisors who created a safe space for talking about mental health responded well to these discussions:

> *"...That felt really proactive and really helpful without too much of fuss. It felt good at a level, but I felt supported. I felt she cared. But I also felt she wasn't trying to interfere. She wasn't trying to push me any certain way, and she was just very respectful of the fact that I knew myself [...] and that felt safe (Maya)."*

Two participants noticed that it felt more comfortable to talk to their supervisors about alternative and seemingly 'acceptable' difficulties and not mental distress or childcare challenges, which could have related to their individual perceptions around stigma. For example, Arianna suffered from depression and used symptoms of pregnancy to talk about poor concentration, tiredness, forgetfulness, whilst requesting extensions, whilst Ria said: *"I found it easier to talk about parenting and Neurodiversity, but not mental health."* For disclosures which were not received well, participants responded by trying to manage on their own and/or not seeking further support from professional supervisors.

"Why do I always have to go explain my difficulties. And people know I'm a parent. [...] Why isn't implicit that you know? Of course you have caring responsibilities (Maya)."

This response may have been related to participant's not feeling as though they had trust in their supervisors to support their wellbeing; participants may have felt as though they were not in a culture that promoted help-seeking behaviours. Self-management approaches might have been a better solution, as it may have mitigated feelings of shame or hopelessness in receiving support from the system.

2.2 Valuing Lived experiences

Contrasting with the notion of the subtheme stigma, it appeared to be important to most participants to have the course ethos, clinical and placement supervisors proactively take steps to ensure lived experiences of mental health (as well as parenting) were valued and welcomed. This helped some participants feel they could take steps to seek support if any mental health challenges were to arise. Two participants spoke about the course's proactive actions through lecturers and course leaders sharing "*their experiences of mental health (Arianna and Leila)*" and having lectures on the topic of lived experiences, whilst others spoke about the benefits of accessing peer support spaces, and having their lived experiences "*well received (Ria)*" and considered as "*a real strength (Arianna)*" in the profession, demonstrating the value of normalising and reducing stigma enabling participants to navigate challenges within their intersectional roles.

"Lots of different lecturers came and shared their experiences of mental health. [...] so they kind of opened the conversation in week one. To say hey, look like if you have anything, if you need anything we don't want you to feel shame because everyone has mental health difficulties. They really normalised it and really kind of encouraged us to come and speak to them if we had a problem, which I think it just set a bit of the scene to say we are really, really open to having these conversations, we want to support you (Leila)."

"People might think that I'm not capable of doing the course or that I shouldn't be a psychologist. That not something I've encountered at all that everyone has understood that it's an asset having the lived experience and everyone has understood how much of a juggle it is being a parent whilst training (Belle)."

Representation of LEMHDs felt important to acknowledge and portrayed as an asset in the profession. But some participants did not feel that their course or the staff had the same approaches and, on some occasions, participants felt invisible with the "*limited discussions around the mental health impacts on training* (Kayleigh)." Some participants felt that there could be more "*people with personal experience in the cohort (Belle)*" who have not spoken about their mental health and wondered if they were less likely to speak about personal experiences of mental health when they did not see any professionals with LEMHDs. I wondered if participants interpreted this perceived lack of representation as not being valued or welcomed in training or the profession. One participant described the lack of representation as silent and unacknowledged, worsening their mental health and experience of training:

> *"Even when, like we had a session on suicide they said…'We could work with people who have made attempts or you'll come across with people who have made attempts…' or they said, 'You might have known someone who died by suicide,' but at no point do they acknowledge that you could be a trainee with past experience of suicide or feeling suicidal at the moment (Ria)."*

Additionally, some participants felt that their dual-role as a parent-trainee and someone with lived experiences, made them feel like they did not belong, that their roles were "*not being modelled enough (Serena*)," and they made sense of this as meaning that they were not a good fit for the profession:

> *"I'm not what they're looking for (Leila)."*
>
> *"You're just feeling that this isn't a place for me (Kirsty)."*

Concerningly, two participants worried about prejudice and discriminatory behaviours and wondered about how professionals involved with their clinical placement were treating them:

> *"[...] Perhaps I'm experiencing like discrimination on a placement (Ria)."*
>
> *"I was having opportunities taken away because of my mental health history (Belle)."*

Some participants demonstrated worry with the consequences of sharing mental health difficulties, affecting their opportunities and progression towards meeting their competencies. It may be that through the process of sharing mental health, participants worried about differential treatment, and being perceived by clinical placement supervisors as being unable to perform the same duties as TCPs without mental health difficulties.

All participants reported concerns about the value of intersectional identities being misaligned in the wider system and within the actions of institutional practices:

"Despite it being kind of a psychology course and mental health being at the forefront of everyone's minds, even some kind of professionals in the workplace don't have a very good attitude towards kind of, I guess, functioning with mental health problems (Leila)."

"Being in a profession where you are helping other people and talking about other people's mental distress and psychological distress. [pause] I just think there's just still a taboo around talking about it (Arianna)."

Leila and Arianna also demonstrated concerns with the academic environment and the responses from professionals in relation to sharing mental health difficulties. They seemed to experience the process of sharing as in contention with psychology, mental health course, which could be interpreted as having the LEMHDs aspect unvalued and unwelcomed in clinical training.

3. GET 3: *"Everything takes pre-planning"* - the ability to balance personal and professional demands[28]

3.1 Time

Time featured as being of great concern and a challenge with navigating mental health as a parent-trainee with LEMHDs. All participants spoke about meticulously planning their personal and professional lives *("everything takes pre-planning (Maya)"),* their children's lives and the wider family (e.g., social events) well in advance for stability and certainty and to help them manage the demands of training (e.g., academic deadlines). This was interpreted as being a "*completely different experience to trainee peers without childcare responsibilities or lived experiences (Arianna)"* and vital to ensure their wellbeing.

"I have to plan my week really, really carefully, so I know I've got an event coming up at the weekend, I know I have to do kind of a couple of hours every single night and probably go to bed a little bit later. And so I just have to plan everything a lot more in advance than I used to (Leila)."

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[28] The concepts captured by this GET demonstrates the challenges with managing time, and balancing prioritise personal and professional needs.

> *"So I kind of look at all the deadlines I have for the next 2-3 years and then I look at all the family events like birthdays, anniversaries and that (...) And I'd try and plan around those things and those times (Kayleigh)."*

All participants experienced challenges when information was perceived as being given out later than they hoped, which they interpreted as being too late for keeping close to their plans for managing all demands related to their intersectional roles e.g., clinical placement details. The emotional impact of this led to feelings of distress, with participants experiencing worry, frustration and conflicting decision-making, leading to difficulties with being able to make or change arrangements at "*short notice (6),*" such as childcare.

Without the ability to effectively pre-plan their demands and responsibilities, participants experienced detrimental effects to their mental health and wellbeing and interpreted this as being uncared for. This was interpreted as adding to the participant's emotional impact, feeling as though aspects of their unique intersectional identity may not have been respected or welcomed in clinical training, and it may have exacerbated the sense of isolation and feeling different to other peers without parenting responsibilities or mental health difficulties:

> *"...Having children is such a logistic exercise. And it hasn't felt like there's been any understanding, adjustment or care for that (Maya)."*

All participants felt pressured with limited time and struggled to engage entirely with the responsibilities associated with being a parent and trainee. Being enrolled full-time left little room for participants to address their mental health ("*I don't have time to do therapy…(Leila)"),* increasing stress and the potential for "*burnout (Kirsty)*" further impacting on their ability to navigate these challenges. If participants were unable to engage with a course activity due to unprecedented events (e.g., an unwell child), their emotional wellbeing was affected and worsened by experiences of no support from the course or placement and with feeling "*penalised (Ria)*" I interpreted the experience of being penalised as being punished for having any difficulties engaging with training and being unable to commit in the same way as peers without LEMHDs or childcare needs. Kirsty also described a sense of punishment for having to attend to urgent childcare needs, which again was interpreted as being uncared for by the course who could not understand the limited time that participants have in comparison to other TCPs.

> *"I would have to make up that work at another time, which if you already don't have enough time, you then can't spend a whole day watching a lecture reflecting on it, doing the whole miss teaching policy that they've got (Kirsty)."*

Kirsty, Leila and Belle mentioned working around available childcare arrangements (*"study days are split between looking after (my daughter) and doing my assignments (Leila)"*), which often meant regularly working on weekends, early morning or late evenings and sacrificing basic needs e.g., sleep (reported by Arianna, Kirsty, Leila and Belle), but this was not always possible when childcare needs took priority:

> *"Most people in my cohort are very open about the fact that they work evenings and weekends just to fit everything in like, particularly in the run up to deadlines. And that's just not something that I can do or not as easily anyway (Belle)."*

Participants felt that having more time meant they were better able to navigate the responsibilities within their intersectional roles enabling them to also manage their wellbeing:

> *"…If I had like a little bit of time, just occasionally to let that valve off because when, you know when you're a parent, every minute of every day is prescribed (Kirsty)."*

> *"It would be lovely to be able to take every Friday off over the summer and have that kind of breathing space in the same way that lots of my cohort do (Belle)."*

Kirsty and Belle's comment demonstrate that there is no time for respite with their intersectional role responsibilities, interpreting peers as being able to engage in leisurely and self-care aspects of their lives in which they cannot. These further highlights that parent-trainees cannot be flexible with their time owing to their parenting responsibilities and any time perceived as being 'downtime' (i.e. no lectures or patient appointments) needs to be used for childcare rather than self-care, and rather than using the time for study.

3.2 Prioritising and boundaries

In attempts to uphold mental health, all participants spoke about the importance of maintaining boundaries to engage with various demands and to implement methods of self-care (*"I have to be very, very boundaried in order to ensure that I at least have 40 minutes to myself (Kirsty)").* Maya experienced a relapse in her mental health during her time on the course and spoke about boundaries aiding recovery giving her "*time on evenings and weekends to just be. And to learn to enjoy life again.*"

All participants discussed difficulties with juggling the demands and responsibilities of their intersectional roles described by one participant as the "*most challenging bit of training (Belle).*" These challenges created intense emotional experiences such as, "*stress levels rising (Kirsty),*" and *"anxiety increasing causing a flare up of OCD (Leila)."* Challenges were reported with trying to implement boundaries ("*it's too much work effectively to do in the hours that we are paid to do it in (Arianna)*"), which led to some participants sacrificing moments of respite (e.g., annual leave and social events) to "*get it (the work) all done (Arianna).*" Kayleigh described how her immense workload caused her to "*miss big family events,*" whilst Kirsty felt like missing social activities made her *"feel like a shitty parent."* Kirsty's comment links to the theme of GET1 (the emotional impact of an intersectional identity) with feeling guilty about being unable to engage with family life and not being good enough as a parent meeting her child's needs. Participants recognised that it was not easy to separate the demands of these intersectional roles, leading them to worry about how they are attending to these needs equally and with sufficient quality:

> *"I can't be a good parent to my kids, do everything that you want on the course and, like, regulate myself for my mental health if working full-time…it just doesn't work (Ria)."*

> *"I don't think I am balancing it. I'm kind of just not doing any one role to the, to my best ability (Arianna)."*

> *"In my parent time my thoughts drift to the doctorate and what needs to be done…When I give time to the doctorate (I'm thinking is) it too much and then you know, inevitably thinking…Is my child OK now without me? (Serena)."*

> *"Trying to be your best in all these roles and realising they do influence each other[…] (but you're) consumed in one area and then you're left without them in the other side of your life (Serena)."*

Serena's quote could be interpreted as having to make decisions about where to juggle the demands of multiple roles, and where you to place energy and effort. It could be that participants had to make these decisions and consider the emotional costs of being under resourced in an area of their life; if one thing was not going to go to plan or how the participant expected, then this would bring up feelings of failure, shame and guilt.

Some participants (Serena, Arianna, Kirsty and Belle) felt as though they "*lost their identity (Belle)*" and "*sense of self (Serena)*" through alternating different roles and demands;

children were prioritised, but this was often at the expense of participant's being able to prioritise their own needs and crucially, mental health needs:

> "*So it almost goes kind of [my child's] stuff and then uni work and then my stuff at the bottom. As a bit of a hierarchy, and she's [her child] definitely at the top (Leila).*"

Finally, most participants, did not feel that their childcare needs were understood by the wider professional network, further exacerbating and creating barriers when seeking support to navigate mental health:

> *"Every job I've ever worked in, there's been a level of understanding that children especially but family or caring responsibilities, do take priority at the end of the day, and if you need to leave early, then you just need to leave early and it's not been an issue. But on this course, it's always been an issue every step of the way, and that's the stressful part (Maya)."*

I interpreted Maya's comment as feeling frustrated that other workplaces understood childcare needs, but that it did not seem to be appreciated in the context of training. This could have resulted in negative consequences to wellbeing and academic work not being completed to the parent-trainees full potential. This could pose as a challenge with participants having to make difficult choices between their family responsibilities and aspects of training.

4. GET 4*: "Well, if I went to therapy, what would I talk about?"* - implementing coping strategies[29]

4. 1 Relational support

Participants spoke to the positive relational support of partners, extended family members and friends to help them meet their needs as parents, trainees and individuals with LEMHDs. Formalised relational support like mentoring, buddy systems and peer support groups (lived experience and parenting groups) were deemed as "*invaluable* (Maya)" to navigate unique difficulties, reduce "*isolation (Arianna and Kayleigh*)" and increase solidarity and "*connection (Arianna)*" both in-person and via social media forums.

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[29] The concepts captured by this GET describes forms of support, and what the participant would hope for to be able to engage with the demands and responsibilities associated with the roles they hold as parent-trainees with LEMHDs.

Participants viewed the groups as essential in maintaining levels of motivation through verbal words of encouragement.

> *"There's been a parent trainee WhatsApp group, Across years and that's been really helpful to kind of connect with other parents (Arianna)." "We've started a little WhatsApp group that is that all the parent trainees, [...] and for the first time we're going to meet up and have a cup of coffee, which I think will be nice (Kirsty)."*

Being amongst like-minded people helped with reassurance and normalising difficulties, sharing advice and tips, motivation, validation and understanding of challenges. Leila and Maya's quote describe that being amongst those who share similar characteristics is essential to cope.

> *"(In our lived experience group) there will be plenty, plenty of good suggestions of of you know, how we can start a discussion and what people need (Serena)."*

> *"But if you're a parent, if you don't have mental health difficulties, you probably don't get it in the same way as someone who does. And I think being able to talk to people who can kind of relate and empathise with you from the same level. Is just. It's absolutely priceless, I think to kind of normalise what you're going through (Leila)."*

> "*I haven't quite put enough emphasis on just how important it was for me to speak to other trainees on my course, who are also parents and them going I get you. This is hard. You are doing well. You're doing your best* (Maya)."

In terms of family support some participants did not have the benefit of relying on family members; some participants moved away from family members to engage with the course and lived far away from them, others had partners/co-parents away for work and one participant's partner experienced their own mental health difficulties due to the increased demands in his own life relating to their partner engaging with the course. Participants noticed that individuals who were not familiar with the programme (i.e., family and friends), could not relate to or understand their experience of clinical training. This meant that participants who felt isolated amongst their peers also felt isolated within their social circles. For these participants, it also could have been interpreted as another moment where they or their experiences were not understood by others, which likely exacerbated distress.

> *"Your friends in your life or your family…They don't really know what training is really about, so it's quite hard for them to, fully understand. So you really need someone who's in it with you who also gets it from that, that other side as well (Arianna)."*

Recommendations were suggested by Maya, Serena, Kirsty and Kayliegh for "*making sure there's a good match between tutors and supervisors to trainees who are parents (Maya).*" This perception and experience of having safe supervisory relationships promoted wellbeing through the supervisor's ability to empathise with the participant, thus, reducing the chance of worsening mental health:

> "*Thankfully I had really understanding placement supervisors. Most of them are mums. Which is really really helpful because they just kind of really connected and supported me. They were really understanding and I think that was a saving grace there (Kayleigh).* "

Support from wider professionals included employee assistant programmes, phased returns to work, and Occupational Health assessments, but engagement with these forms of support were often experienced as lacking in "*compassion*" and "*understanding"* (Arianna and Maya). Seven out of eight participants accessed psychology support in the past, but only three out of eight participants (Maya, Ria and Leila) were actively engaging in therapy at the time of the research interviews (one participant was on anti-depressant medication). These participants perceived some benefits of therapy to address challenges at a lower level but understandably would not "*fix the stress issues with the course (Maya)"* where stress issues were specifically related to the demands and responsibilities associated with multiple intersectional roles (e.g., childcare, flexible working and feeling different to peers).

4.2 Making requests for reasonable adjustments

Reasonable adjustments (either formally through the wider university or employer, or via local discussions with course/clinical tutors) were mentioned by all participants and included assignment extensions, shorter commute to clinical placements, flexible working arrangements/adjusted hours, and being able to access lectures online. These were viewed as *"incredibly helpful options (Arianna)"* to allow participants to navigate mental health difficulties and reduce the potential for distress. But awareness of these adjustments varied between participants, with parents being "*missed (Belle)*" and deemed as ineligible to receive these adjustments.

> "*Parenting is often missed…so they need to make it really explicit that we are allowed to request reasonable adjustments (Belle).*"

Participants viewed flexibility as essential for enabling wellbeing and physical rest, whilst providing a fairer approach to those who were at a disadvantage, specifically parent-trainees with LEMHDs (*"I want to be treated like any other trainee (Arianna)").*

The impact of being missed was perceived by some as discrimination and more feelings of difference (especially in relation to peers who could access reasonable adjustments more readily. Participants appeared to want equity with treatment, acknowledging that they were at a disadvantage and needed additional support to be able to engage with the course.

Recommendations were offered, such as accessing a set number of remote lectures (Maya, Serena and Kirsty), reducing placement days, or completing the course over a longer period (Ria). Participants understood this to be a chance for respite, to increase wellbeing and reduce the experience of distress within their intersectional roles.

Collectively, participants expressed their frustration with the inflexible nature of the course and with the "*limited (Kirsty)*" adjustments being made to parent-trainees to provide support with navigating mental health. This may have led to feelings of invisibility and powerlessness against those in a position of power, finding that being assertive does not always get needs met. Terms and phrases used to describe this experience included "*inaccessible (Belle),*" "*not good enough (Maya),*" an "*ongoing battle*" and *"fighting for [reasonable adjustments] for a long time (Ria)."* This can be interpreted as a sense of powerlessness and feeling at conflict with the course programme. I also interpreted the term 'inaccessible' as constantly meeting blocks when trying to implement changes of support.

" The course that I'm on, say they absolutely cannot do it, you know, not for mental health, not for neurodiversity reasons, not for parenting reasons. It's always the same answer. They can't put anything [in place] that actually helps (Ria)."

"You have to have meetings if you miss too many lectures the course gives us 0 leeway. They have very strict guidance and you can only take this many days off placement. You have to do these and these and these amounts of work on your study days. Therefore you are also limited on how many study days you can take off (Maya)."

Arianna, Maya, Serena, Ria and Kayleigh spoke about needing to advocate for themselves regularly to have their needs met and manage their wellbeing and mental health:

"There is a fatigue for people to advocate for themselves…It can be relentless (Serena)."

You need to do this or I'll leave the course. I don't have an option. I either do it in my time scale or I leave the course. And they did make an adaptation to let me have one study day every week (Ria)."

4.3 Self-care

Acknowledging that there is some overlap with the section relating to managing demands through implementing boundaries, I believed it was important to have self-care as a separate subtheme. Firstly, it helped me to honour the participants interpretations that self-care was about employing methods to nurture themselves in the context of structural and emotional pressures (e.g., restorative practices), and boundaries felt more externally strategic (managing and planning workloads, delegating time to different responsibilities). And secondly, I felt that self-care related to personal methods of wellbeing, whereas setting boundaries felt like more universal strategies to all participants.

Self-care (e.g., eating and sleeping well, socialising, engaging with hobbies and leisurely activities, therapy) featured as essential for all participants wellbeing and ensuring their personal identity was maintained, whilst also allowing for participants to effectively engage with various demands from their intersectional roles.

"That's what I need. Is that time to just...Regulate to have like a time in the week where I stop. And then I can be like a better...I can be like a better parent (Ria)."

Unfortunately, most participants viewed implementing self-care as a challenge, perceiving them as less important against balancing too many demands, increased workloads and limited time, thereby self-care "*getting missed because they have no deadlines attached (Leila).*"

"It's 50% teaching and 50% placement and 50% research and then on top of that we've got 50% parenting as well.[...]When I'm short on time, the first thing that goes or the easiest thing for me to drop is looking after myself (Belle)."

One participant spoke about the seemingly hopeless nature of trying to implement self-care strategies without the course offering flexibility to be able to do so, thus, making no improvements to wellbeing:

> *"Well, if I went to therapy, what would I talk about? I'd be saying that I'm really stressed with this course. It's too much…they won't let me work flexibility to give me time to put all the self-care into place (Ria)."*

Arianna, Maya, Serena, Leila, Belle and Kayleigh described the concept of "*good enough*" within their intersectional roles and with their academic abilities ("*ensuring you can be a present enough and a good enough parent around your work commitments* (Maya)."). Being and feeling good enough allowed for participants to change their previous expectations, by dismissing or lessening the need for perfection, thus enhancing wellbeing ("*You don't need to do anything really well […] just to be good enough (Arianna)."*). Most participants were aware that they would have performed better academically at a time when they did not have childcare or significant mental health needs. While some participants were content with accepting this change ("*I have not excelled anywhere personally, I'm OK with that. Don't care. I just want it to pass (Maya)"*), others experienced distress in the form of self-doubt and self-criticism:

> *"I'm not getting the grades that I used to. So that feeds into the depression side of things, because I'm like, oh, I only passed that. I would have got something else before […] You're not good enough because now you haven't been able to do this, amongst other things (Leila)."*

Finally, the concept of implementing self-care was something that participants had an awareness and understanding of. However, it appeared that engaging in self-care strategies was not possible in the context of the perceived limited time associated with the demands of intersectional roles, when prioritising needs, self-care likely appeared further towards the bottom of this list. In the context of a lack of flexibility with the academic schedule, there was no ability to implement self-care strategies, which Ria described as hindered by the rigid nature of the course:

> *"…They [the course staff/employer/placement supervisors] won't let me work flexibility to give me time to put all the self-care into place (Ria)."*

Chapter 5: Discussion

Chapter overview

The following summarises the findings from my empirical research on navigating mental health difficulties as a parent-trainee on the DClinPsy programme. I will relate my findings to the wider literature whilst critically evaluating my research. Finally, I will present the implications of my findings and any research recommendations.

Overview of key findings

My empirical study aimed to answer the following research question:

“How do parent-trainees navigate mental health whilst on the DClinPsy programme?”

With the following exploratory questions:

- *What is the impact of navigating mental health and the role of a parent-trainee with LEMHDs?*
- *Are there any challenges and how do trainees make sense of these challenges?*
- *How are personal and professional demands balanced and prioritised in training?*
- *How do parent-trainees manage self-care, wellbeing and their mental health?*
- *What sources of support are available for parent-trainees with LEMHDs?*

Eight female parent-trainees engaged with the DClinPsy programme were interviewed with transcripts analysed using the IPA framework. Four GETs were identified with their respective subthemes (refer to Table 17 for GETs and subthemes). Collectively, participants shared experiences of mental health difficulties and worsening mental health engaging with the DClinPsy programme whilst holding dual roles as parents and TCPs. In navigating the dual-role as a parent-trainee, participants describe circumstances where their mental health was less prioritised and neglected. This was often due to a lack of time, managing competing demands and the inflexible approaches posed within the structure of DClinPsy courses, causing further suffering and impacting on TCPs perceived levels of competence. Sharing mental health problems with course staff or clinical placement supervisors resulted in varying forms of support, with some TCPs feeling validated when provided with provisions (e.g., extensions for assignment deadlines, flexible working patterns), and others feeling unsupported with mental health difficulties remaining or worsening. For parent-trainees, strategies such as boundaries setting and advanced planning was implemented to mitigate distress, but this still felt challenging to apply effectively within the restraints of the course.

The following section will explore my findings and themes in relation to the research question and aims in further detail, integrating them with the existing literature.

Interpretation of findings and integration with the existing literature

1. *How do parents-trainees navigate mental health difficulties whilst on the DClinPsy programme?*

Overall, parent-trainees experienced significant challenges in their attempts to navigate mental health difficulties whilst engaging with the DClinPsy programme. Multiple, appropriate strategies were attempted by parent-trainees with the intention to prevent and manage wellbeing, which included setting boundaries, advanced planning, advocating and requesting for reasonable adjustments and relying on different forms of support for childcare arrangements. These were experienced as impossible or complicated to implement owing to the inflexible structures imposed by DClinPsy programmes. All GETs illustrated challenges with navigating mental health difficulties alongside the demands of the programme and parenting, with no participant depicting consistently successful methods to maintain wellbeing. This corresponds with the existing literature describing how parents struggle to engage with the academic demands (Cushway, 1992; Cushway & Tyler, 1996; Jones & Thompson, 2017; Pakenham & Stafford-Brown, 2012) and supported by findings from my SLR (Clayton et al., 2024; Evans, 2024; Gerrard & Roberts, 2006; Misca & Thornton, 2021; Moreau et al., 2013).

Captured in GET1 ‘the emotional impact of an intersectional identity,’ parent-trainee’s challenges with navigating mental health meant that they endured distress rather than having distress alleviated. The GET of ‘ implementing coping strategies’ explored the attempts to seek formalised support, where responses were often conflicting, sometimes met with reasonable adjustments being applied (e.g., closer commutes to placement and assignment extensions) and sometimes dismissed, leading to invalidating experiences and little understanding from professionals akin to what has been described in the existing literature (Clayton et al., 2024; Comerford, 2025; Digiuni et al., 2013; Johnson, 2024; Marandet & Wainwright, 2010; Moreau et al., 2013; Todd, 2024; Turner et al., 2020). Ultimately, the lack of help enabling parent-trainees to meet their needs, left participants in this research hitting blocks, and silently suffering but continuing to engage with elements of the course in inconducive ways.

Interestingly, there seemed to be different approaches and responses between the course staff and placement staff when discussing mental health and parenting needs. Although not unanimous, most participants reported more compassionate and understanding approaches from placements with reasonable adjustments (e.g., flexible working patterns) being implemented much more readily than by the course. Participants felt that it was the sole responsibility of the course to make amendments, without mention of how the course is constrained the HCPC/BPS accreditation standards.

In line with the findings from Turner and colleagues (2020), parent-trainees shared mental health difficulties to seek and explore realms of support and provide explanations for why they could not reach their full potential academically and clinically. Some participants felt obligated to share due to their levels of difficulty, whereas others shared to mitigate the chance of deterioration in their wellbeing. The findings from my research are consistent with the existing literature describing how parent-trainees sought relief but struggled with the competing demands from multiple roles (Comerford, 2025; Johnson, 20204; Matheson & Rosen, 2012).

2. *What is the impact of navigating mental health and the role of a parent-trainee with LEMHDs?*

There appeared to be a negative impact with navigating mental health and balancing the dual-role as a parent-trainee. Relating GET1 ‘the emotional impact of an intersectional identity,’ collectively, participants described an increase in mental health difficulties (e.g., relapses, depression, anxiety), presenting with a range of negative symptoms, such a crying, poor sleep, a lack of enjoyment and low levels of confidence and low self-esteem. These descriptions correspond with findings from existing literature related to student-parents in HE settings (e.g., Bamber et al., 2024; Cronshaw et al., 2024; Cushway & Tyler, 1994; Evans, 2024; Marandet & Wainwright, 2010; Rawlinson, 2024).

Like the research by Catalano and Radin (2021), participants believed that their performance was negatively impacted with around half of the parent-trainees feeling less competent academically and clinically. This led them to believe that they were not suitable for training, which had the consequence of them considering withdrawing from the programme. Another impact reported by participants navigating mental health and the role of a parent-trainee with LEMHDs involved reported cognitive functioning difficulties, such as impaired concentration and learning, specifically in the context of academic and clinical performance rather than parenting. Participant's executive functioning abilities were likely impacted, leading to difficulties with sustaining attention, juggling multiple tasks and memory, which might have had academic implications such as missing key information in lectures and struggling to apply learnt material. Relating to the theme of 'the ability to balance personal and professional demands,' it was not uncommon for participants to experience difficulties with time management and prioritising the demands of being a parent and a trainee (despite strategies implemented to minimise the risks associated with lack of time), as with existing research from my introduction (Cushway, 1992; Cushway & Tyler, 1996; Jones & Thompson, 2017) and all studies within my SLR (Clayton et al., 2024; Cronshaw et al., 2023; Evans, 2024; Gerrard & Roberts, 2006; Marandet & Wainwright, 2010; Misca & Thornton, 2021; Moreau & Kerner, 2013; Rawlinson, 2024; Todd, 2024; Trotter, 2023). The DClinPsy programme was viewed as demanding so much time, that it left little space for respite and recovery, affecting all areas of their personal and professional life.

Negative impacts were also noticed with participant's social wellbeing. Relating to the theme of 'the emotional impact of an intersectional identity,' perceptions of difference and isolation featured strongly for parent-trainees, comparing themselves to their peers who could engage with leisurely and social activities (Clayton et al., 2024; Cleary & Armour, 2022; Cronshaw et al., 2024; Hinshaw, 2008; Misca & Thornton, 2021). Many participants felt they had to sacrifice family time, social events and social engagements with peers to meet academic deadlines, but not primarily as a direct response to mental health difficulties. This contrasts with existing literature from my SLR, which speaks to mental health difficulties imposing on one's ability to engage with course demands (i.e. assignments and attending lectures/seminars) (Clayton et al., 2024; Cronshaw et al., 2024; Todd, 2024). Participants described dissociative experiences and noticed that they could not be fully present in one role, as their minds were often distracted by thinking about the responsibilities of another role. As with my SLR studies (Evans, 2024; Gerrard & Roberts, 2006), this had the impact of exacerbating and maintaining distress. Furthermore, some participants described masking or hiding their difficulties from others, which may have been related to a fear of being judged by others (e.g., being labelled as a bad parent, incompetent TCP, not fit for the profession with mental health difficulties), fear of missing out on opportunities for developing as a psychologist, and with wanting to avoid burdening others, especially loved ones like family members.

Though not mentioned in my introduction, the impact on participants was suggestive of burnout with the presence of three key components related to exhaustion, inefficacy and cynicism (Maslach & Leiter, 2016). Applying this to participants in my research, exhaustion could have been considered as lacking in motivation, fatigue, wanting to abandon the course and feeling diminished. Cynicism could be related to the dissociative experiences, such as withdrawing from others, not wanting their family to see them in distress and hiding or masking difficulties. Finally, inefficacy was related to participants describing incompetence, lower academic achievements and abilities and reduced productivity.

Participants experiences can be understood by the diathesis-stress model mentioned previously by Engel (1980). Inherent and genetic vulnerabilities again might serve as predisposing factor to mental health difficulties. For the most part, these lay dormant, but are triggered and worsened through environmental stress, i.e. aspects of the DClinPsy training such as assignment deadlines, complex interventions, evaluation and assessments. Considering parents, time pressure likely featured as an environmental stressor with managing childcare, household duties and academic/research/clinical aspects of training. Some parents may have experienced sleep difficulties with children waking up regularly throughout the night or when their child was unwell. Student-parents with LEMHDs may have struggled more due to having higher diatheses leading to poor mental health when under stress, compared to those with fewer vulnerabilities, who may had had better methods to adapt.

3. *Are there any challenges and how do trainees make sense of these challenges?*

There were a variety of trigger to distress, which were mostly related to the DClinPsy activities (assignment deadlines, uncertainty associated with placements and location changes, inflexible and rigid structures) rather than personal challenges, similarly shared by Comerford (2025). In addition to the challenges already mentioned, the relentless advocating for both mental health and parenting needs to be met left participants feeling exhausted and stressed viewing their respective training programme as compassionless and dampening their experience of training. Feeling hopeless about changes being made caused further worry, especially about their mental health deteriorating and their ability to continue engaging with the course. This corresponds with research by Pereira and colleagues (2020) and Ibrahim and colleagues (2013) where findings suggested that without organisational support student could be at further risk of their mental health declining.

Relating this to the GET of ‘the impact of stigma on the parent-trainee,’ participants felt more able to share mental health difficulties with positive proactive approaches, and when LEMHDs was explicitly welcomed and viewed as an asset rather than a burden to the profession. This is comparable to the research findings by Turner and colleagues (2022). Contrary to this, if sharing mental health difficulties was not received well and participants felt as though they were not in inclusive working environments, participants responded by seeking alternative forms of support or remaining silent and not disclosing personal or professional challenges further, which bears likeness to some of the existing literature (Boyd et al., 2016; Brohan et al., 2014; Moll, 2014). Other challenges included participants experiencing exclusionary practices, prejudice or discrimination and having opportunities taken away from them unfairly (like the research by Tay et al., 2018).

Parent-trainees with LEMHDs have unique intersectional identities. Participants felt pressure to be efficient within their respective roles (as with the findings from my SLR; Marandet & Wainwright, 2010; Moreau et al., 2013; Rawlinson, 2024; Todd, 2024), but this and the combined challenges associated with juggling the demands led to further experiences of distress and feelings of guilt with or without adjustments being made. In juggling these roles, parent-trainees had less compassion, care and kindness for themselves and they engaged in self-criticism, without considering the complexity of the challenges that they were navigating.

4. *How are personal and professional demands balanced and prioritised in training?*

TCPs must hold in mind the care of multiple individuals (such as service users on their caseloads) including themselves, their children and for some additional family members. My findings suggest that parent-trainees were usually attending to the needs of others as priority, above their own needs. Like the research by Roy and colleagues (2018) childcare needs always took precedence over other competing demands, but not without worry related to the potential academic and clinical consequences (e.g., missing out on learning and training opportunities). Referring to previous findings by Cushway (1992), 59% of TCPs (*N*=287) felt moderately to severely stressed whilst engaging with the course, with many challenges related to attempts to juggle and meet the demands of multiple roles as a student and trainee. Time was the greatest challenge for all participants in my research as well as the research findings from my SLR (Clayton et al., 2024; Evans, 2024; Gerrard & Roberts, 2006; Misca & Thornton, 2021; Moreau et al., 2013). This relates to the GET 'the ability to balance personal and professional demands' where a lack of time led to participants feeling overwhelmed and needing to sacrifice activities in many aspects of their lives, for example social events and time needed to engage in psychological therapy.

For all participants advanced planning was essential for balancing and keeping in mind activities of importance (e.g., academic deadlines) and for being able to separate the responsibilities within dual roles. Being able to stay as close to plans mostly enabled participants to balance demands, but if something unprecedented occurred, plans were thwarted and participants experienced this as stressful with an increase in mental health difficulties. Linking to the theme of 'implementing coping strategies' my empirical findings are supported by findings from both my SLR (Clayton et al., 2024; Cronshaw et al., 2024; Todd, 2024), and introduction (Cushway & Tyler, 1996) with trying to maintain as much certainty and stability as possible but having too many different things to do. Attempts to juggle demands were experienced by my participants as futile, for example when being given short notice of placement locations and experiencing anxiety and stress with whether they could practically and logistically manage childcare arrangements. The unwanted chaotic nature of balancing and prioritising demands (by no fault of the parent-trainees) bears some similarity with chaotic parenting aspects for individuals presenting with severe mental health difficulties (Oakes et al., 2023).

5. *How do parent-trainees manage self-care, wellbeing and their mental health?*

Like the research around psychology professionals managing their wellbeing and mental health (Burke et al., 2003), parent-trainees in my research could not engage with self-care practices as demonstrated by the GETs 'implementing coping strategies' and 'the emotional impact of an intersectional identity.' Participants cited too many demands, too little time, poor organisational support and fewer resources to aid wellbeing, as did research by Cushway and Tyler (1996) and Roy and colleagues (2018). In keeping with the work of Comerford (2025) who found that onus was placed on parent-trainees to manage self-care needs, participants felt that clinical training courses needed to make more viable changes (reasonable adjustments such as accessing remote or recorded lectures) to enable them to create time to implement self-care and wellbeing strategies. For those participants who sought support or who tried to engage in wellbeing activities, this was hindered by imperative demands associated with being a parent and trainee. Consequently, mental health difficulties persisted when wellbeing attempts were sacrificed or neglected. The inflexible nature of the course left inadequate opportunities for respite or recovery, and it appeared that a limited work-life balance meant that this unique group of trainees could not effectively prioritise self-care needs (Lee et al., 2009).

Forms of resilience (physical, emotional, mental and social resilience) to manage mental health were mentioned by parent-trainees. Some participants coped by having the mental resilience that 'good enough' was sufficient, although this was mostly related to their role as a TCP and not as parents. These challenges relate to Winnicott's (1953) 'good enough parenting' approach where some participants in my research did not feel they were providing good enough care for their children, exacerbating mental health difficulties. But overall, participants spoke very little about the impact on their parenting. This reluctance may be related to feelings of shame or embarrassment associated with their abilities or worry/fear around the potential negative perceptions around their abilities as parents.

As mentioned previously, attempts were made to ensure boundaries were maintained, which included separated time for family and work (social resilience), but challenges with implementing boundaries worsened mental health, like the findings in some of my SLR studies (Clayton et al., 2024; Cronshaw et al., 2024; Todd, 2024). Strategies to support physical resilience was not present in my research, with many participants describing sleep difficulties and fatigue when working longer hours, which had consequential effects for example on regulating emotions. Goyal and colleagues (2007) support this with sleep deprivation as common for mothers of young children and babies, and where wellbeing, emotion regulation and cognitive functioning was affected amongst new mothers.

6. *What sources of support are available for parent-trainees with LEMHDs?*

To consider the sources of support for parent-trainees with LEMHDs, it is important to think about how the systems around parent-trainees work together to support their needs and maintain wellbeing. Utilising Ecological Theory (Bronfenbrenner, 1979) to think of systems, the microsystems around the parent-trainee involved drawing on support for childcare (e.g., nursery, school, babysitters or family members). A variety of support was discussed by parent-trainees, and it seemed that this was offered by individual training programmes. This included formalised support such as peer support spaces (either for parents or those with LEMHDs, but not both), buddying and mentoring, support from employment (e.g., Occupational Health) and the wider university institute (e.g., student wellbeing services), and support from course tutors and placement supervisors. Positive social engagement described by Burke and colleagues (2003) was seen as valuable by parent-trainees and this was reflected by participants in my empirical study who maintained connection and friendships through peer groups helping them to navigate training. Interestingly, specific mention was made by parent-trainees with being assigned to buddies, mentors, course tutors and placement supervisors who also had children, but not for them to be assigned to someone with LEMHDs, which implies that parent-trainees may feel like their role as parents are less recognised or attended to whilst engaged in training. It may also be related to the lack of visibility or representation of peers presenting with specific characteristics such as parenting and mental health.

Next, policies and processes from HCPC, BPS, the NHS and the government also influence how parent-trainees receive support (exosystems). Some reasonable adjustments were much more easily granted, for example extension deadlines. There were also negative experiences of seeking support, with some participants finding that there were barriers or complex processes involved which made it harder to effectively implement strategies to enable wellbeing whilst under significant level of distress (for example distance to placements and flexible working in the form of online lectures and reduced hours). Previous research has explored that when there are organisational challenges, mental health difficulties persist for individuals seeking support (Cleary & Armour, 2022). Whilst the course specifically does not offer psychology support or counselling, the university's student wellbeing services can sometimes offer brief intervention to TCPs. Like the studies presented in my SLR, this form of support was not discussed and may not have been accessed by parent-trainees with LEMHDs. Due to the nature of the profession, parent-trainees may be more aware of the type of support offered in student wellbeing services and may have more insight into whether this would be appropriate to meet their mental health needs. With only a few participants drawing on personal resources to navigating mental health difficulties, this implies that there is a need for specific support for parent-trainees with LEMHDs. Furthermore, whilst three participants were actively engaging in personal therapy, many spoke to the limited time available to engage with this whilst working a full-time job as a trainee and the full-time nature of being a parent.

Lastly, social and cultural values represent the macrosystems, which are specific to the parent-trainee, but these were hardly discussed and may be related to participants struggling to engage with their self-care strategies and personal values.

Implications and recommendations

Navigating mental health as a parent-trainee with LEMHDs requires an approach which needs consideration from multiple perspectives, i.e., course and placement staff, the employer and wider university institute, the HCPC who regulates DClinPsy programmes in the UK, the BPS who accredits the programme and the NHS as a governing body. Navigating mental health also requires the implementation of multiple strategies enabling the wellbeing of parent-trainees and my research has highlighted the need for professionals supporting parent-trainees to be more sensitive to the pressures of parenting in the context of LEMHDs. Combined, this should allow for a more holistic understanding of the complexities associated with these three intersectional identities, granting opportunities and provisions for effective solutions. My findings are an underdiscussed area of research, and I see importance in highlighting both the recommendation and the practical and systemic recommendations for DClinPsy programmes in this section.

The findings suggest that currently, the DClinPsy takes a one-size-fits-all approach overall to how parent-trainees with LEMHDs engage with clinical training, which ultimately, is not viable and does not meet the needs of a highly valued, yet underrepresented group of TCPs. For many of my participants who experienced discrimination and difference in relation to their own power and privilege (or lack of), these findings have the potential to normalise LEMHDs and vulnerability within psychology professionals. It is evident that stigma and shame still exist within a field that is centred around the NHS constitutional values of compassion and respect (NHS, 2023) and it is hoped that sharing my findings can reduce the culture of silence around Clinical Psychology training and parenting.

DClinPsy training programmes can be informed by my findings which begins to raise awareness of challenges faced by parents with LEMHDs on DClinPsy courses. Affirming LEMHDs and explicitly welcoming parents through various practices can enhance insight, rather than one which questions the competence and abilities of parent-trainees with LEMHDs. My research suggests that courses need to endorse more flexible approaches, which is essential providing it does not compromise the BPS or HCPC standards for training; adjusted working patterns, flexible placements locations and practices within placements will enable trainees to engage to the best of their clinical ability without worrying about potential repercussions or ramifications when set structures are in place, and which do not meet the needs of parent-trainees with LEMHDs. All participants in my study spoke about reasonable adjustments, and remote working options for academic teaching, which were successfully implemented during the Covid-19 pandemic as suggested by research from my SLR surrounding parents engaging with HE courses in the UK (Evans, 2024; Misca & Thornton, 2021; Trotter, 2023). As mentioned in my introduction, nearly all DClinPsy training programmes are offered on a full-time basis, which again assumes that trainees can fully immerse themselves with training, irrespective of the context of their personal life. It would be of benefit for employers, course staff and placement supervisors to consider a compassionate training model which ensures flexible approaches and allowing safe spaces for parent-trainees to discuss mental health difficulties without fear of penalisation, judgement or repercussions. My findings inferred that better community connection reduced feelings of isolation and feelings of difference through sharing experiences and providing a forum for support and advice. It is recommended that DClinPsy courses offer solidarity spaces to facilitate better connection and validation, which also has the benefit of normalising and reducing stigma amongst professionals. Representation and visibility will be of merit to DClinPsy programmes, and it may be possible that current-parent-trainees can be mentored or paired with either current or former parents (e.g., supervisors or buddies) who have navigated mental health difficulties during training to increase relatability. Peer support groups/spaces and ongoing awareness through cohort and lecture discussions will also help increase awareness and the visibility of this unique group of individuals. Peer support groups/spaces are viewed as protective factors (supported by research by Sidebotham, 2017) and it is hoped that this is employed across all DClinPsy programmes. This will help promote empathy towards modern day parents engaged in education and training, such as DClinPsy training.

In addition, regular discussions around LEMHDs and parenting can increase thinking about both the challenges and assets that this group of unique trainees bring to the profession.

These recommendations around visibility and representation should be maintained throughout training and not presented as tokenistic during inductions. Essential training for course staff may help alert staff to the personal issues parent-trainees with LEMHDs face, as well as to generate possible solutions, suggested by Turner and colleagues (2020). DClinPsy courses might wish to consider making available a list of support options to parent-trainees with LEMHDs, which they can refer to if they notice mental health difficulties arising.

The findings can also inform current parent-trainees who described invalidation and a lack of understanding as a consistent part of their challenges. Sharing these findings can provide some validation that parent-trainees with LEMHDs are not alone in their struggles and that their experiences are not unnoticed or unrecognised. It is hoped that my findings will give parent-trainees permission to prioritise mental health needs, including self-care and activities towards wellbeing, to help sustain their training and development of clinical practice. If DClinPsy programmes can improve access to psychological support services either through the employer or in-house, they should consider tailoring this for parents and those presenting with LEMHDs. Importantly, parent-trainees need to be able to prioritise this whilst also having systemic structures in place to meet their needs considering flexible and adjusted working practices. It is hoped that this can relieve pressure and develop parent-trainees own self-compassion.

Finally, future applicants will also be informed of my findings (the challenges experienced with being trainee-parent and someone with LEMHDs and how they are navigated), giving some insight and transparency into the demands of training and the support available. From the time that aspiring CPs apply, the Clearing House and BPS Alternative Handbook could make lived experiences and parenting explicitly visible to applicants, rather than grouped within the disability and impairment categories. It may be beneficial to begin collecting, reporting and publishing data around the application stages, and where aspiring CPs with LEMHDs and parenting needs might experience challenges for the purpose of transparency and raising awareness of the difficulties that this group of trainees face. This could include information around reasonable adjustments, clearer guaranteed interview processes and placement and academic-related information on how adjustments translate in practice.

The DClinPsy programmes could communicate either through open days of via their websites, that being a parent and someone with LEMHDs should not be a barrier to accessing the course, but instead should be viewed as a strength, viewing this group of individuals as an asset to clinical training and shaping mental health services (HCPC, 2017). It might be helpful to have forums where alumni with unique intersectional identities, like those who are parents and those with LEMHDs, present and share their experiences of training, which would again provide a perspective into the experience of the course. Having a parenting and lived experience lead on each programme would help to improve representation, enable TCPs to feel valued through co-collaboration ensuring processes are streamlined. Leads across programmes could meet regularly to help maintain consistency with approaches and help to creatively provide solutions to problems.

Whilst my findings are considered in the context of DClinPsy training, many of these suggestions could be transferable to other mental health training programmes and courses, such as the Cognitive Behavioural Therapy Postgraduate Diploma (PGDip) and Counselling Doctorate. Suggestions could apply to anyone who occupies the parent, student and individual with LEMHDs role.

Critical appraisal for empirical study

To appraise my research, I used the CASP quality appraisal tool (CASP, 2018), an effective tool for appraising research of a qualitative nature. This ensured my research was rigorous and reliable. To begin with, Table 18 shows how many times the GETs and subthemes appeared for each participant, providing a rationale for why the most reoccurring themes were used for the analysis.

Table 18: Number of times themes reoccurred amongst participants

GETs	**Subthemes**	**Number of times themes were represented**							
		2	**3**	**4**	**5**	**6**	**7**	**8**	**9**
The emotional impact of an intersectional identity									
	Distress	x	x	x	x	x	x	x	x
	Experiencing difference	x	x			x			x
The impact of stigma on the parent-trainee									
	Talking about mental health	x	x	x	x		x	x	x
	Valuing lived experiences	x		x	x	x	x	x	x
The ability to balance personal and professional demands									
	Time	x	x	x	x	x	x	x	x
	Prioritising and Boundaries	x	x	x	x	x	x	x	x
Implementing coping strategies									

	Relational support	x	x	x	x	x	x	x	x
	Making requests for reasonable adjustments	x	x	x	x	x	x	x	
	Self-care	x	x	x	x	x	x	x	x

Table 19 displays my CASP checklist for my empirical research[30]. Like Table 8 in my SLR section, 10 questions are used to assess the quality, relevance and risk of bias for my research. The CASP checklist was deemed as suitable for my empirical research question and chosen for its consistent appraisal approaches discussed and agreed with my supervisory team, thus enhancing credibility and reducing bias. This method has allowed me to critically analyse my research design, recruitment and adequacy of data analysis.

Table 19: CASP checklist for empirical research

Clear statement of research aims?	**Appropriate qualitative methodology?**	**Appropriate research design ?**	**Appropriate recruitment strategy?**	**Appropriate data collection?**	**Relationship between researcher and participant considered?**	**Consideration of ethical issues ?**	**Data analysed sufficiently rigorously?**	**Clear statement of findings?**	**Is the research valuable?**
Y Includes main and exploratory questions	Y Explore the experiences of participants and does not utilise numerical or statistical data.	Y Design was appropriate to address the research question.	Y Advertised on appropriate social media platforms, recruitment through universities which facilitate training.	Y Using semi-structured interviews and the use of additional follow-up prompt to gather further information.	Y Explored the insider/outsider perspective and my positionality; I maintained reflexive research diary entries, regularly , thereby consider	Y All ethical guidance and procedures were followed with any queries and challenges being discussed with my supervisory team. Any	Y Data analysed with three members of my supervisory team, and within regular IPA workshops, allowing for reflect	Y Findings have been presented according to the research questions. Participants voices have been shared using direct quotes,	Y The first study of its kind to explore the intersectional identities of a parent, trainee and individual with LEMHD. This provid

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[30] As a reminder, the CASP checklist considers the areas of importance, appropriateness and scientific rigour, and provides a rating of ‘yes’ ‘no’ or ‘can’t tell’ against each of the 10 questions.

					ing any influences on my data analysis.	chance of upset related to the topic of parenting, LEMHDs was discussed with participant and shared within a debrief form	ion, multiple perspectives and reducing the risk of bias	with my own hermeneutic interpretations.	es a relevant and significant addition to existing research.

Strengths, limitations and future research

Strengths

There are several strengths associated with this study. Firstly, this empirical research is unique, combining the intersectional identities of being a parent, trainee and an individual with LEMHDs. To my knowledge, currently, this is the only study that has attempted to make sense of these experiences. Its originality contributes to the wider literature related to Clinical Psychology training, providing new insights and perspectives to explore how parent-trainees navigate mental health difficulties whilst engaged with the DClinPsy programme. This research provides some advancement of understanding multiple identities in professional training contexts.

This study has provided a unique and necessary opportunity to validate and sensitively explore phenomena within a group of individuals who are underrepresented in research. This research has benefits in its ability to amplify the nuances that parent-trainees with LEMHDs face in DClinPsy training. Through IPA, a rich in-depth analysis was conducted to understand how participants have made sense of their experiences, including a hermeneutics approach. This may not have been possible through other methodologies such as Thematic Analysis, where there is often a summary of themes, but less intricate, personal meaning-making. This illumination of challenges allows for potential revisions of policies, processes and procedures, to help make DClinPsy training more accessible. If effective changes are made, it might better the mental health of parent-trainees with LEMHDs, with a positive result of creating more competent reflexive practitioners in training. Representing these individuals has the potential to inspire future applicants, but also to inform them of the challenges which they may not have been aware of previously. Finally, this research implemented rigorous methodological transparency and reflexivity using reflexive research diary entries and research journal activities.

Limitations

All participants in my research identified as female and demonstrated the importance of their roles as primary caregiving mothers (Field, 1996). In terms of the study limitations, self-selection bias may have been present with participants being more vocal and reflecting the challenges but not necessarily hearing about those who have successfully been able to navigate mental health. Alternative methodology could have been used to capture qualitative data, such as writing diaries, as engaging in interviews may have been experienced as intense, and may have prevented participants from talking about challenges in detail due to shame and fear of judgment, for example parenting challenges.

This research has not been able to capture the role of fathers who are parent-trainees with LEMHDs, nor do we know the experiences of parent-trainees in same-sex couples. We also do not know the experiences of any parent-trainees, who may have terminated their engagement with the programme prematurely due to mental health difficulties, nor do we know of the experiences of any parent-trainees who may have been off signed off from training due to severe mental health difficulties, meaning that they may not have been aware of the recruitment. It is also possible that some parent-trainees with LEMHDs may have been experiencing challenges such as limited time and too many demands, impacting their ability to engage in this research. Despite collaborating with my supervisory team to mitigate the risk of personal bias, my interpretation of the GETs and subthemes are subjective and reflect personal judgement, common in qualitative research.

Future research

Future research might look to explore the experiences of parent-trainees who have had to temporarily pause their training due to mental health difficulties. This could provide insight into the mental health challenges experienced in clinical and academic settings, as well as the processes, interactions and forms of support amongst key individuals, such as academic and clinical supervisors and the employing manager. Future research could also explore longitudinal designs, tracking the wellbeing of student-parents with LEMHDs across the three years of training. Finally, insight could be provided into the experience of parent-trainees who have permanently disengaged from the course due to severe mental health difficulties as this research area is not currently available.

Conclusion

My research highlights the greater need for support structures for parent-trainees with LEMHDs, who struggling to navigate the demands of their intersectional roles, and whose mental health difficulties are triggered or exacerbated by the course. DClinPsy courses would benefit from moving towards more inclusive practices for parent-trainees, considering their individuals needs and responsibilities holistically, enabling them to engage effectively with clinical training.

See Appendix A, Excerpt K for Reflexive research diary, final reflections[31]

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[31] See Appendix A, Excerpt K for Reflexive research diary entry on final reflections

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Appendices

Appendix A – Reflexive research diary entry excerpts

Reflexive Research Diary

Excerpt A: 15/01/2024

Creating the research poster

I was keen to create a poster that would appeal to parents, and which would also be personal to me. Before starting the course, we went on our first family holiday, and someone took a photo of me in the sunset holding my daughter. On the surface, you see us connecting and being so happy together. But I remember feeling so many overwhelming emotions; anxious to start the DClinPsy, fear to move away from our first home together away from our family and friends, sadness and guilt with having to stop maternity leave early and doubt about whether I was making the right decision. I spoke about these feelings to my cousin, Nadia, and she was able to edit the photo with a graduation gown and hat in the UoH colours. Now, for me, this photo has been reframed to represent achievement and success towards reaching my goal of being a Clinical Psychologist. The picture serves as a reminder that yes, the course experience was incredibly difficult, but I have overcome the challenges, and no longer feel guilty about making tough decisions, everything I did for those three years especially was for my daughter.

Excerpt B: February / March 2024

Bracketing interviews and practice

I have had two practice interviews. After creating the questions (from my interview guide) with the support of my supervisors, I asked the questions to my consultant to explore if the questions made sense, if the questions flowed naturally and if the questions were going to help answer my research question. I also noted down any follow-up questions I had. After feedback from my consultant, some of the wording and ordering of questions were changed, making them flow better for the participant. This also helped to ensure my questions had the ability to answer the research question. I found it helpful to see how my consultant was answering questions, to see if the responses matched the research question.

I also completed a bracketing interview. I found this helpful to understand the way that I was answering questions, realising that some questions evoked strong emotions for me, and may do the same for other participants, which could affect the way that they might answer and how I might ask questions. This helped me to be aware of my potential bias (being drawn to more questions, asking more follow-ups because a topic personally resonates with me and because I was seeking particular answers) and created a plan with my supervisors for how I need to balance validation and neutral responses. I also considered in my supervisory team meetings how I can reduce bias and not influence the interview with my responses (or requests for follow-up questions), and how to use supervision/mindfulness techniques to look after my own emotions, especially if there is a chance that the participant says something which could resonate with me. During the interview, I will note down any moments where I have had any biases/judgements. After the interview, I will write reflective entries for each participant (noted in upcoming excerpts). Finally, during my data analysis, I will not any personal connections and interpretations, I will aim to discuss these with my supervisory team, and present in IPA workshops with the hope to eliminate any biases and preconceived notions. It may be that my supervisory team (who know my personal context and relationship to the research) are also able to point out and notice any of my own biases, which might influence my interpretation of the results.

Excerpt C: 21/06/2024

Ethical approval and participant interest.

Feeling proud of myself for a successful MRP proposal and for getting through the ethical approval process without any major bumps. I am looking forward to advertising my poster and starting the process of recruiting participants for the study.

Within just a few days of sending out my recruitment information, I have participants who have emailed and expressed their interest to participate in the study. I will pause for a couple of days and see how many people are interested. But so far this interest already has reminded me of the importance of this topic.

Excerpt D: 24/06/2024

Request for interview themes to be sent, prior to the interviews

Two participants requested for themes around interview questions to be sent beforehand to help reduce anxiety and uncertainty. It was important for me to consider both the participant's perspective and my own perspective. My first thought related to stigma, and what it must be like for participants to feel anxiety, not knowing what I, as the researcher, might think of them in relation to their mental health and parenting. I wondered how they might think of me, assuming that I am also a parent and individual with LEMHDs and whether they might be more or less likely to share difficulties with me.

I do want to get the best out of participant's responses, especially when it is important for part of my analysis of themes to understand the meaning and feelings related to their experiences. But I am also aware that they asked for the themes to be sent beforehand, possible due to a vulnerability and fear of what disclosing this vulnerability might lead to. It will be important to maintain and create a safe space with participants, so validating and being empathic will be key responses I make during these interviews, providing that I don't bias their responses- I still need to maintain neutrality and not influences their responses. I plan to pay more attention to participants' indications of distress, particularly in the context of uncertainty (for e.g. any risks to self?), offering breaks or reminding participants that they can take breaks if they need to. With discussing sensitive topics, I might need to also adjust the pace of my questions, balancing and maintaining ethical considerations, like risk of psychological harm/distress, over the benefits of my research.

I am going to ensure I maintain ethical standards by reminding the participant of confidentiality, re-seeking their consent after sharing the themes, and doing this prior to the interview when joining the online meeting, and share the information around participants right to withdraw, should they wish to. Finally at the end of the interview, (as will all of my participants) I will ask participants about their experience of the interview (asking for any feedback they might have) and engage in a process which attempts to ensure their wellbeing, in addition to sending them the debrief form which includes forms of support.

As an added measure, I will review participant's videos, noting if there are any areas of improvement (reflecting on my interview technique) that I could make for the next participant who asked for themes to be shared.

Excerpt E: August-September 2025

The interviews

- PPT1: similar personal experiences (ppt described hierarchy of child, course, herself, so I felt a strong pull towards wanting to agree with her about the difficulties. I anticipated that there could be a challenge with balancing my therapeutic approach and my researcher approach. But I think I did a good job of remaining neutral, not influencing the interview with my clinical assessment skills and paraphrasing what the participant said to check my understanding of their experiences. I don't think I had any leading questions, and I was able to ask questions that helped to answer my research question. But this was a shorter interview than I expected. When I reviewed the video, I felt I could have asked for more examples of experiences and follow-up questions to help answer my research question, so I planned to do this with future participants. I also noted my behavioural and verbal responses (nodding, agreeing, and also lack of these behaviours), which might have influenced how much information the participant gave. I decided that after participants finish speaking, I will pause for a bit longer before moving onto my next question, and, I will also say something along the lines of, "based on what you said/in re-telling did you notice any emotions come up for you and how do you make sense of it?" with my rationale to gather more information about specific experiences, and the participant's own interpretations.

- PPT5: This was the hardest interview for me. I needed to hold my emotional and verbal responses much more, and after the interview, I felt so upset and saddened to hear about this participant's experience. They spoke about how the course led them to experience suicidal thoughts, which they hadn't done for some time. I thought about how horrible it must have been for these challenges to have gone unnoticed, how they felt hopeless and how they couldn't talk to any professional associated with the course for help. A theme of flexibility has come up in all the interviews so far, I need to remain mindful not to draw links between interviews just yet. I need to remain open-minded of the upcoming themes and different experiences. For example, there might be a participant who has had mental health difficulties, and the course is presented as a protective factor rather than a perpetuating factor or triggering event.
- There were powerful comments mentioned in this interview, and I am aware that I want to make sure these comments are included somehow because of their importance, but I also need to make sure they are in line with the identified themes and that they are answering my research question. It will be important for me to discuss this with my supervisory team. I plan to discuss with my team how to ensure that participants voices are heard and not lost through the process of simplifying the gathered information.
- In terms of ethics, when the participant began to talk about suicide, I reassured them that they should only say what they are comfortable with saying and sharing, whilst reminding

them that there is a chance what they say is included in the final discussion/discussed in supervisory team meetings and the IPA workshops. They were offered an opportunity to pause, and take a break for self-care purposes. I also ensured that at the end of the interview, I reminded them of the sources of support and the information about withdrawing data, should they wish to. I think I did well with not pressurising them and giving them enough information to make an informed decision about what they want to do. I discussed this scenario with my supervisory team to ensure I was acting in accordance with research and ethical guidelines.

Excerpt F: October-November 2025

Sharing excerpts for the analysis

- I was able to share excerpts with my supervisory team and in the IPA workshops, which was part of the exploratory comments phase- I felt comforted by seeing the team share similar ideas of what stood out for them and how they interpreted the data and what sense the participant made of their experiences. It is also interesting to see different people's perceptions, what resonates with them as well as me.
- Through analysis, there have been a lot of times where I feel angry or upset about my own experiences- I am finding some of the immersive experiences difficult, but luckily, I am able to reflect and talk through this with my consultant. My placement is a mother and baby unit, and a community perinatal team. I love the work that I am doing, and my project, but I realise how much I am hearing about parental mental health difficulties. I am noticing the effect that hearing the difficult situations from others, means I need to do more of my own self-care, particularly in my research analysis where I am sharing many similar characteristics as my participants.

Excerpt G: 24/04/25

Personal challenge and pressure

- After a difficult month with personal challenges, I reflect on feeling very supported and held by my supervisory team. I am aware that I put pressure on myself to meet thesis deadlines, but it feels really important for me ensure I am conducting research in the best possible way. But I am also reminded by my supervisory team of how life and parenting often throw plans off course, and that if this were to happen for me, I will still be able to complete the course with a flexible deadline that meets my personal and professional needs. This feels familiar with what was being mentioned by my participants- the desire to finish as quickly as possible, and good enough being good enough. I remember wanting to say I understand, and I relate, and I get it. But to say this within the interview would have met my own needs rather than my participants, and it would not have been appropriate for the interviewer to over-identify in the moment. It was incredibly important to remain neutral and not influence my participants' discussions.
- I don't want to rush the project because it won't be helpful and I am keen to make an impact; I have put a lot of effort into a topic which is close to my heart and where I strongly hope for change in the future. I need to keep the conversation going with my supervisory

team about the feelings of pressure that I put on myself, and I want to continue adhering to ethical practices and producing good quality research without the risk of losing crucial information, particularly when I analyse and interpret the meaning of participants' experiences.

Excerpt H: April 2025- May 2025

Screening phase – SLR

- I've noticed that my results for one database have produced a lot of results (1572 for Scopus after including the year and English language parameters). After importing the references into Covidence, I notice that there are some irrelevant articles within my screening phase. I wonder if the other databases will have the same effect, and I may need to seek advice from my supervisory team or the librarian. For the moment, I will continue screening in the same way. Luckily, I can see that there is one article which will be moving to full-text review screening, and three articles within the 'maybe' section and this is only through the first 200/1572 articles. I plan to review these with my second reviewer/my supervisory research team.
- Today I have noticed that a lot of the articles that could be so useful are international, I'm only on my second database, I've identified two potential studies, but I still feel nervous about how many UK studies there are. There are a lot of articles related to the pandemic too..
- I have now had a training session with the librarian to help me chose the best databases for searches and the key concepts/search terms. Together we have been able to narrow down returned results, making screening more reliable and bringing back results which will answer the research question.
- During the extraction phase, I originally thought that this article was suitable for inclusion (The care-less academy? Making space for parents and carers in higher education.
- Spacey et al., (2024). Upon cross-checking with a peer, it became apparent that this study was more quantitative focused and therefore should be removed from being included in the SLR review. before removing, I checked the article against the inclusion and exclusion criteria, I still remained unsure, therefore I discussed this with my supervisor and came to a conclusion, which was to remove the article from the review. this process demonstrates high reliability.

Excerpt I: May-June 2025

Extraction and narrative synthesis – SLR

- Having completed the screening, full-text review and data extraction. I am surprised at how little information is available on the successful aspects of engaging in mental health support for student-parents in HE. It seems that there is a need for support, but adequate support is not offered and student-parents do not have time to access it because they are already juggling many other demands. With my own insider-research position, I can relate to this. It doesn't seem to make sense to seek support from wider institutions, who are not familiar with the processes and requirements of the course. I wonder if my empirical analysis will speak to something similar. I will be mindful of my own personal experiences with access support, and maintain reflexivity to ensure it does not bias my own interpretations. To do this, I will speak with my supervisory team and consider alternative perspectives and interpretations of my own participants' experiences.

Excerpt J: June-July 2025

Analysis and discussion

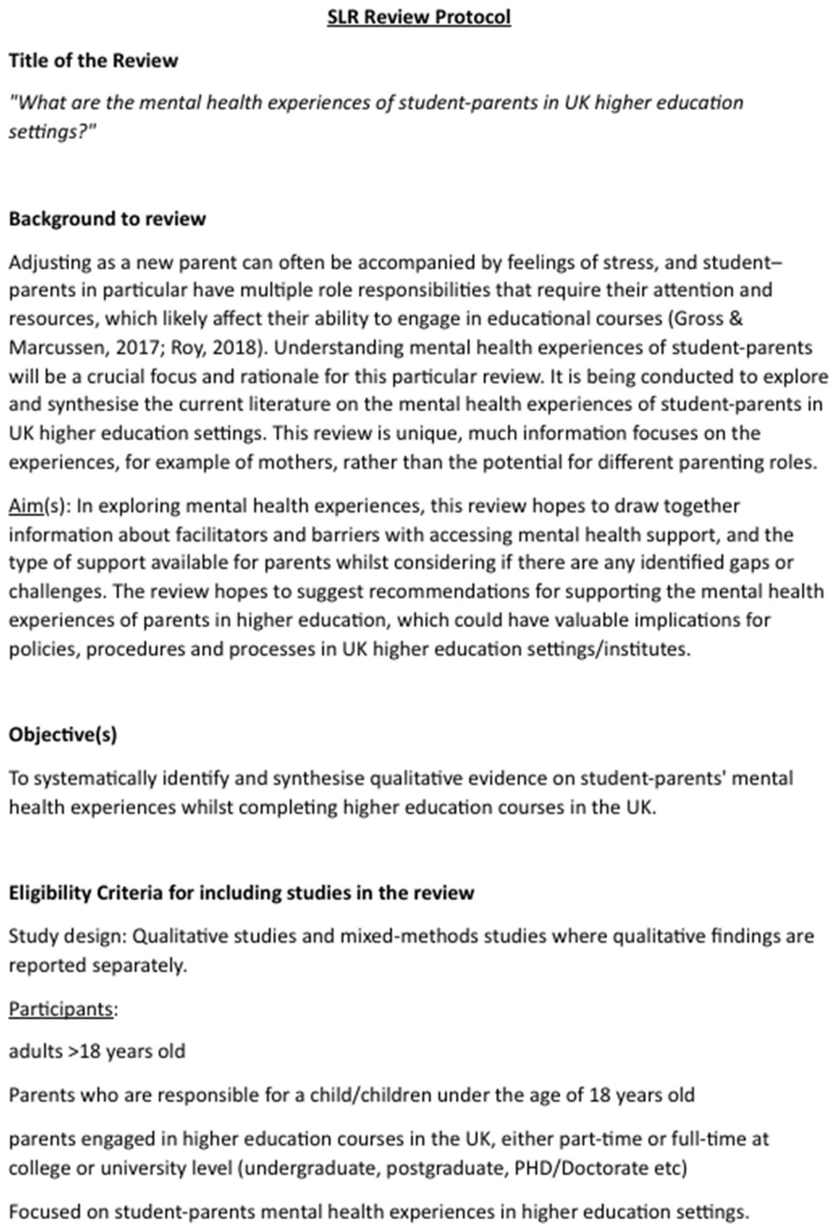
- Having fully immersed myself in the data, I have now selected the most relevant quotes to include in my analysis, which portrays the group experiential themes in the best way, and which shares a collective story of participants experiences of training. I noticed being pulled by my personal biases, for example, I wanted to include so many more quotes about participants experiencing 'guilt,' (because of my own experiences of guilt during training). But when I re-read my themes, revisited what I wrote and compared the comments with what supervisory team said, I went back and tried to make sure that my interpretations were about what the participant's said rather than my own personal experiences. Remaining in line with the critical realist epistemology stance, I wanted to somehow ensure *all* participants voices were heard in the best possible way, but I realised I couldn't do that with the word count for the whole thesis.

Excerpt K: August 2025

Final reflections and submission

- I am a researcher who shares many of the same characteristics as my participants in the study. As an insider-researcher, I was mindful of the lens I was looking through throughout my analysis, interpretation of findings and my discussion. As with IPA research, it was of value and importance to bracket my assumptions and maintain my reflexive research diary and continue discussions with my supervisory team.
- I feel privileged to be able to conduct this study for a topic in which I hold close to my heart. Through interpreting and understanding the experiences of parent-trainees with LEMHDs I have found solace and comfort, realising that some parts of my own personal challenges can collectively be shared with like-minded individuals. I am in a position where I can now envision life beyond training and transition away from feelings of distress, isolation and parental guilt. Parent-trainees and trainees with LEMHDs need more representation and more visibility in the profession and I hope that my research can be of positive impact and a move towards this.
- Conducting this research has been an emotional, mentally challenging and intense journey. I have walked similar journeys with my participants, navigating similar challenges of being a parent, and specifically a mother (for example the times where my daughter was unwell, arranging childcare through nursery and pre-school), pursuing my Clinical Psychology Doctorate, and understanding and navigating my own wellbeing. My family and friends have been unbelievably supportive and patient with me, especially my husband and daughter. I feel excited to disseminate my research findings, and nervous about feedback that might be received for example when I hope to present at a research conference, or when sharing findings with universities. This research felt incredibly important to me, and I hope for positive change for current TCP parents and aspiring CPs with lived experiences of mental health difficulties.

Appendix B – SLR review protocol and search strategy



SLR Review Protocol

Title of the Review

"What are the mental health experiences of student-parents in UK higher education settings?"

Background to review

Adjusting as a new parent can often be accompanied by feelings of stress, and student–parents in particular have multiple role responsibilities that require their attention and resources, which likely affect their ability to engage in educational courses (Gross & Marcussen, 2017; Roy, 2018). Understanding mental health experiences of student-parents will be a crucial focus and rationale for this particular review. It is being conducted to explore and synthesise the current literature on the mental health experiences of student-parents in UK higher education settings. This review is unique, much information focuses on the experiences, for example of mothers, rather than the potential for different parenting roles.

Aim(s): In exploring mental health experiences, this review hopes to draw together information about facilitators and barriers with accessing mental health support, and the type of support available for parents whilst considering if there are any identified gaps or challenges. The review hopes to suggest recommendations for supporting the mental health experiences of parents in higher education, which could have valuable implications for policies, procedures and processes in UK higher education settings/institutes.

Objective(s)

To systematically identify and synthesise qualitative evidence on student-parents' mental health experiences whilst completing higher education courses in the UK.

Eligibility Criteria for including studies in the review

Study design: Qualitative studies and mixed-methods studies where qualitative findings are reported separately.

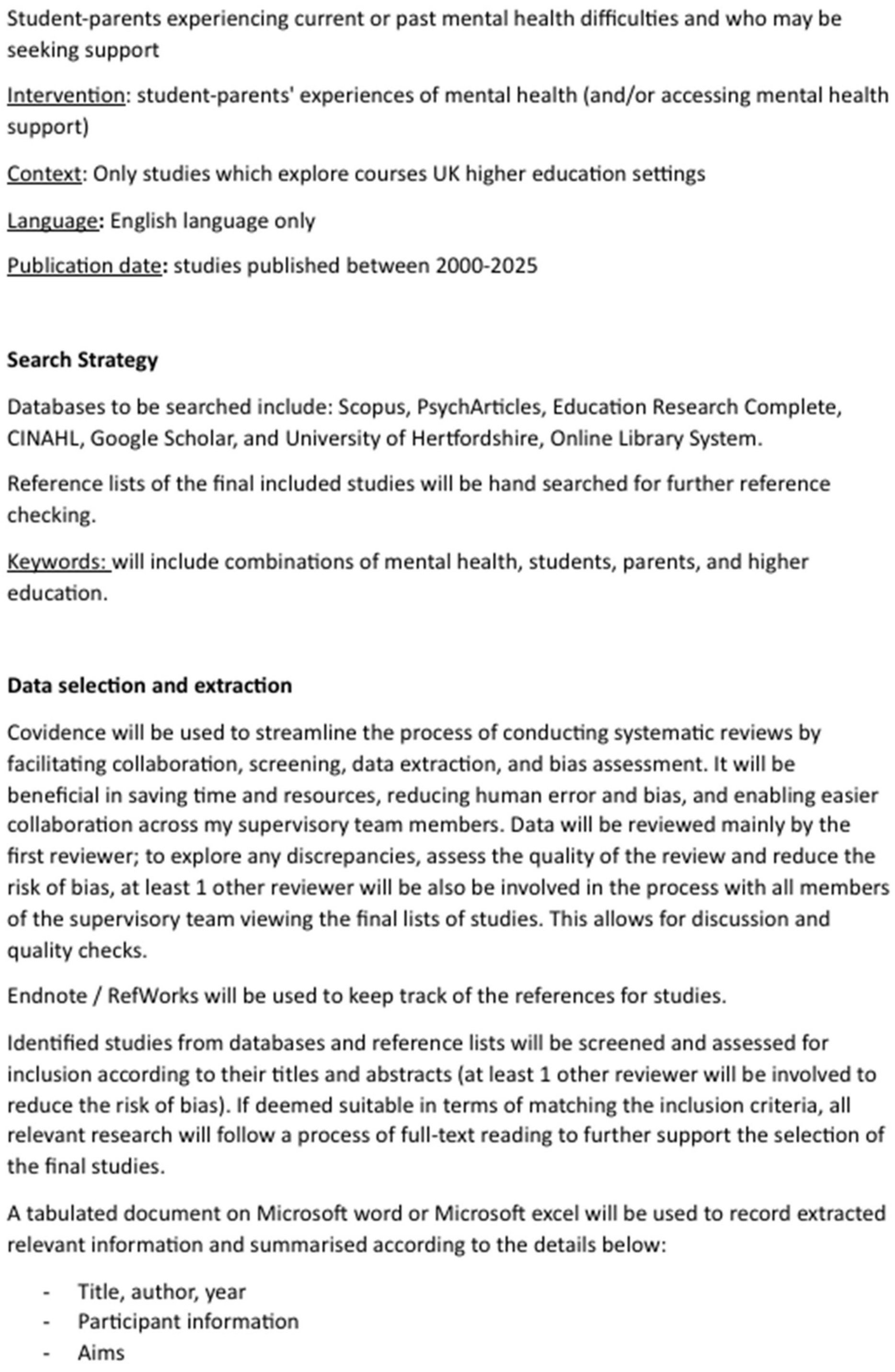
Participants:

adults >18 years old

Parents who are responsible for a child/children under the age of 18 years old

parents engaged in higher education courses in the UK, either part-time or full-time at college or university level (undergraduate, postgraduate, PHD/Doctorate etc)

Focused on student-parents mental health experiences in higher education settings.



Student-parents experiencing current or past mental health difficulties and who may be seeking support

Intervention: student-parents' experiences of mental health (and/or accessing mental health support)

Context: Only studies which explore courses UK higher education settings

Language**:** English language only

Publication date**:** studies published between 2000-2025

Search Strategy

Databases to be searched include: Scopus, PsychArticles, Education Research Complete, CINAHL, Google Scholar, and University of Hertfordshire, Online Library System.

Reference lists of the final included studies will be hand searched for further reference checking.

Keywords: will include combinations of mental health, students, parents, and higher education.

Data selection and extraction

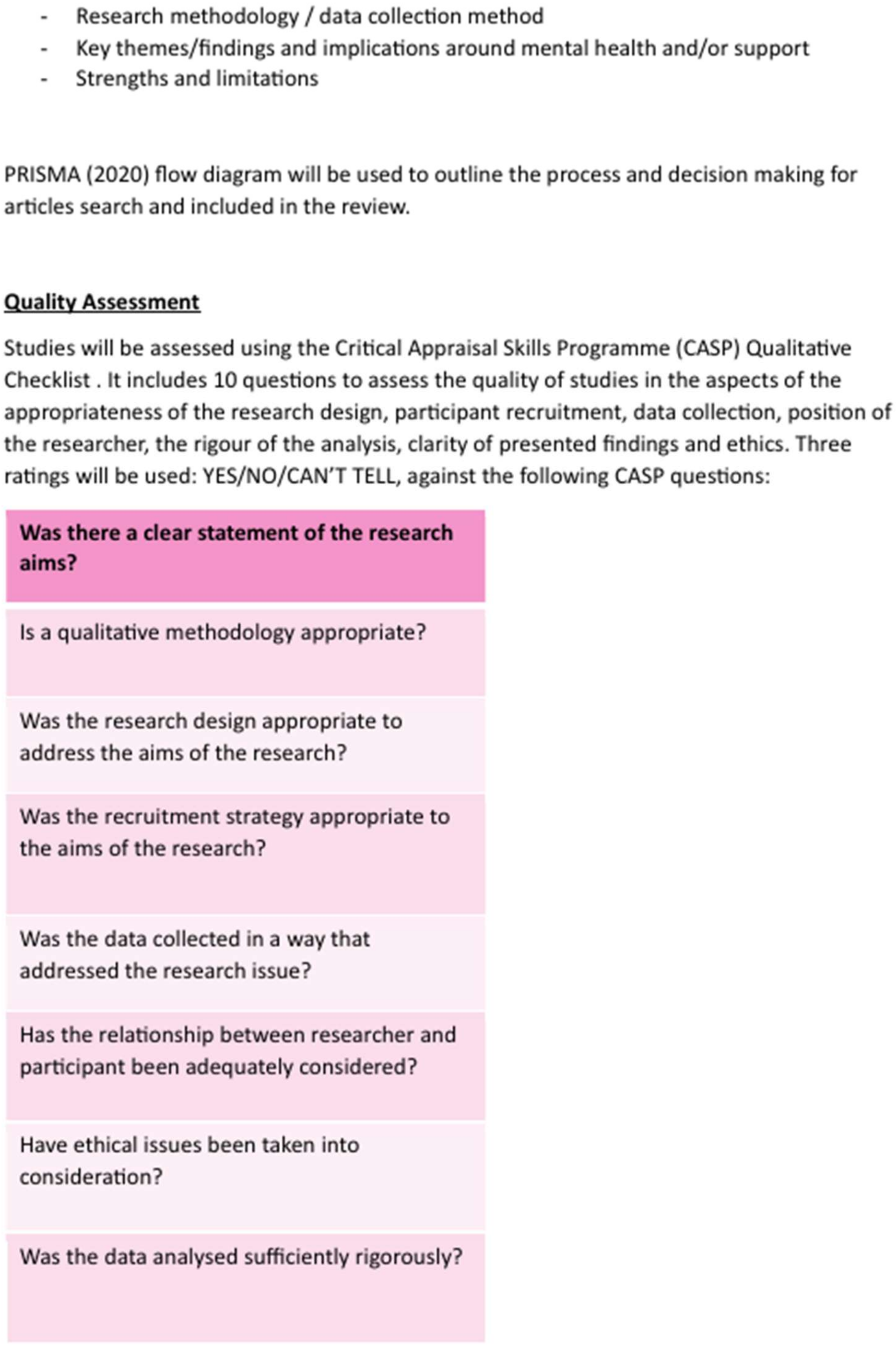
Covidence will be used to streamline the process of conducting systematic reviews by facilitating collaboration, screening, data extraction, and bias assessment. It will be beneficial in saving time and resources, reducing human error and bias, and enabling easier collaboration across my supervisory team members. Data will be reviewed mainly by the first reviewer; to explore any discrepancies, assess the quality of the review and reduce the risk of bias, at least 1 other reviewer will be also be involved in the process with all members of the supervisory team viewing the final lists of studies. This allows for discussion and quality checks.

Endnote / RefWorks will be used to keep track of the references for studies.

Identified studies from databases and reference lists will be screened and assessed for inclusion according to their titles and abstracts (at least 1 other reviewer will be involved to reduce the risk of bias). If deemed suitable in terms of matching the inclusion criteria, all relevant research will follow a process of full-text reading to further support the selection of the final studies.

A tabulated document on Microsoft word or Microsoft excel will be used to record extracted relevant information and summarised according to the details below:

- Title, author, year
- Participant information
- Aims



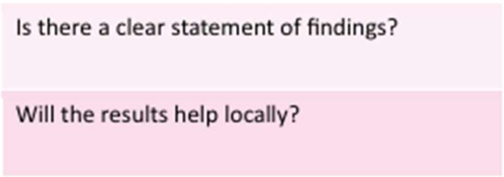
- Research methodology / data collection method
- Key themes/findings and implications around mental health and/or support
- Strengths and limitations

PRISMA (2020) flow diagram will be used to outline the process and decision making for articles search and included in the review.

Quality Assessment

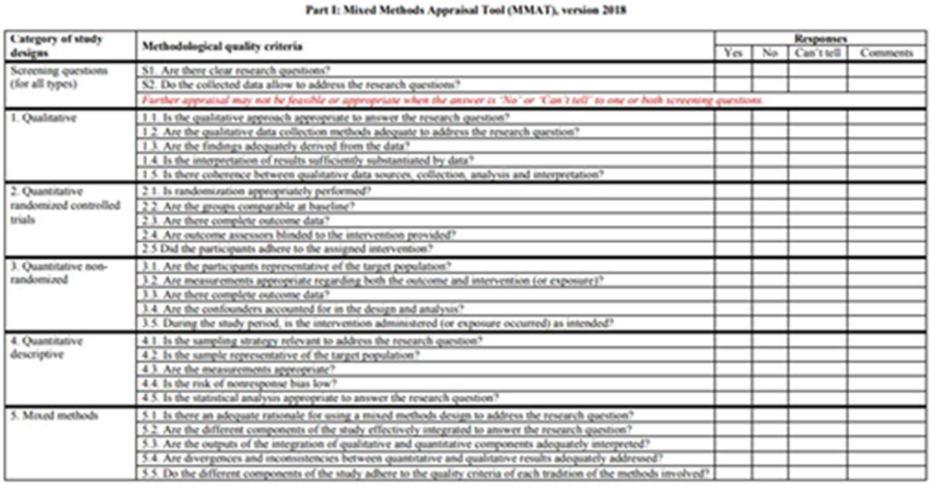
Studies will be assessed using the Critical Appraisal Skills Programme (CASP) Qualitative Checklist . It includes 10 questions to assess the quality of studies in the aspects of the appropriateness of the research design, participant recruitment, data collection, position of the researcher, the rigour of the analysis, clarity of presented findings and ethics. Three ratings will be used: YES/NO/CAN'T TELL, against the following CASP questions:

Was there a clear statement of the research aims?
Is a qualitative methodology appropriate?
Was the research design appropriate to address the aims of the research?
Was the recruitment strategy appropriate to the aims of the research?
Was the data collected in a way that addressed the research issue?
Has the relationship between researcher and participant been adequately considered?
Have ethical issues been taken into consideration?
Was the data analysed sufficiently rigorously?



Is there a clear statement of findings?
Will the results help locally?

The Mixed Methods Appraisal Tool (MMAT) will also be used for reviews that include mixed methods studies.



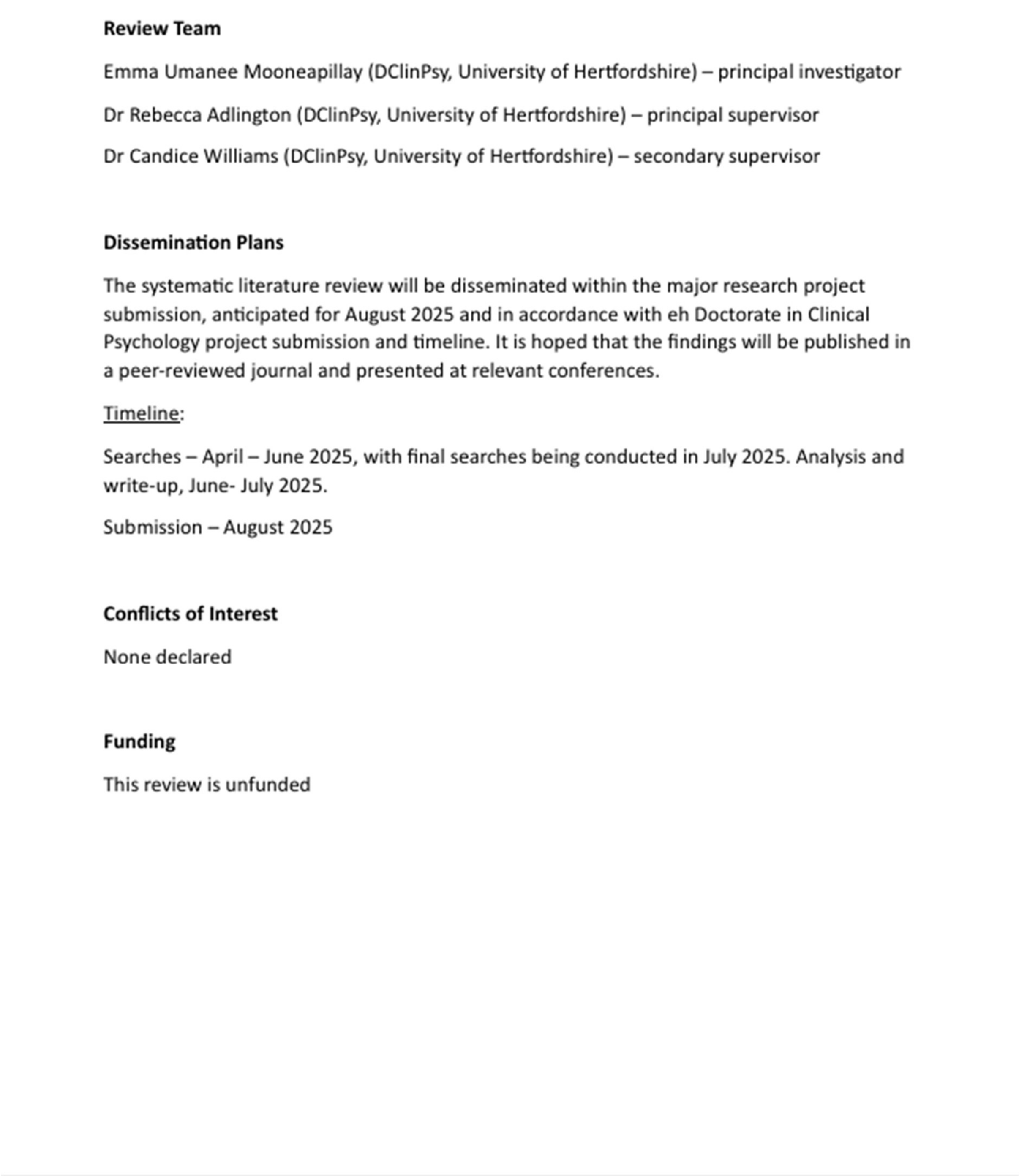
Part I: Mixed Methods Appraisal Tool (MMAT), version 2018

Category of study designs	Methodological quality criteria	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?				
	S2. Do the collected data allow to address the research questions?				
	Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.				
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?				
	1.2. Are the qualitative data collection methods adequate to address the research question?				
	1.3. Are the findings adequately derived from the data?				
	1.4. Is the interpretation of results sufficiently substantiated by data?				
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?				
2. Quantitative randomized controlled trials	2.1. Is randomization appropriately performed?				
	2.2. Are the groups comparable at baseline?				
	2.3. Are there complete outcome data?				
	2.4. Are outcome assessors blinded to the intervention provided?				
	2.5 Did the participants adhere to the assigned intervention?				
3. Quantitative non-randomized	3.1. Are the participants representative of the target population?				
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?				
	3.3. Are there complete outcome data?				
	3.4. Are the confounders accounted for in the design and analysis?				
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?				
	4.2. Is the sample representative of the target population?				
	4.3. Are the measurements appropriate?				
	4.4. Is the risk of nonresponse bias low?				
	4.5. Is the statistical analysis appropriate to answer the research question?				
5. Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?				
	5.2. Are the different components of the study effectively integrated to answer the research question?				
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?				
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?				
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?				

(reference for MMAT) Hong QN, Pluye P, Fàbregues S, Bartlett G, Boardman F, Cargo M, Dagenais P, Gagnon M-P, Griffiths F, Nicolau B, O'Cathain A, Rousseau M-C, Vedel I. Mixed Methods Appraisal Tool (MMAT), version 2018. Registration of Copyright (#1148552), Canadian Intellectual Property Office, Industry Canada.

Data Synthesis

To synthesise data, narrative synthesis will be applied using Popay et al's (2006) method (developing a theory, preliminary synthesis, exploring relationships within and between studies, assessing the robustness of the synthesis). This was deemed appropriate by the supervisory team in exploring the mental health experiences of student-parents completing UK higher education courses. It is hoped that through synthesis, themes will appear which tell a story regarding the mental health experiences of student-parents, whilst also considering barriers and facilitators to receiving support. This may also include secondary benefits of providing recommendations to support policies and procedures when supporting the mental health of student-parents in higher education.



Review Team

Emma Umanee Mooneapillay (DClinPsy, University of Hertfordshire) – principal investigator

Dr Rebecca Adlington (DClinPsy, University of Hertfordshire) – principal supervisor

Dr Candice Williams (DClinPsy, University of Hertfordshire) – secondary supervisor

Dissemination Plans

The systematic literature review will be disseminated within the major research project submission, anticipated for August 2025 and in accordance with eh Doctorate in Clinical Psychology project submission and timeline. It is hoped that the findings will be published in a peer-reviewed journal and presented at relevant conferences.

Timeline:

Searches – April – June 2025, with final searches being conducted in July 2025. Analysis and write-up, June- July 2025.

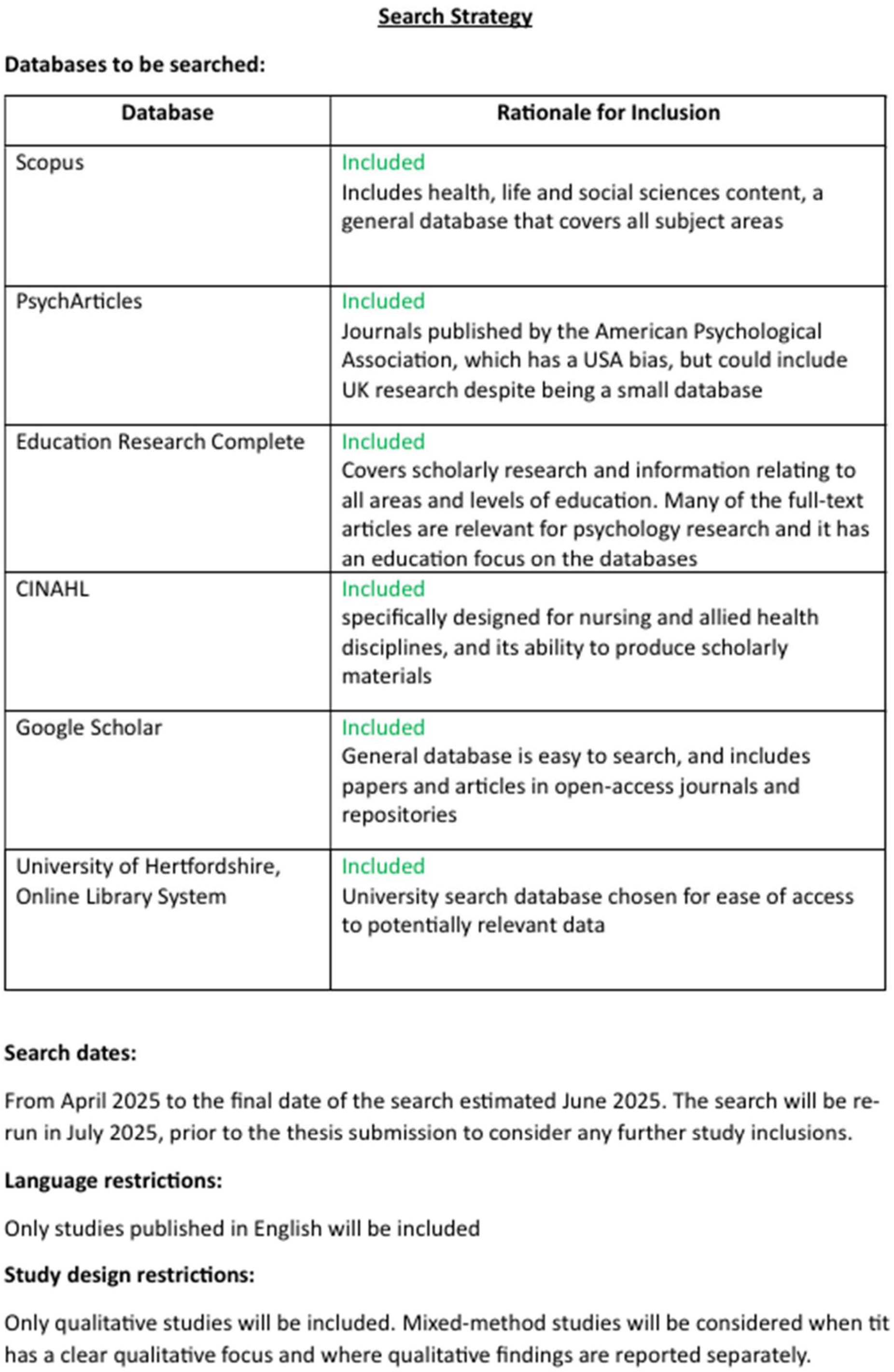
Submission – August 2025

Conflicts of Interest

None declared

Funding

This review is unfunded



Search Strategy

Databases to be searched:

Database	Rationale for Inclusion
Scopus	Included Includes health, life and social sciences content, a general database that covers all subject areas
PsychArticles	Included Journals published by the American Psychological Association, which has a USA bias, but could include UK research despite being a small database
Education Research Complete	Included Covers scholarly research and information relating to all areas and levels of education. Many of the full-text articles are relevant for psychology research and it has an education focus on the databases
CINAHL	Included specifically designed for nursing and allied health disciplines, and its ability to produce scholarly materials
Google Scholar	Included General database is easy to search, and includes papers and articles in open-access journals and repositories
University of Hertfordshire, Online Library System	Included University search database chosen for ease of access to potentially relevant data

Search dates:

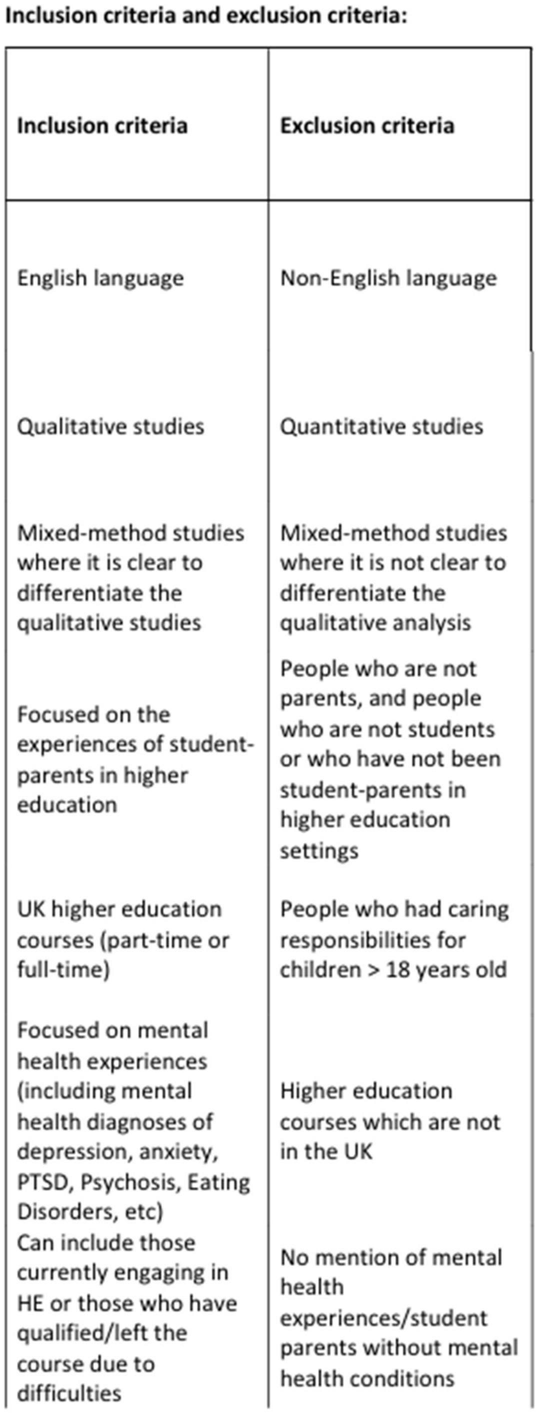
From April 2025 to the final date of the search estimated June 2025. The search will be re-run in July 2025, prior to the thesis submission to consider any further study inclusions.

Language restrictions:

Only studies published in English will be included

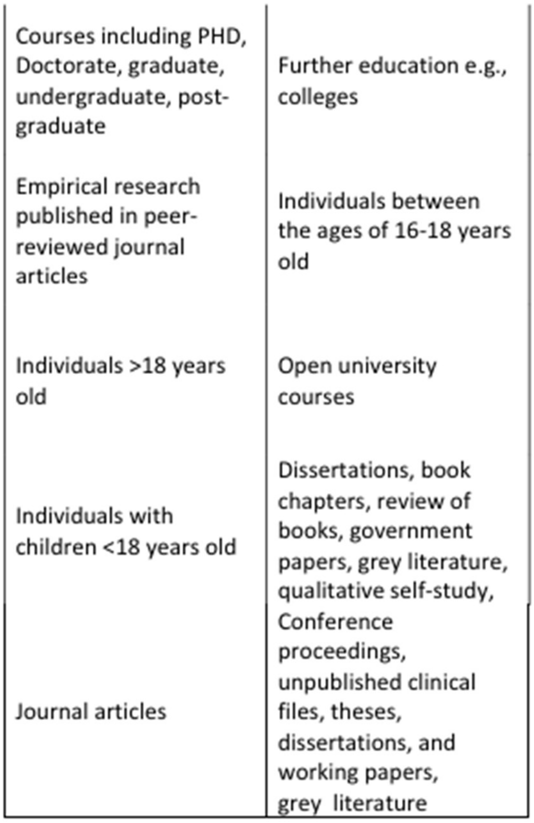
Study design restrictions:

Only qualitative studies will be included. Mixed-method studies will be considered when tit has a clear qualitative focus and where qualitative findings are reported separately.

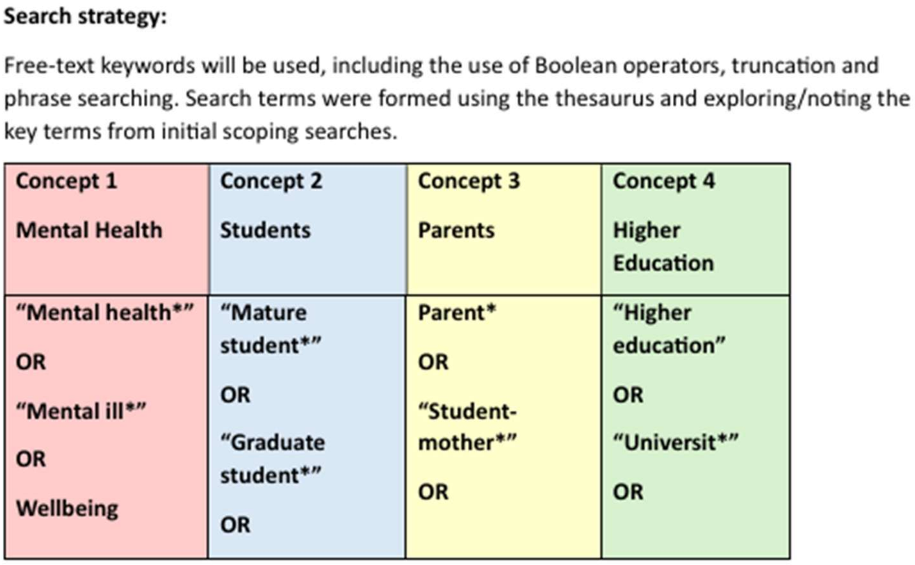


Inclusion criteria and exclusion criteria:

Inclusion criteria	Exclusion criteria
English language	Non-English language
Qualitative studies	Quantitative studies
Mixed-method studies where it is clear to differentiate the qualitative studies	Mixed-method studies where it is not clear to differentiate the qualitative analysis
Focused on the experiences of student-parents in higher education	People who are not parents, and people who are not students or who have not been student-parents in higher education settings
UK higher education courses (part-time or full-time)	People who had caring responsibilities for children > 18 years old
Focused on mental health experiences (including mental health diagnoses of depression, anxiety, PTSD, Psychosis, Eating Disorders, etc)	Higher education courses which are not in the UK
Can include those currently engaging in HE or those who have qualified/left the course due to difficulties	No mention of mental health experiences/student parents without mental health conditions



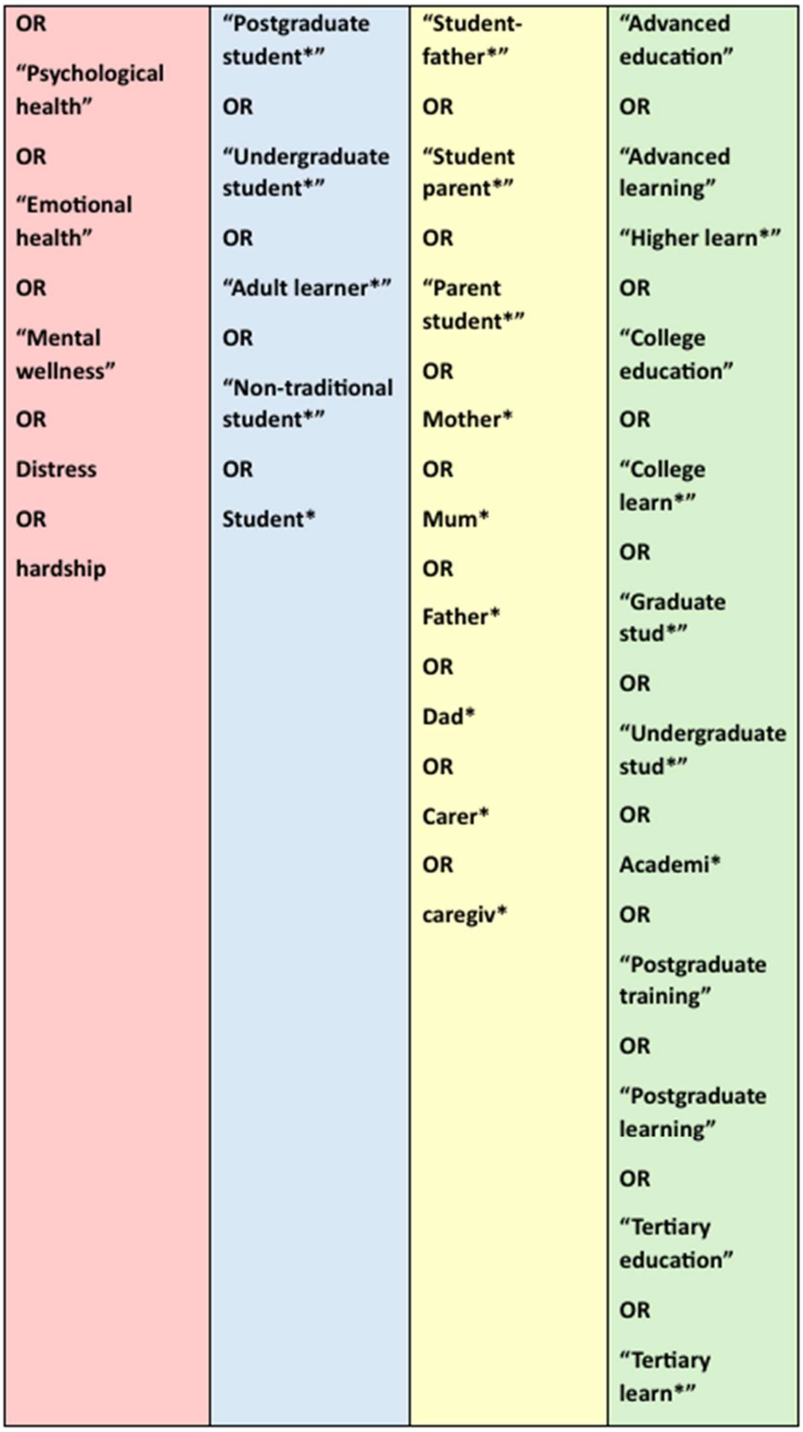
Courses including PHD, Doctorate, graduate, undergraduate, post-graduate	Further education e.g., colleges
Empirical research published in peer-reviewed journal articles	Individuals between the ages of 16-18 years old
Individuals >18 years old	Open university courses
Individuals with children <18 years old	Dissertations, book chapters, review of books, government papers, grey literature, qualitative self-study,
Journal articles	Conference proceedings, unpublished clinical files, theses, dissertations, and working papers, grey literature



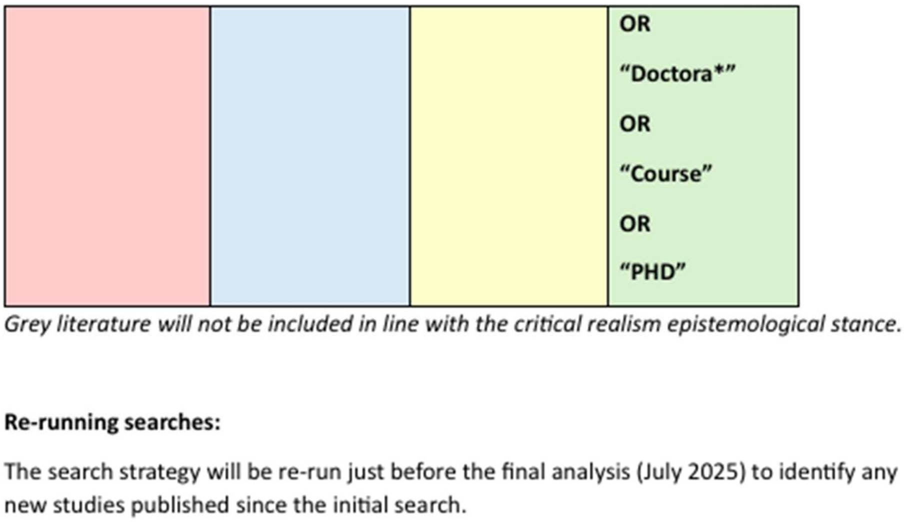
Search strategy:

Free-text keywords will be used, including the use of Boolean operators, truncation and phrase searching. Search terms were formed using the thesaurus and exploring/noting the key terms from initial scoping searches.

Concept 1 **Mental Health**	**Concept 2** **Students**	**Concept 3** **Parents**	**Concept 4** **Higher Education**
"Mental health*" **OR** **"Mental ill*"** **OR** **Wellbeing**	**"Mature student*"** **OR** **"Graduate student*"** **OR**	**Parent*** **OR** **"Student-mother*"** **OR**	**"Higher education"** **OR** **"Universit*"** **OR**



OR "Psychological health" OR "Emotional health" OR "Mental wellness" OR Distress OR hardship	"Postgraduate student*" OR "Undergraduate student*" OR "Adult learner*" OR "Non-traditional student*" OR Student*	"Student-father*" OR "Student parent*" OR "Parent student*" OR Mother* OR Mum* OR Father* OR Dad* OR Carer* OR caregiv*	"Advanced education" OR "Advanced learning" "Higher learn*" OR "College education" OR "College learn*" OR "Graduate stud*" OR "Undergraduate stud*" OR Academi* OR "Postgraduate training" OR "Postgraduate learning" OR "Tertiary education" OR "Tertiary learn*"



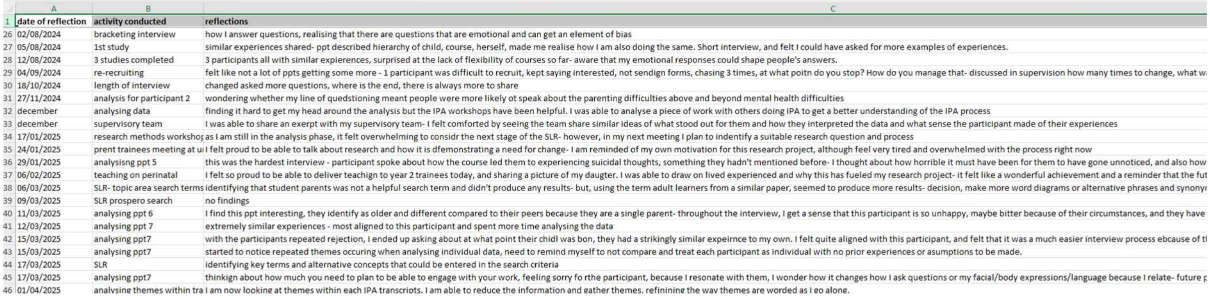
			OR **“Doctora*”** **OR** **“Course”** **OR** **“PHD”**

Grey literature will not be included in line with the critical realism epistemological stance.

Re-running searches:

The search strategy will be re-run just before the final analysis (July 2025) to identify any new studies published since the initial search.

Appendix C – Example of Research activity logs



	A	B	C
1	date of reflection	activity conducted	reflections
26	02/08/2024	bracketing interview	how I answer questions, realising that there are questions that are emotional and can get an element of bias
27	05/08/2024	1st study	similar experiences shared- ppt described hierarchy of child, course, herself, made me realise how I am also doing the same. Short interview, and felt I could have asked for more examples of experiences.
28	12/08/2024	3 studies completed	3 participants all with similar expierences, surprised at the lack of flexibility of courses so far- aware that my emotional responses could shape people's answers.
29	04/09/2024	re-recruiting	felt like not a lot of ppts getting some more - 1 participant was difficult to recruit, kept saying interested, not sendign forms, chasing 3 times, at what poitn do you stop? How do you manage that- discussed in supervision how many times to change, what w
30	18/10/2024	length of interview	changed asked more questions, where is the end, there is always more to share
31	27/11/2024	analysis for participant 2	wondering whether my line of quedstioning meant people were more likely ot speak about the parenting difficulties above and beyond mental health difficulties
32	december	analysing data	finding it hard to get my head around the analysis but the IPA workshops have been helpful. I was able to analyse a piece of work with others doing IPA to get a better understanding of the IPA process
33	december	supervisory team	I was able to share an exerpt with my supervisory team- I felt comforted by seeing the team share similar ideas of what stood out for them and how they interpreted the data and what sense the participant made of their experiences
34	17/01/2025	research methods worksho	as I am still in the analysis phase, it felt overwhelming to considr the next stage of the SLR- however, in my next meeting I plan to indentify a suitable research question and process
35	24/01/2025	prent trainees meeting at u	I felt proud to be able to talk about research and how it is dfemonstrating a need for change- I am reminded of my own motivation for this research project, although feel very tired and overwhelmed with the process right now
36	29/01/2025	analysisng ppt 5	this was the hardest interview - participant spoke about how the course led them to experiencing suicidal thoughts, something they hadn't mentioned before- I thought about how horrible it must have been for them to have gone unnoticed, and also how
37	06/02/2025	teaching on perinatal	I felt so proud to be able to deliver teachign to year 2 trainees today, and sharing a picture of my daugter. I was able to draw on lived experienced and why this has fueled my research project- it felt like a wonderful achievement and a reminder that the fut
38	06/03/2025	SLR- topic area search terms	identifying that student parents was not a helpful search term and didn't produce any results- but, using the term adult learners from a similar paper, seemed to produce more results- decision, make more word diagrams or alternative phrases and synony
39	09/03/2025	SLR prospero search	no findings
40	11/03/2025	analysing ppt 6	I find this ppt interesting, they identify as older and different compared to their peers because they are a single parent- throughout the interview, I get a sense that this participant is so unhappy, maybe bitter because of their circumstances, and they have
41	12/03/2025	analysing ppt 7	extremely similar experiences - most aligned to this participant and spent more time analysing the data
42	15/03/2025	analysing ppt7	with the participants repeated rejection, I ended up asking about at what point their chidl was bon, they had a strikingly similar expeirnce to my own. I felt quite aligned with this participant, and felt that it was a much easier interview process ebcause of t
43	15/03/2025	analysing ppt7	started to notice repeated themes occuring when analysing individual data, need to remind myself to not compare and treat each participant as individual with no prior experiences or asumptions to be made.
44	17/03/2025	SLR	identifying key terms and alternative concepts that could be entered in the search criteria
45	17/03/2025	analysing ppt7	thinkign about how much you need to plan to be able to engage with your work, feeling sorry fo rthe participant, because I resonate with them, I wonder how it changes how I ask questions or my facial/body expressions/language because I relate- future
46	01/04/2025	analysing themes within tra	I am now looking at themes within each IPA transcripts. I am able to reduce the information and gather themes. refinining the way themes are worded as I go along.

Appendix D – PROSPERO registration

Prospero Registration

NIHR | National Institute for Health and Care Research

PROSPERO

International prospective register of systematic reviews

"What are the mental health experiences of student-parents in UK higher education settings?"

Emma Umanee Mooneapillay, Rebecca Adlington, Candice Williams

Citation

Emma Umanee Mooneapillay, Rebecca Adlington, Candice Williams. "What are the mental health experiences of student-parents in UK higher education settings?". PROSPERO 2025 CRD420251011372. Available from https://www.crd.york.ac.uk/PROSPERO/view/CRD420251011372.

REVIEW TITLE AND BASIC DETAILS

Review title

"What are the mental health experiences of student-parents in UK higher education settings?"

Condition or domain being studied

Parent; Student; Education; Mental Distress; Well-being; Mental state; Mental disorder

Rationale for the review

The following review is being conducted to explore and synthesise the current literature on the mental health experiences of student-parents in UK higher education settings. This review is unique, much information focuses on the experiences, for example of mothers, rather than the potential for different parenting roles. In exploring mental health experiences, this review hopes to draw together information about facilitators and barriers with accessing mental health support, and the type of support available for parents whilst considering if there are any identified gaps or challenges. The review hopes to suggest recommendations for supporting the mental health experiences of parents in higher education, which could have valuable implications for policies, procedures and processes in UK higher education settings/institutes.

Review objectives

What are the mental health experiences of students, who are also parents, in UK higher education settings/institutes?

Keywords

Mental health; Parents; Higher education; Students

Country

United Kingdom

ELIGIBILITY CRITERIA

Population

Included

adults >18 years old

parents responsible for a child/children under the age of 18 years old

parents engaged in higher education courses in the UK, either part-time or full-time at college or university level (undergraduate, postgraduate, PHD/Doctorate etc)

focused on student-parents mental health experiences in higher education settings.

include those experiencing current or past mental health difficulties and who may be seeking support

Excluded

individuals <18 years old, and a who are not in higher education settings (and/or who are not in education)

non-parents, individuals who do not have caring responsibility for a child/children

parents with a child >18 years old

individuals attending open university courses

Intervention(s) or exposure(s)

Included

not applicable

Excluded

not applicable

Comparator(s) or control(s)

This review does not have any comparators

Study design

Only nonrandomized study types will be included.

Included

Only qualitative studies whereby findings were reported using established qualitative data analysis techniques.

Mixed-methods studies can be considered where it is clear to differentiate the qualitative studies

Excluded

quantitative studies

Context

Only studies published in English will be included

Only studies which explore UK higher education settings

TIMELINE OF THE REVIEW

Date of first submission to PROSPERO

25 April 2025

Review timeline

Start date: 14 April 2025. End date: 25 September 2025.

Date of registration in PROSPERO

08 May 2025

AVAILABILITY OF FULL PROTOCOL

Availability of full protocol

A full protocol has been written and uploaded to PROSPERO. The protocol will be made available after the review is completed.

SEARCHING AND SCREENING

Search for unpublished studies

Only published studies will be sought.

Main bibliographic databases that will be searched

The main databases to be searched are *CINAHL - Cumulative Index to Nursing and Allied Health Literature*, *PsycInfo* and *Scopus*.

Other important or specialist databases that will be searched

Education Research Complete, PsychArticles, University of Hertfordshire online library system and Google Scholar

Search language restrictions

The review will only include studies published in English.

Search date restrictions

Databases will be searched for articles published from 1 January 2000, there are no search end date restrictions.

Other methods of identifying studies

Other studies will be identified by: *looking through all the articles that cite the papers included in the review ("snowballing")* and *reference list checking*.

Link to search strategy

A full search strategy is available in the full protocol as described in the *Availability of full protocol* section

Selection process

Studies will be screened by one person (or a machine) and checked by at least one other person (or machine).

Other relevant information about searching and screening

None

DATA COLLECTION PROCESS

Data extraction from published articles and reports

Data will be extracted by one person (or a machine) and checked by at least one other person (or machine).

Authors will not be contacted for further information.

Study risk of bias or quality assessment

Risk of bias will be assessed using:

CASP

Data will be assessed by one person (or a machine) and checked by at least one other person (or machine).

Additional information will be sought from study investigators if required information is unclear or unavailable in the study publications/reports.

Reporting bias assessment

Studies will be assessed using the Critical Appraisal Skills Programme (CASP) Qualitative Checklist and by at least 1 independent reviewer. It includes 10 questions to assess the quality of studies in the aspects of the appropriateness of the research design, participant recruitment, data collection, position of the researcher, the rigour of the analysis, clarity of presented findings and ethics.

The Mixed Methods Appraisal Tool (MMAT) will also be used for reviews that include mixed methods studies with discrepancies being reviewed by the supervisory team.

Certainty assessment

Certainty of findings will not be assessed

OUTCOMES TO BE ANALYSED

Main outcomes

The outcome is to explore what student-parents have described and experienced regarding their own mental health whils in pursuing a course in UK higher education settings. This could include mental health challenges and barriers faced with seeking support, as well as facilitators and enablers with seeking support for their wellbeing. The outcome will explore the meaning that student-parents have made of their experiences.

Additional outcomes

It may be that recommendations are provided for how student-parents can be supported with mental health difficulties, and how they can be supported to continue with their studies.

PLANNED DATA SYNTHESIS

Strategy for data synthesis

To synthesis data, narrative synthesis will be applied using Popay et al's (2006) method. This was deemed appropriate by the supervisory team in exploring the mental health experiences of student-parents completing UK higher education courses. It is hoped that through synthesis, themes will appear which tell a story regarding the mental health experiences of student-parents, whilst also considering barriers and facilitators to receiving support. This may also include secondary benefits of providing

recommendations to support policies and procedures when supporting the mental health of student-parents in higher education.

CURRENT REVIEW STAGE

Stage of the review at this submission

Review stage	**Started**	**Completed**
Pilot work	✓	
Formal searching/study identification	✓	
Screening search results against inclusion criteria	✓	
Data extraction or receipt of IPD		
Risk of bias/quality assessment		
Data synthesis		

Review status

The review is currently planned or ongoing.

Publication of review results

Results of the review will be published in English.

REVIEW AFFILIATION, FUNDING AND PEER REVIEW

Review team members

Mrs Emma Umanee Mooneapillay (review guarantor and contact) University of Hertfordshire. England.

No conflict of interest declared.

Dr Rebecca Adlington. University of Hertfordshire. England.

No conflict of interest declared.

Dr Candice Williams. University of Hertfordshire. England.

No conflict of interest declared.

Named contact

Mrs Emma Umanee Mooneapillay (emma.mooneapillay@nhs.net). University of Hertfordshire. England.

Review affiliation

University of Hertfordshire

Funding source

Review has no funding and no agreed support from an academic institution and is done in authors' own time.

Additional information about funding

N/A

Peer review

There has been no peer review of this planned review.

ADDITIONAL INFORMATION

Review conflict of interest

Declared individual interests are recorded under team member details.. No additional interests are recorded for this review.

Medical Subject Headings

Mental Health; Parents; Students; United Kingdom; Education

SIMILAR REVIEWS

Check for similar records already in PROSPERO

PROSPERO identified a number of existing PROSPERO records that were similar to this one (last check made on 24 April 2025). These are shown below along with the reasons given by that the review team for the reviews being different and/or proceeding.

- **Student experiences of mental health problems at UK universities: a qualitative systematic review and meta-synthesis [published 20 September 2023] [CRD42023445910]. The review was judged not to be similar**
- **Perceived barriers and facilitators in help-seeking for mental health support in UK students in higher education: a systematic review [published 17 October 2022] [CRD42022367442]. The review was judged not to be similar**
- **University Student Wellbeing During the Covid-19 Pandemic: A Meta-Synthesis of Experiences in UK Higher Education Institutions. [published 1 September 2023] [CRD42023441254]. The review was judged not to be similar**

PROSPERO version history

- **Version 1.0, published 08 May 2025**

Disclaimer

The content of this record displays the information provided by the review team. PROSPERO does not peer review registration records or endorse their content.

PROSPERO accepts and posts the information provided in good faith; responsibility for record content rests with the review team. The guarantor for this record has affirmed that the information provided is truthful and that they understand that

deliberate provision of inaccurate information may be construed as scientific misconduct.

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Any enquiries about the record should be referred to the named review contact

Appendix E – Rational for included and excluded databases

Database	Rationale for Inclusion/Exclusion
Scopus	Included Includes health, life and social sciences content, a general database that covers all subject areas
PsychArticles	Included Journals published by the American Psychological Association, which has a USA bias, but could include UK research despite being a small database
Education Research Information Centre (ERIC)	Excluded Journals from American Research, deemed irrelevant
Education Research Complete	Included Covers scholarly research and information relating to all areas and levels of education. Many of the full-text articles are relevant for psychology research and it has an education focus on the databases
CINAHL	Included specifically designed for nursing and allied health disciplines, and its ability to produce scholarly materials
PubMed/Medline	Excluded A database for biomedical research, irrelevant for this SLR topic area
Google Scholar	Included General database is easy to search, and includes papers and articles in open-access journals and repositories
University of Hertfordshire, Online Library System	Included University search database chosen for ease of access to potentially relevant data

Appendix F – Search planning form

Search Planning Form

Question : *"What are the mental health experiences of student-parents in UK higher education settings?"*

Identify the main concepts of the question

Concept 1	Concept 2	Concept 3	Concept 4
Mental health	students	parents	Higher education

List alternative keywords, terms and phrases below

Concept 1 Mental Health	Concept 2 Students	Concept 3 Parents	Concept 4 Higher Education
"Mental health*" OR "Mental ill*" OR Wellbeing OR "Psychological health" OR "Emotional health" OR "Mental wellness" OR Distress OR hardship	"Mature student*" OR "Graduate student*" OR "Postgraduate student*" OR "Undergraduate student*" OR "Adult learner*" OR "Non-traditional student*" OR Student*	Parent* OR "Student-mother*" OR "Student-father*" OR "Student parent*" OR "Parent student*" OR Mother* OR Mum* OR Father*	"Higher education" OR "Universit*" OR "Advanced education" OR "Advanced learning" "Higher learn*" OR "College education" OR "College learn*" OR "Graduate stud*"

		OR **Dad*** **OR** **Carer*** **OR** **caregiv***	**OR** **“Undergraduate stud*”** **OR** **Academi*** **OR** **“Postgraduate training”** **OR** **“Postgraduate learn*”** **OR** **“Tertiary education”** **OR** **“Tertiary learn*”** **OR** **“Doctora*”** **OR** **“Course”** **OR** **“PHD”**

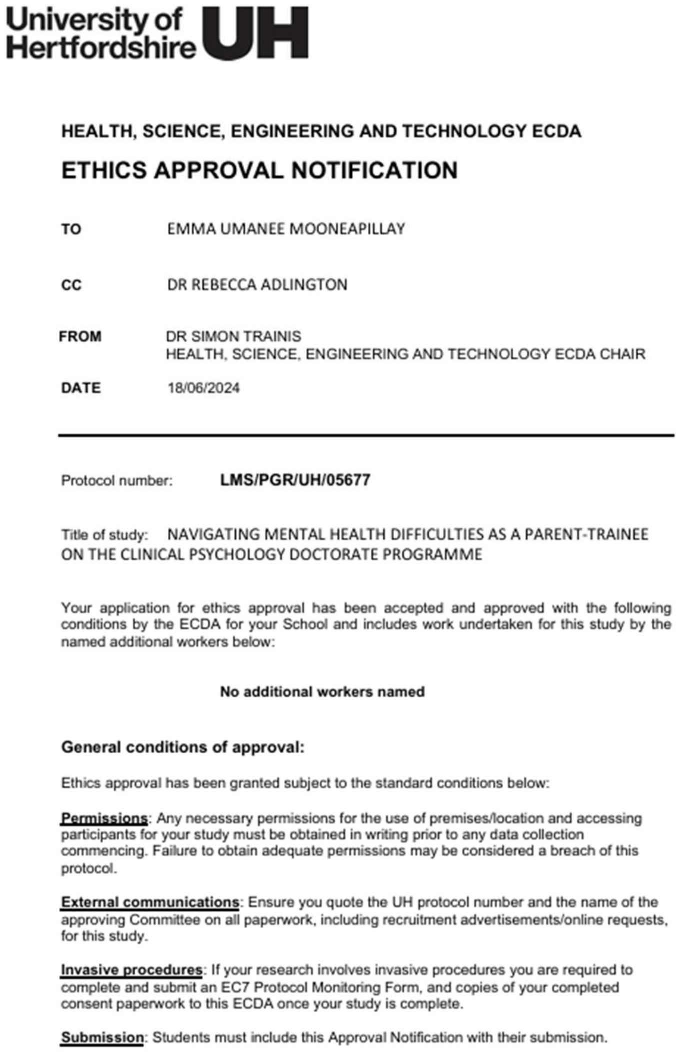
AND AND AND

(TITLE-ABS-KEY ("higher education" OR "universit*" OR "advanced education" OR "advanced learning" OR "higher learn*" OR "college education" OR "college learn*" OR "graduate stud*" OR "undergraduate stud*" OR "academi" OR "postgraduate training" OR "postgraduate learn*" OR "tertiary education" OR "tertiary learn*" OR "doctora*" OR "course" OR phd)) AND (TITLE-ABS-KEY (parent* OR "student-mother*" OR "student mother*" OR "student-father*" OR "student father*" OR "student parent*" OR "student-parent*" OR "parent student*" OR "parent-student*" OR "mother*" OR mum* OR father* OR dad OR caregiv* OR carer*)) AND (TITLE-ABS-KEY ("student*" OR "mature student*" OR "graduate student*" OR "postgraduate student*" OR "undergraduate student*" OR "adult learner*" OR "non-traditional student*")) AND (TITLE-ABS-KEY ("mental health " OR "mental ill*" OR wellbeing OR "psychological health" OR "emotional health" OR "mental wellness" OR distress OR hardship)) AND PUBYEAR > 1999 AND PUBYEAR < 2026 AND (LIMIT-TO (LANGUAGE , "English"))

Appendix G – Explorations for the relationship in the SLR data

	idea	quote for similarity	quote for difference	implications
clayton	challenges are created when balancing parenting and academic	young fathers experienced similar time constraints to stu		HE providers should advertise what support is available for students in a more visible and inclusive manner.
	pressure of needing to do well to prove self, or be a role model, create something better for themselves			
	performance, anxiety with falling behind, failing, not getting a job afterwards, good grades = pride, proving they could do it to others	obligatory feelings of having to do well for some of the HE young fathers, which could then create anxieties around ‘falling behind’ or ‘failing.’ Worries about securing employment after HE could also exacerbate mental health issues. // being successful at university was a way of proving to others that they ‘could do it		
	financial factors contributed to mental health deterioration	Managing finances can be challenging as student parents have been shown to have higher outgoings than other students, creating extra financial pressures and impacting upon mental and physical health		
	unclear support services, invisible, not for all individuals, stigma and poor experiences of accessing services	limited knowledge of the support provision available at the HEI or felt reluctant to turn to their institution for help // for young fathers who went on to study at HEIs, they experienced difficulties in identifying and using necessary and tailored support. // HEI support services, the young fathers had little knowledge of what help was available to them generally and were often not aware of which support they were specifically entitled to		
	parents feel marginalised / isolated, excluded from being able to engage as a student, campus actvities			
	lack of time for work, parenting, self-care, sleep, socialising=tiredness and guilt, finding time distracting kids, evening work, burnout	mental health issues and feelings of being ‘burned out’ were reported due to the strains associated with managing and juggling parenthood alongside studying. //Evening times were frequently cited as a period to complete or catch up on HE activities when children had gone to sleep, but participants were often tired themselves at this point after attending to several commitments in the daytime. // Student-parents are		
	invisible as parents in acdemic settings	parental status was often not fully considered by other students, course leaders, or by those organising events or timetables		
	finding a new identity	individuals aimed at being a ‘good parent’ and a ‘good student’ through dual identities,		
	transferrable skills of managing time, organising, prioritising demands			
	flexibility to fit studying with family life	felt it was important to attend regularly and to engage fully with assessments, tasks, and lectures.		
	feelings of guilt for not being present as a parent or student	unable to embrace or engage with the student experience fully, as they often had limited time to spend on campus or to partake in any social activities due to their family commitments. // Some young fathers would try to complete short university tasks when their children were preoccupied with playing or other activities, such as watching television. However, interruptions from children would then affect the young m		
cronshaw	competing demands/ role conflict	competing demands and gendered expectations faced by them can threaten to overwhelm their mental, physical and emotional capacity, resulting in negative impacts on their well- being // "Mental health, mental stability. There's some days you're clinging on by your finger nails. Because it's just immense carrying the full work load and all the commitments that come with our job, then doing a PhD, then organising a fa		
	feeling guilty/anxious when leaving their child to engage in work	woman takes responsibility for the child's welfare, leaving them with feelings of guilt and anxiety when they have to leave the child for their own employment or study demands.		
	navigating different aspects of identity, professional, student, and personal identity as a parent	fractured identities // student mental health can be impacted due to the interactions between the multiple roles within the university, workplace, home and community. Identity roles were also highlighted as a key factor causing conflict within the lives of the participants in this		
	exclusion from opportunies, involvmeent, limited interaction with faculty staff and fellow students, remaining on the peripheral	women feel they lose some of their identity. This process of ‘maternal transition’ (Darvill et al., 2008) experienced by women on becoming mothers can lead to changes in their ‘self- concept’ and a sense of a lack of belonging in other social groups. // The women's circumstances left them on the periphery or completely excluded from the doctoral student community and therefore lacking that sense of identity enjoyed		
	feeling lonliness from the lack of understanding of what they were going through	his lack of understanding led to a feeling of disconnectedness (McCulloch & Stokes, 2008), which in turn, left the women questioning themselves and their ability. There was no reassurance that what they were thinking, feeling and experiencing was a normal part of the PhD process and this resulted in the women feeling they were on their own. "You know, formal connections, more things that made it a more supportive experience. (Grace)""		
	wanting to feel competent and autonomouse in their achievements, but conflicted gendered roles resulted in feelings of guilty			
	wanting to give up and questioning their motiation to continue with the course	with the subsequent isolation and lack of support leaving them questioning their ability to continue. // “Either I take a week off sick or I work from home, because if I don't I'm either going to kill someone or kill myself.” I said, “Ihave reached capacity.” (June) ""		
	feeling like novices, lacked condience in their knowledge - related to exclusion from academic activities, not intelligent enough, lack of self-	" I think maybe I partly didn't feel I was worthy of doing it		[illegible] forced to rely on individual learning resources instead of the shared repertoire of the wider community // The women expressed a lack of confidence and self- belief in their academic abilities despite having previously had successful careers and being accepted on to a doctoral programme (and therefore being recognise
	guilt between the role of parent and student	the women experienced conflict between roles, leaving them with feelings of anxiety at the lack of involvement in the student community, then guilt when they tried to address this balance and were not fully engaged with the mother role // led to the women feeling excluded as they lacked the opportunities, involvement and knowledge required to participate fully: "I find it very difficult sometimes changing the hats to meet different situations, you were never a great mum beca		
evans	parents identity inviisible	the student mother with two children had to cope with a		to recnogise diverse individuals
	gendered roles and responsibilities of parenting, with mothers taking the lead on academic support for their children	gendered expectation can raise anxiety level		
	emotional toil of guilt/regret	student-parents often find	student mothers who experienced no guilt as they felt their children’s pride and acting as a good role model was sufficient	
	effect of mental health on parenting	student-parents in their survey considered they had shown “bad parenting” skills, because they felt they did not give their children adequate attention or were stressed and consequently irritable with them // student-parents similarly felt that they were not performing well in work or parenting, "I felt very guilty that I wasn’t doing the best I could do in my work and felt guilty I wasn’t doing enough for my PhD. I felt guil		
gerrard and roberts	mental health and the impact that it has on their own child	Seven participants (58.33%) reported suffering depression, with a majority also indicating that they were under considerable stress. Three participants (25%) reported receiving counselling for depression. " I do wake in the middle of the night and lay awake wondering how I am going to cope so it probably makes me feel anxious and tired. (L119, case 4)" // "Yes I have suffered depression and yes I feel anxious and tire		
	financial adversity affected psychological wellbeing, feeling guilty for not being able to contribute financially	Fed up, stressed, concerned for the future. (L64, case 10) I feel guilty that I am not contributing as a family. (L52, case 5) // Disrupted sleep and poor eating habits were reported		
	isolated and alienated, making personal sacrifices, having to work and limiting socialising,	‘restricted, alienated if you can’t go out with friends’ and was seeing a counsellor for depression (L41, case 6)		
	juggling work with studies and childcare	emotional strain, depression, guilt, exhaustion and lack of sleep		
	wanting to give up	the sacrifice you are making in your family, your personal life, your well being—its not worth it. (L294, case 1)		
marandet	little time	three most commonly cited problems faced by students v		flex learning options, better support services
	financial pressure			
	isolation	non-traditional students tend to choose universities where they feel they will be able to develop a sense of belonging // The lack of other students in a similar situation can lead parents to feel isolated, with over a quarter of respondents (25.4%) saying they felt that they did not belong in uni // the importance of having classmates sharing similar circumstances was seen as a significant element for studying parents in a		
	confidence and self-efficacy	Lack of skills necessary for higher education learning is closely linked to the issues of confidence and motivation, as it may hinder academic progress and accentuate students’ sense of alienation		
	invisible as parents in acdemic settings, problems going unnoticed	‘non-traditional’ students in particular might suffer from isolation and the problems they may face go unnoticed		
	conflicting role as parent and students	one of the biggest problems adult learners experience is a conflict between their role as carers and their role as students’		
	being a better role model, good start in life, improve life cahnces	to help them get a good start in life, gain good study skills and improve their life chances // be a role model for their children,		
	reluctancy for counselling support, get on with problems, not as severe	many students expressed varying degrees of reluctance, linked to the perceived mundane nature of their problems and the association of counselling with more serious issues		
mischa	getting on with it, mhs less of a priority	“Carrying on with my work. Trying to bounce back throug		opportunities for supported, developing intervnetions // Facilitating contact and creating opportunities for students to connect with their peers for both academic purposes and socially,
	flexibility to fit studying with family life	Flexibility in access to content enables parents to fit thei		more longitudinal designs
	negative emotional copinng	“Feeling very tired Having little motivation. Feeling anxiou		evalutating the supports offered
	parenting a stress	the ways in which parenting intersects with wellbeing are		more research into vulnerable student groups
moreau	time-related, financial, health and emotional problems prevail. high levels of sleep deprivation, and a high occurrence of depression among this group.			
	not listened to? did not feel that their mental health issues were taken seriously	students complained that their parental status was interpreted by university staff as a lack of commitment // I’ve been suffering a bit with depression recently, which is a bit of a pain … the university counsellor seemed to be of the opinion that I just needed to manage my time better and there was nothing really wrong with me and kind of sent me packing. (Natalie)		
	guilt with demands they did not dedicate enough time to their children and partner or studies, nor with the default image of the childfree	Students talked of a ‘balanc	I think I’ve had to learn what is a good enough point for me, what is a good enough amount of parenting and what is a good enough amount of studying and how I am going to make that balance. (Nesha)	
	feelings of ‘missing out’ and ‘not fitting in’	. the lack of time for activiti	A sense of isolation and of ‘not belonging’ (Read, Archer, and Leathwood 2003) was not, however, experienced by all with the same intensity. Participants enrolled on programmes in which student parents concentrate (e.g. nursing or education) were less likely to express such feelings. They often talked of supporting each other, although more in moral than practical terms, and were overall	
	dropping out of studies	some to consider dropping out // At times, I have felt like giving up, because I have been struggling for the money to pay for the childcare. I have struggled for the time for myself to do the work that I needed to do. (Stephanie)		
	juggling work and parenting	Common strategies include studying when children are in childcare, at school or sleeping, restricting the time dedicated to activities other than studying and parenting. // "time that I am at home, it is really difficult because, obviously, the kids don’t go to bed until half seven, eight o’clock, which is the time I basically get to do my work. (Stephanie)" // many students to cut down on what they described as ‘time for mysel		
	pressure being a role model and doing well	I thought ‘I really have to do this’, it makes me a better help for them and … quite a good role model for them (lauren)		
	identity		When you have a child, as a mother, you lose your identity … You suddenly become just that mum over there. People don’t see you for being anything other than that, but it gives you just a little piece of you back. (Lisa)	
rawlinson	wanting to give up	consider giving up because of the pressure. //[T]here have been times actually when I’ve thought of not coming to university and giving up or getting a gap’ (Student Carer 10).		
	excluded from events	not being able to go out with friends/classmates or celeb		infancy of inclusion policies and practices
	guilt of parenting and childcare	feeling ‘overwhelmed’ or feeling guilty for not making the ‘sacrifice’ to care for a child and instead prioritising studying, leading to a self-perception that they are a ‘bad’ parent, // One student with a young child stated that, ‘[s]ometimes I’m not able to attend classes because … I have, maybe my [child] is not well’ (Student Carer 10). // One student parent, driven in their pursuit of future career goals, spoke of guilt at wishing to undertake further studies and apprehensiveness abo		
	being a better role model, good start in life, improve life cahnces	determination to succeed, and be successful for themselves and their child		
	visibiility of services	they do not learn about the processes by chance. extensions, but tailored to individual needs. support with the transition back into education.		
	little time	limited opportunity for self-care. student-parents are highly organised and plan their time with limited time. // it’s all about time management really, you know, and being able to work around [my child’s] time, not just mine’ (Student Carer 1)		

Appendix H – Ethical approval



University of Hertfordshire UH

HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO EMMA UMANEE MOONEAPILLAY

CC DR REBECCA ADLINGTON

FROM DR SIMON TRAINIS
HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA CHAIR

DATE 18/06/2024

Protocol number: **LMS/PGR/UH/05677**

Title of study: NAVIGATING MENTAL HEALTH DIFFICULTIES AS A PARENT-TRAINEE ON THE CLINICAL PSYCHOLOGY DOCTORATE PROGRAMME

Your application for ethics approval has been accepted and approved with the following conditions by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

No additional workers named

General conditions of approval:

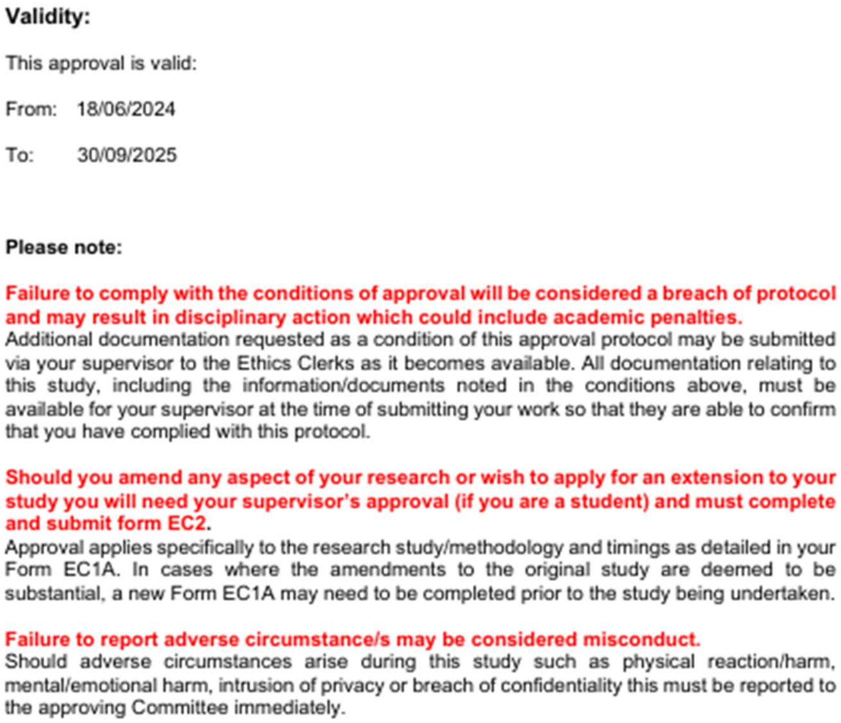
Ethics approval has been granted subject to the standard conditions below:

Permissions: Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

External communications: Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

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

Submission: Students must include this Approval Notification with their submission.



Validity:

This approval is valid:

From: 18/06/2024

To: 30/09/2025

Please note:

Failure to comply with the conditions of approval will be considered a breach of protocol and may result in disciplinary action which could include academic penalties.
Additional documentation requested as a condition of this approval protocol may be submitted via your supervisor to the Ethics Clerks as it becomes available. All documentation relating to this study, including the information/documents noted in the conditions above, must be available for your supervisor at the time of submitting your work so that they are able to confirm that you have complied with this protocol.

Should you amend any aspect of your research or wish to apply for an extension to your study you will need your supervisor's approval (if you are a student) and must complete and submit form EC2.
Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1A. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1A may need to be completed prior to the study being undertaken.

Failure to report adverse circumstance/s may be considered misconduct.
Should adverse circumstances arise during this study such as physical reaction/harm, mental/emotional harm, intrusion of privacy or breach of confidentiality this must be reported to the approving Committee immediately.

Appendix I – Semi-Structured interview guide with prompts

Semi-structured interview guide with prompts

Welcome, thank you for your interest in participating in this study. My name is Emma and I am a 2nd/3rd Year trainee. Can I check that you are in a confidential space to talk? This interview should last around 1 hour, and your participation is voluntary. Please provide as much detail as you wish to and take as much time as you need to. The online interview will be recorded for transcription purposes, I will let you know when I press the record button. Do you need any other reminders about confidentiality, risk, right to withdraw? Did you have any questions before we start? Are there any adjustments I can make for you?

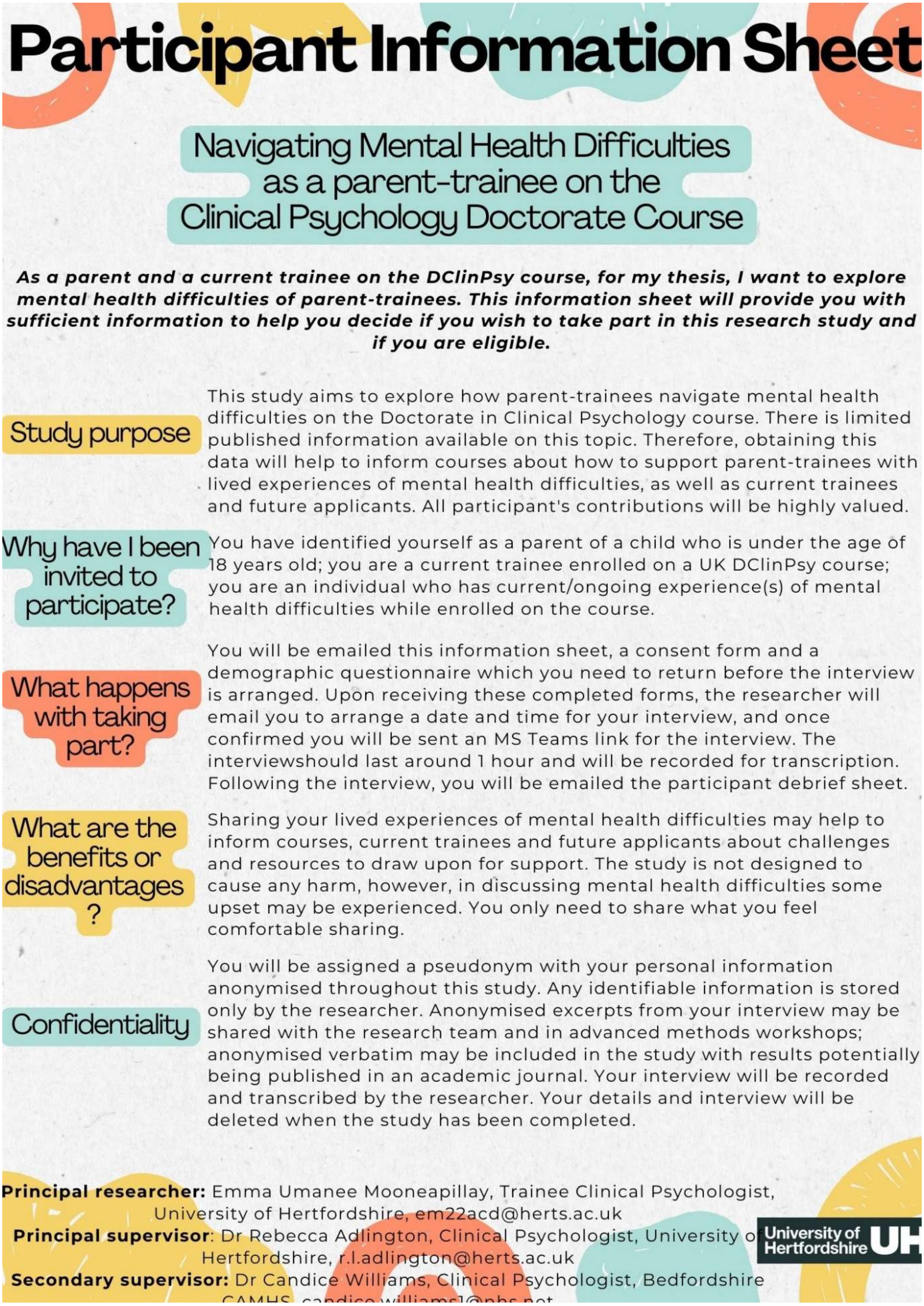
Recording starting now (I am interested in you and your experiences)

1. **how did you become interested in clinical psychology?** Tell me about your journey which led to you being on the clinical psychology course? How did you feel during the process?
2. **What challenges related to mental health difficulties and parenting have you experienced during training?** What would it be like/was it like to raise these difficulties? How would/did it make you feel? How would it be/was it received by others? How would/did you cope? Were you offered support/what would it be like for you to be offered support?
3. **How have you found balancing aspects of the course in a dual-role as parent/trainee with lived experience of mental health difficulties?** How do you prioritise your personal and professional life?
4. **As a parent-trainee with lived experiences of mental health difficulties, what worries you about the rest of training/post-qualification?** How does this make you feel?
5. **What do you think is essential for good mental health whilst training?** What needs to happen to enable you and other parent-trainees to have good mental health whilst training?
6. **How do you think future parent-trainees could be better supported with mental health difficulties whilst on training?** what recommendations/improvements do you think could be made by the courses?
7. **Based on what you know now and from your current position of experience, what words of advice/support would you say to your former self at the start of training?**

Recording ended.

Thank you, we have come to the end of the interview. How did you find it? Thank you for participating, I am grateful for your time and for you sharing your experiences of parenthood, mental health and training. The debrief sheet will be sent to your email address. Please do not hesitate to contact me if you have any further thoughts or if you wish to discuss the information in the debrief form further. I am still recruiting participants, so if you do know of anyone who might be interested, please can you share the study with them.

Appendix J – Participant information sheet



Participant Information Sheet

Navigating Mental Health Difficulties as a parent-trainee on the Clinical Psychology Doctorate Course

As a parent and a current trainee on the DClinPsy course, for my thesis, I want to explore mental health difficulties of parent-trainees. This information sheet will provide you with sufficient information to help you decide if you wish to take part in this research study and if you are eligible.

Study purpose

This study aims to explore how parent-trainees navigate mental health difficulties on the Doctorate in Clinical Psychology course. There is limited published information available on this topic. Therefore, obtaining this data will help to inform courses about how to support parent-trainees with lived experiences of mental health difficulties, as well as current trainees and future applicants. All participant's contributions will be highly valued.

Why have I been invited to participate?

You have identified yourself as a parent of a child who is under the age of 18 years old; you are a current trainee enrolled on a UK DClinPsy course; you are an individual who has current/ongoing experience(s) of mental health difficulties while enrolled on the course.

What happens with taking part?

You will be emailed this information sheet, a consent form and a demographic questionnaire which you need to return before the interview is arranged. Upon receiving these completed forms, the researcher will email you to arrange a date and time for your interview, and once confirmed you will be sent an MS Teams link for the interview. The interviewshould last around 1 hour and will be recorded for transcription. Following the interview, you will be emailed the participant debrief sheet.

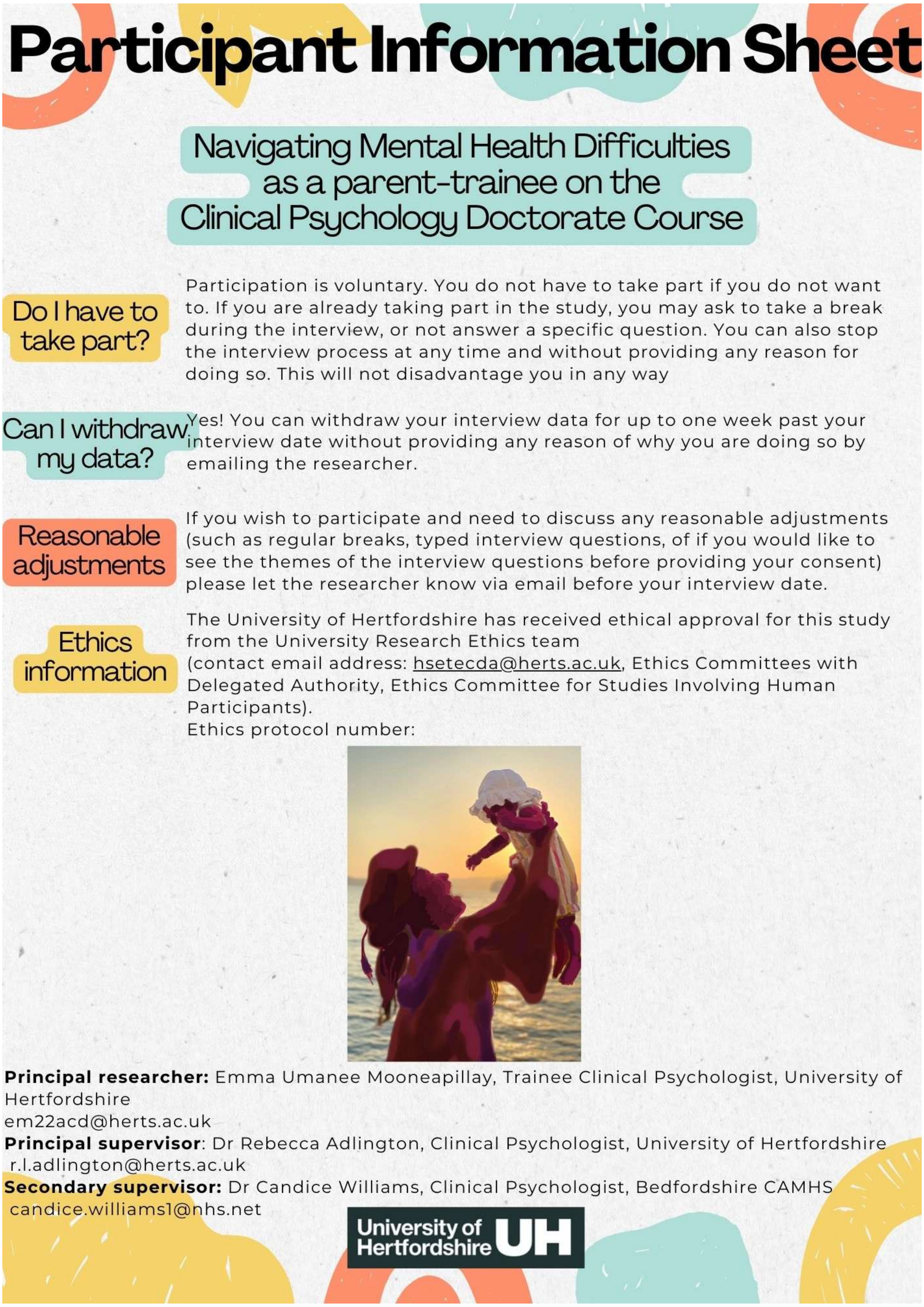
What are the benefits or disadvantages ?

Sharing your lived experiences of mental health difficulties may help to inform courses, current trainees and future applicants about challenges and resources to draw upon for support. The study is not designed to cause any harm, however, in discussing mental health difficulties some upset may be experienced. You only need to share what you feel comfortable sharing.

Confidentiality

You will be assigned a pseudonym with your personal information anonymised throughout this study. Any identifiable information is stored only by the researcher. Anonymised excerpts from your interview may be shared with the research team and in advanced methods workshops; anonymised verbatim may be included in the study with results potentially being published in an academic journal. Your interview will be recorded and transcribed by the researcher. Your details and interview will be deleted when the study has been completed.

Principal researcher: Emma Umanee Mooneapillay, Trainee Clinical Psychologist, University of Hertfordshire, em22acd@herts.ac.uk
Principal supervisor: Dr Rebecca Adlington, Clinical Psychologist, University of Hertfordshire, r.l.adlington@herts.ac.uk
Secondary supervisor: Dr Candice Williams, Clinical Psychologist, Bedfordshire CAMHS, candice.williams1@nhs.net



Participant Information Sheet

Navigating Mental Health Difficulties as a parent-trainee on the Clinical Psychology Doctorate Course

Do I have to take part?

Participation is voluntary. You do not have to take part if you do not want to. If you are already taking part in the study, you may ask to take a break during the interview, or not answer a specific question. You can also stop the interview process at any time and without providing any reason for doing so. This will not disadvantage you in any way

Can I withdraw my data?

Yes! You can withdraw your interview data for up to one week past your interview date without providing any reason of why you are doing so by emailing the researcher.

Reasonable adjustments

If you wish to participate and need to discuss any reasonable adjustments (such as regular breaks, typed interview questions, of if you would like to see the themes of the interview questions before providing your consent) please let the researcher know via email before your interview date.

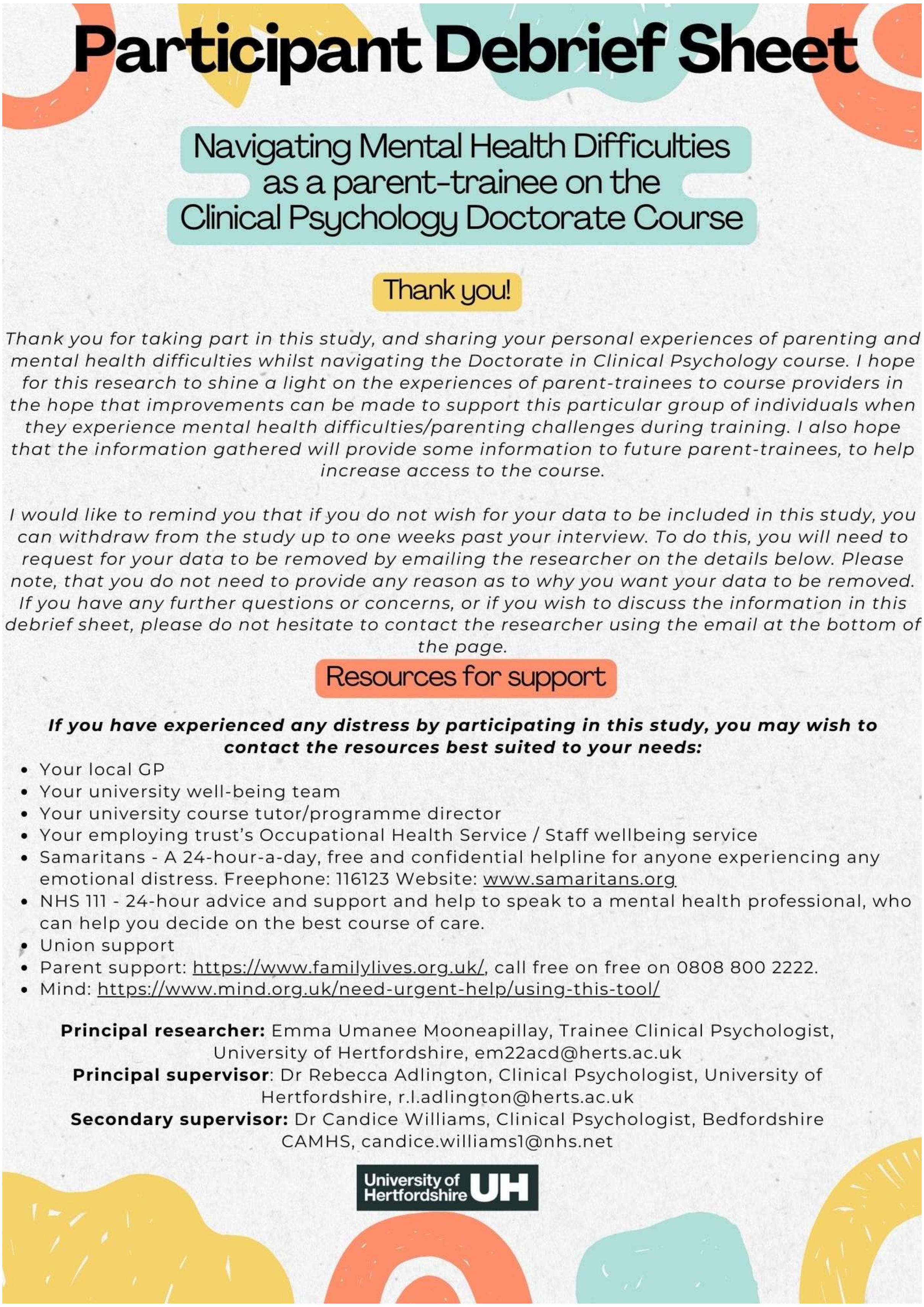
Ethics information

The University of Hertfordshire has received ethical approval for this study from the University Research Ethics team
(contact email address: hsetecda@herts.ac.uk, Ethics Committees with Delegated Authority, Ethics Committee for Studies Involving Human Participants).
Ethics protocol number:

Principal researcher: Emma Umanee Mooneapillay, Trainee Clinical Psychologist, University of Hertfordshire
em22acd@herts.ac.uk
Principal supervisor: Dr Rebecca Adlington, Clinical Psychologist, University of Hertfordshire
r.l.adlington@herts.ac.uk
Secondary supervisor: Dr Candice Williams, Clinical Psychologist, Bedfordshire CAMHS
candice.williams1@nhs.net

University of Hertfordshire UH

Appendix K – Debrief form



Participant Debrief Sheet

Navigating Mental Health Difficulties as a parent-trainee on the Clinical Psychology Doctorate Course

Thank you!

Thank you for taking part in this study, and sharing your personal experiences of parenting and mental health difficulties whilst navigating the Doctorate in Clinical Psychology course. I hope for this research to shine a light on the experiences of parent-trainees to course providers in the hope that improvements can be made to support this particular group of individuals when they experience mental health difficulties/parenting challenges during training. I also hope that the information gathered will provide some information to future parent-trainees, to help increase access to the course.

I would like to remind you that if you do not wish for your data to be included in this study, you can withdraw from the study up to one weeks past your interview. To do this, you will need to request for your data to be removed by emailing the researcher on the details below. Please note, that you do not need to provide any reason as to why you want your data to be removed. If you have any further questions or concerns, or if you wish to discuss the information in this debrief sheet, please do not hesitate to contact the researcher using the email at the bottom of the page.

Resources for support

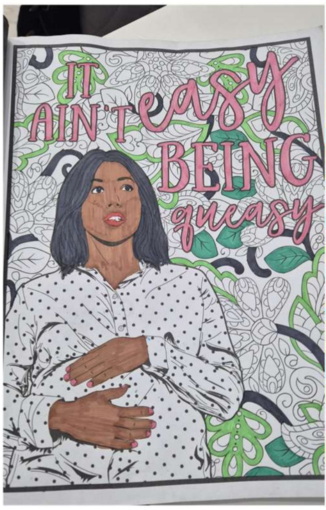
If you have experienced any distress by participating in this study, you may wish to contact the resources best suited to your needs:

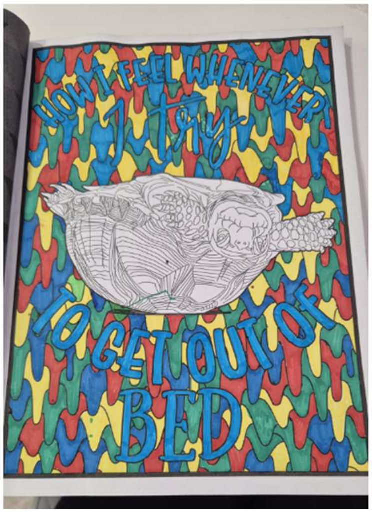
- Your local GP
- Your university well-being team
- Your university course tutor/programme director
- Your employing trust's Occupational Health Service / Staff wellbeing service
- Samaritans - A 24-hour-a-day, free and confidential helpline for anyone experiencing any emotional distress. Freephone: 116123 Website: www.samaritans.org
- NHS 111 - 24-hour advice and support and help to speak to a mental health professional, who can help you decide on the best course of care.
- Union support
- Parent support: https://www.familylives.org.uk/, call free on free on 0808 800 2222.
- Mind: https://www.mind.org.uk/need-urgent-help/using-this-tool/

Principal researcher: Emma Umanee Mooneapillay, Trainee Clinical Psychologist, University of Hertfordshire, em22acd@herts.ac.uk
Principal supervisor: Dr Rebecca Adlington, Clinical Psychologist, University of Hertfordshire, r.l.adlington@herts.ac.uk
Secondary supervisor: Dr Candice Williams, Clinical Psychologist, Bedfordshire CAMHS, candice.williams1@nhs.net

University of Hertfordshire UH

Appendix L – engagement with self-care practices



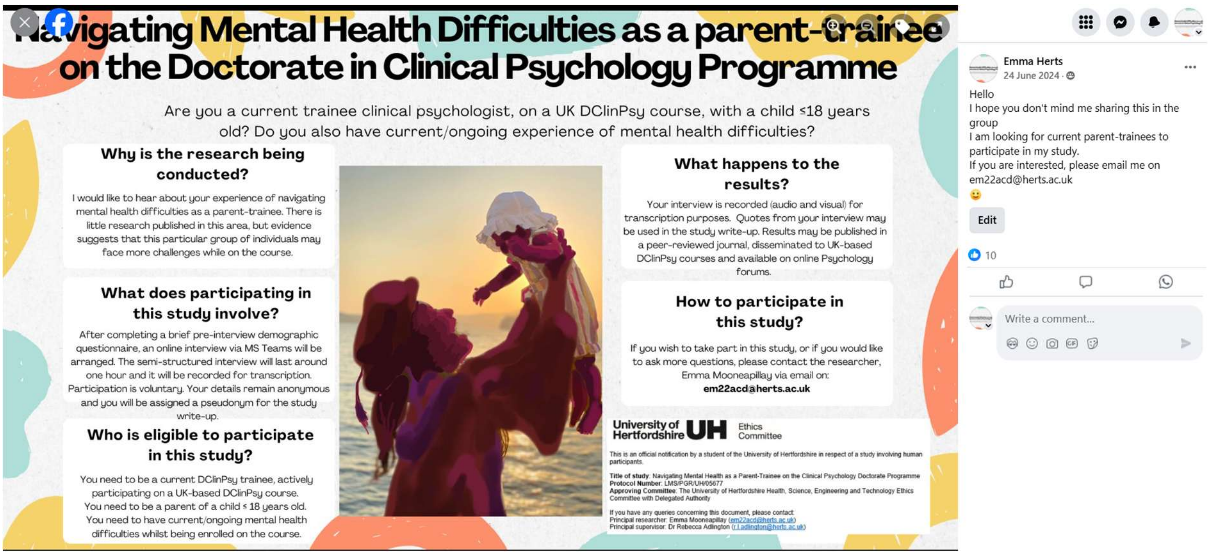


Appendix M – analysing excerpts with my consultant

Original Transcript	Initial Noting	Descriptive Comments	Linguistic Comments	Conceptual Comments	Emerging Themes
And what challenges related to mental health difficulties and parenting have you experienced during training? So [sighs] they're so intertwined, aren't they? Because you know, if if you're coming, you've already got pressures and demands on your time and energy, and particularly your emotional energy, and particularly when there's kind of, you know, sleep deprivation involved as well. Those were all things that would be…You know that those are the kind of the type of things that would put my mental health at risk or. You know, under pressure, under strain and then starting, you know, you're having finished maternity leave and then start after being off for a year like, you know, basically. And then suddenly going back to start training what you're supposed to be this kind of very competent. You know? Yeah. So starting training, following	Assumptions are powerful The burden of pressure from multiple places Acknowledged triggers but feels powerless What were the ways of coping? This feels familiar Trauma and loss- no space/time to process How was this acknowledged by the course? Did they offer any support? The expectations to carry on and turn up are huge Processing change and meaning/looking back on their experience/the story Multiple roles are draining/exhausting, where is the scope to recharge and look after mental health?	Time pressure vs energy Sleep deprivation as a trigger The notion of a competent trainee The start of training symbolises uncertainty and is a lot to figure out Separation anxiety Change is triggering Description of IVF journey comes with unprocessed meaning, emotional pain and uncertainty A significant event of pregnancy the day before the course started Associations of what would've been a landmark day in training to start the first day of placement was overwritten with an experience of loss, physical pain and heartache Grief as another layer of transition after returning from maternity leave Visible pregnancy creates compassion Experience of miscarriage is invisible The power and connection of shared lived experience Post-birth there are significant changes physically and emotionally which are not accounted for 'It's just a massive massive change' Needing to spend additional emotional resource Transition and attachment Past year as mind blowing Visible pregnancy changes the responses of others	Statements of truth and experience alongside the tone of questioning and seeking validation/shared understanding through questions and 'yeahs' 'you know' Some repetition, hesitation and emotive responses when recalling difficulty Moment needed to repeat question/have more time to think Whilst recalling making different links between parts/aspects of the experience indicated by 'kind of/yeahs' (Did not hear audio so there will be more context)	As a parent you already have pressures and demands on emotional energy and capacity. When you then experience a difficult personal situation that triggers your mental health, you are meant to put that aside and be a competent person (trainee) The transition from maternity leave to training is a minefield and that is without considering the organisation, how you will do things and how you will experience and feel leaving your child for the first time The ingredients for potentially struggling with mental health Suffering in silence with personal experiences, chronic pain and an untold story of a fertility journey that included loss and changes to breastfeeding a child which is another loss and transition. Placement signified pain and indicates another loss of an expected experience of training. This experience holds another comparable meaning/feeling when thinking to (maybe present) and being visibly pregnant and	

Appendix N – Recruitment and social media adverts

Facebook



Navigating Mental Health Difficulties as a parent-trainee on the Doctorate in Clinical Psychology Programme

Are you a current trainee clinical psychologist, on a UK DClinPsy course, with a child ≤18 years old? Do you also have current/ongoing experience of mental health difficulties?

Why is the research being conducted?

I would like to hear about your experience of navigating mental health difficulties as a parent-trainee. There is little research published in this area, but evidence suggests that this particular group of individuals may face more challenges while on the course.

What does participating in this study involve?

After completing a brief pre-interview demographic questionnaire, an online interview via MS Teams will be arranged. The semi-structured interview will last around one hour and it will be recorded for transcription. Participation is voluntary. Your details remain anonymous and you will be assigned a pseudonym for the study write-up.

Who is eligible to participate in this study?

You need to be a current DClinPsy trainee, actively participating on a UK-based DClinPsy course.
You need to be a parent of a child ≤ 18 years old.
You need to have current/ongoing mental health difficulties whilst being enrolled on the course.

What happens to the results?

Your interview is recorded (audio and visual) for transcription purposes. Quotes from your interview may be used in the study write-up. Results may be published in a peer-reviewed journal, disseminated to UK-based DClinPsy courses and available on online Psychology forums.

How to participate in this study?

If you wish to take part in this study, or if you would like to ask more questions, please contact the researcher, Emma Mooneapillay via email on:
em22acd@herts.ac.uk

University of Hertfordshire UH Ethics Committee

This is an official notification by a student of the University of Hertfordshire in respect of a study involving human participants.

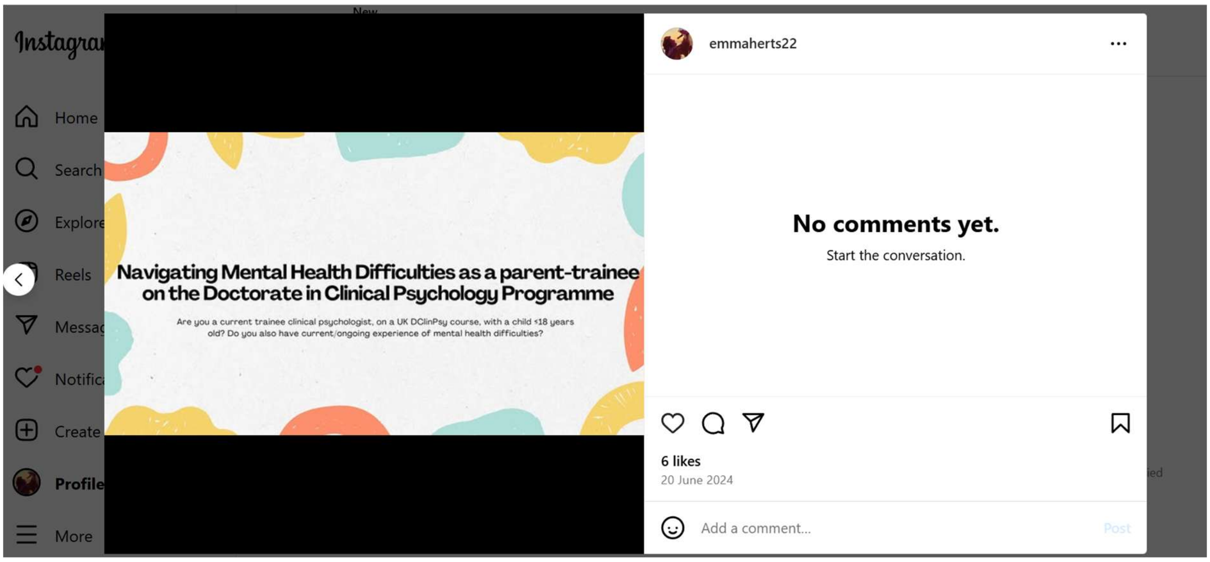
Title of study: Navigating Mental Health as a Parent-Trainee on the Clinical Psychology Doctorate Programme
Protocol Number: LMS/PGR/UH/05677
Approving Committee: The University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority

If you have any queries concerning this document, please contact:
Principal researcher: Emma Mooneapillay (em22acd@herts.ac.uk)
Principal supervisor: Dr Rebecca Adlington (r.l.adlington@herts.ac.uk)

Emma Herts
24 June 2024 ·

Hello
I hope you don't mind me sharing this in the group
I am looking for current parent-trainees to participate in my study.
If you are interested, please email me on em22acd@herts.ac.uk
🙂

Instagram



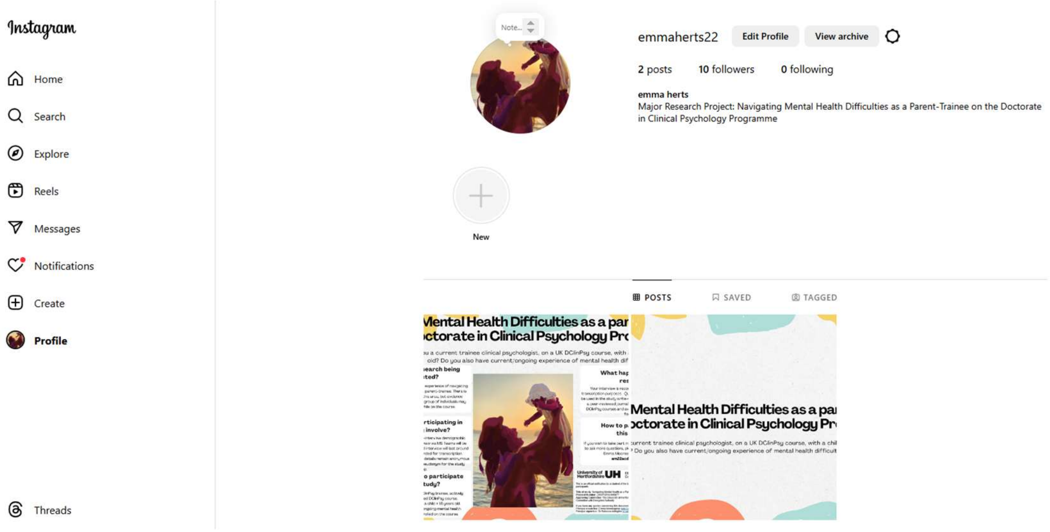
Navigating Mental Health Difficulties as a parent-trainee on the Doctorate in Clinical Psychology Programme

Are you a current trainee clinical psychologist, on a UK DClinPsy course, with a child ≤18 years old? Do you also have current/ongoing experience of mental health difficulties?

emmaherts22

No comments yet.
Start the conversation.

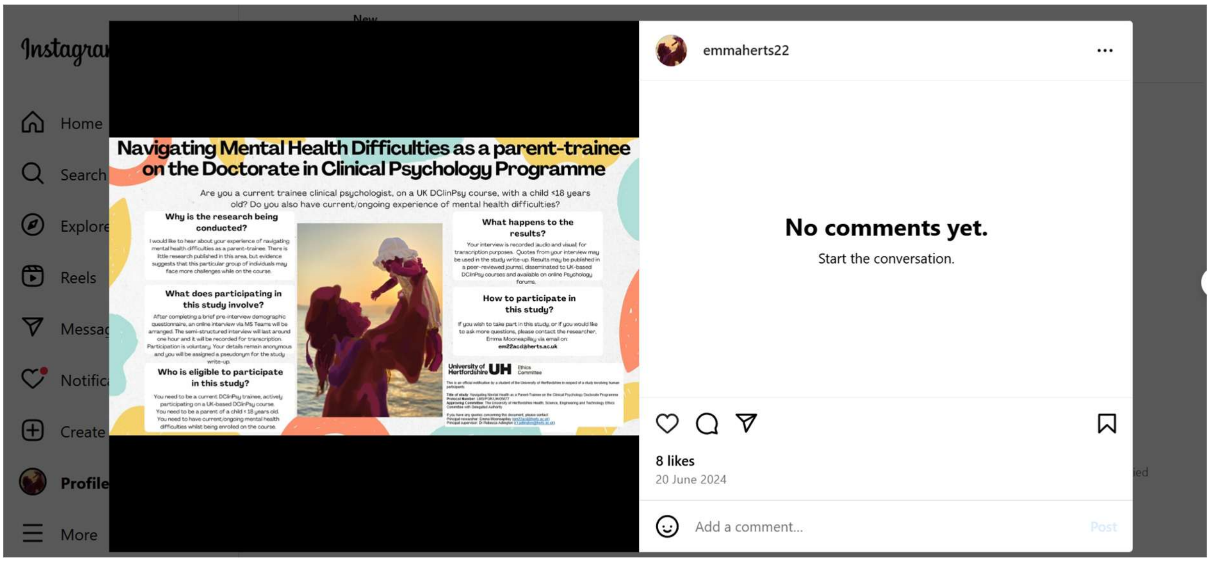
6 likes
20 June 2024



emmaherts22

2 posts 10 followers 0 following

emma herts
Major Research Project: Navigating Mental Health Difficulties as a Parent-Trainee on the Doctorate in Clinical Psychology Programme



emmaherts22

Navigating Mental Health Difficulties as a parent-trainee on the Doctorate in Clinical Psychology Programme

Are you a current trainee clinical psychologist, on a UK DClinPsy course, with a child <18 years old? Do you also have current/ongoing experience of mental health difficulties?

Why is the research being conducted?

I would like to hear about your experience of navigating mental health difficulties as a parent-trainee. There is little research published in this area, but evidence suggests that this particular group of individuals may face more challenges while on the course.

What does participating in this study involve?

After completing a brief pre-interview demographic questionnaire, an online interview via MS Teams will be arranged. The semi-structured interview will last around one hour and it will be recorded for transcription. Participation is voluntary. Your details remain anonymous and you will be assigned a pseudonym for the study write-up.

Who is eligible to participate in this study?

You need to be a current DClinPsy trainee, actively participating on a UK-based DClinPsy course. You need to be a parent of a child ≤ 18 years old. You need to have current/ongoing mental health difficulties whilst being enrolled on the course.

What happens to the results?

Your interview is recorded (audio and visual) for transcription purposes. Quotes from your interview may be used in the study write-up. Results may be published in a peer-reviewed journal, disseminated to UK-based DClinPsy courses and available on online Psychology forums.

How to participate in this study?

If you wish to take part in this study, or if you would like to ask more questions, please contact the researcher, Emma Mooneapillay via email on:
em22acd@herts.ac.uk

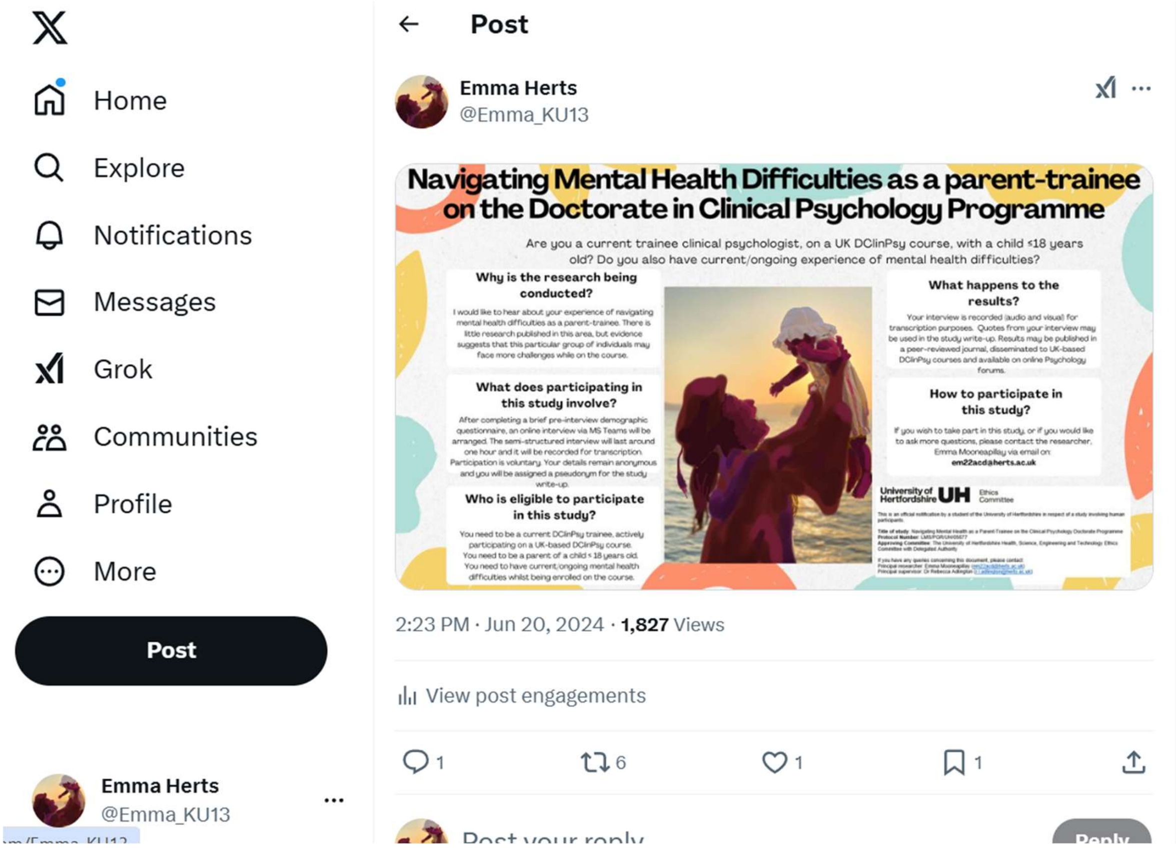
No comments yet.

Start the conversation.

8 likes
20 June 2024

Add a comment...

X



Emma Herts
@Emma_KU13

Navigating Mental Health Difficulties as a parent-trainee on the Doctorate in Clinical Psychology Programme

Are you a current trainee clinical psychologist, on a UK DClinPsy course, with a child ≤18 years old? Do you also have current/ongoing experience of mental health difficulties?

Why is the research being conducted?

I would like to hear about your experience of navigating mental health difficulties as a parent-trainee. There is little research published in this area, but evidence suggests that this particular group of individuals may face more challenges while on the course.

What does participating in this study involve?

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Who is eligible to participate in this study?

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You need to be a parent of a child ≤ 18 years old.
You need to have current/ongoing mental health difficulties whilst being enrolled on the course.

What happens to the results?

Your interview is recorded (audio and visual) for transcription purposes. Quotes from your interview may be used in the study write-up. Results may be published in a peer-reviewed journal, disseminated to UK-based DClinPsy courses and available on online Psychology forums.

How to participate in this study?

If you wish to take part in this study, or if you would like to ask more questions, please contact the researcher, Emma Mooneapillay via email on:
em22acd@herts.ac.uk

University of Hertfordshire UH Ethics Committee

This is an official notification by a student of the University of Hertfordshire in respect of a study involving human participants.

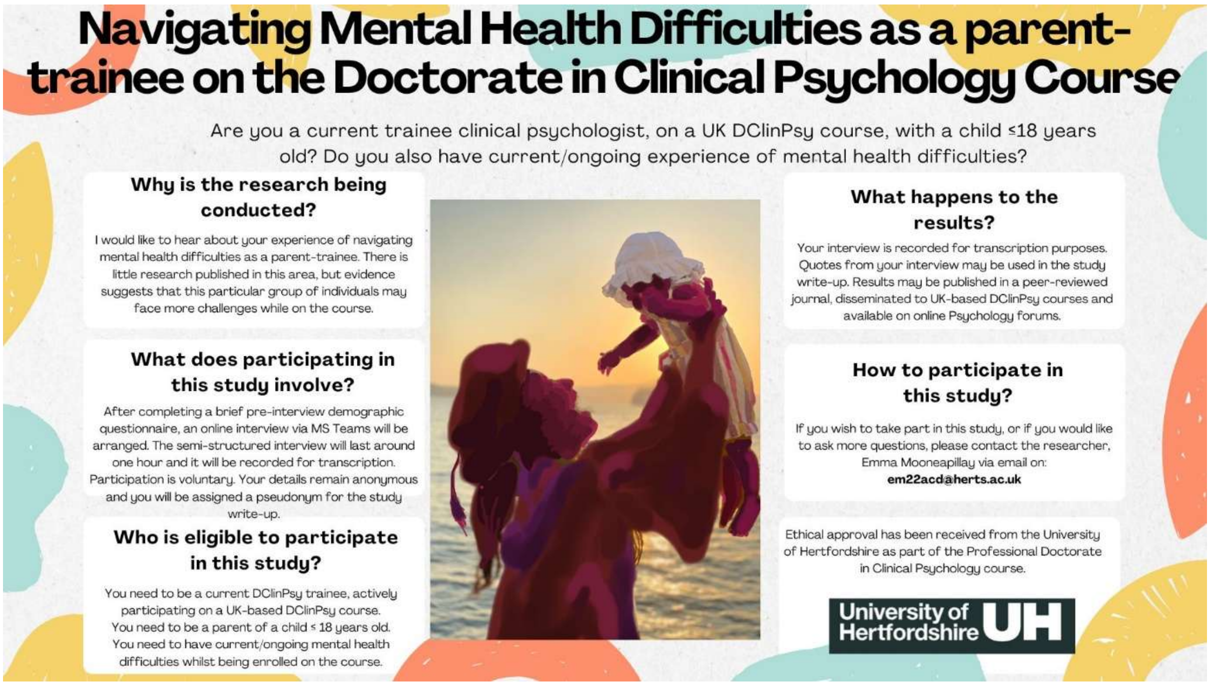
Title of study: Navigating Mental Health as a Parent Trainee on the Clinical Psychology Doctorate Programme

Approving Committee: The University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority

If you have any queries concerning this document, please contact:
Principal researcher: Emma Mooneapillay
Principal supervisor: Dr Rebecca Adlington

2:23 PM · Jun 20, 2024 · **1,827** Views

Appendix O – Research poster



Navigating Mental Health Difficulties as a parent-trainee on the Doctorate in Clinical Psychology Course

Are you a current trainee clinical psychologist, on a UK DClinPsy course, with a child ≤18 years old? Do you also have current/ongoing experience of mental health difficulties?

Why is the research being conducted?

I would like to hear about your experience of navigating mental health difficulties as a parent-trainee. There is little research published in this area, but evidence suggests that this particular group of individuals may face more challenges while on the course.

What does participating in this study involve?

After completing a brief pre-interview demographic questionnaire, an online interview via MS Teams will be arranged. The semi-structured interview will last around one hour and it will be recorded for transcription. Participation is voluntary. Your details remain anonymous and you will be assigned a pseudonym for the study write-up.

Who is eligible to participate in this study?

You need to be a current DClinPsy trainee, actively participating on a UK-based DClinPsy course.
You need to be a parent of a child ≤ 18 years old.
You need to have current/ongoing mental health difficulties whilst being enrolled on the course.

What happens to the results?

Your interview is recorded for transcription purposes. Quotes from your interview may be used in the study write-up. Results may be published in a peer-reviewed journal, disseminated to UK-based DClinPsy courses and available on online Psychology forums.

How to participate in this study?

If you wish to take part in this study, or if you would like to ask more questions, please contact the researcher, Emma Mooneapillay via email on:
em22acd@herts.ac.uk

Ethical approval has been received from the University of Hertfordshire as part of the Professional Doctorate in Clinical Psychology course.

University of Hertfordshire UH

Appendix P – Consent form

Consent Form

After reading the participant information sheet, please read the following statements before agreeing to take part in this study.
You can indicate your preference (YES/NO) by highlighting or editing your chosen answer. e.g., YES/[✓ NO]

1. I have been given the participant information sheet. I have read and understood this and I have had the opportunity to ask questions. I have been provided with enough information to understand what participating in this study involves. YES/NO
2. I understand that the information gathered, including personal information, will be stored securely by the researcher for use in this study only. YES/NO
3. I understand that my participation is voluntarily. I can withdraw all my details at any time during the study and up to one week after the interview date. I understand that I do not need to give a reason for withdrawing. If I withdraw the information gathered (including personal data) will be deleted by the researcher. YES/NO
4. For this study, I understand that I must be in a confidential and private space, ensuring that no children or adults will be able to hear the content of the interview. YES/NO
5. I understand the risks associated with this study as documented in the participant information sheet. YES/NO
6. I understand that the information gathered for this study may be published or disseminated in a journal, which may include my anonymised verbatim. YES/NO
7. I understand that I will not be receiving any financial benefits from taking part in this study if it is published. YES/NO
8. I have been provided with the necessary contact information for the research and ethics team should I wish to clarify any information, make a complaint or raise any concerns. YES/NO
9. I understand that my interview will be recorded and transcribed by the researcher. I understand that verbatim may be discussed with the research team and in advanced research methods workshops. I understand that all my personal data and my recorded interview will be deleted by the researcher at the end of this study.

I would like to view themes of the interview questions, BEFORE providing consent. YES/NO
If you wish to see the themes of the interview questions or discuss any of the points above, please let the researcher know via email, BEFORE agreeing to take part in this study.

Having read all the information above on the participant information sheet, I agree to sign this consent form and take part in this study. YES/NO

NAME OF PARTICIPANT
SIGNED

DATE:

NAME OF PRINCIPAL RESEARCHER
SIGNED
DATE:

University of Hertfordshire UH Ethics Committee

This is an official notification by a student of the University of Hertfordshire in respect of a study involving human participants.

Title of study: Navigating Mental Health as a Parent-Trainee on the Clinical Psychology Doctorate Programme
Protocol Number: LMS/PGR/UH/05677
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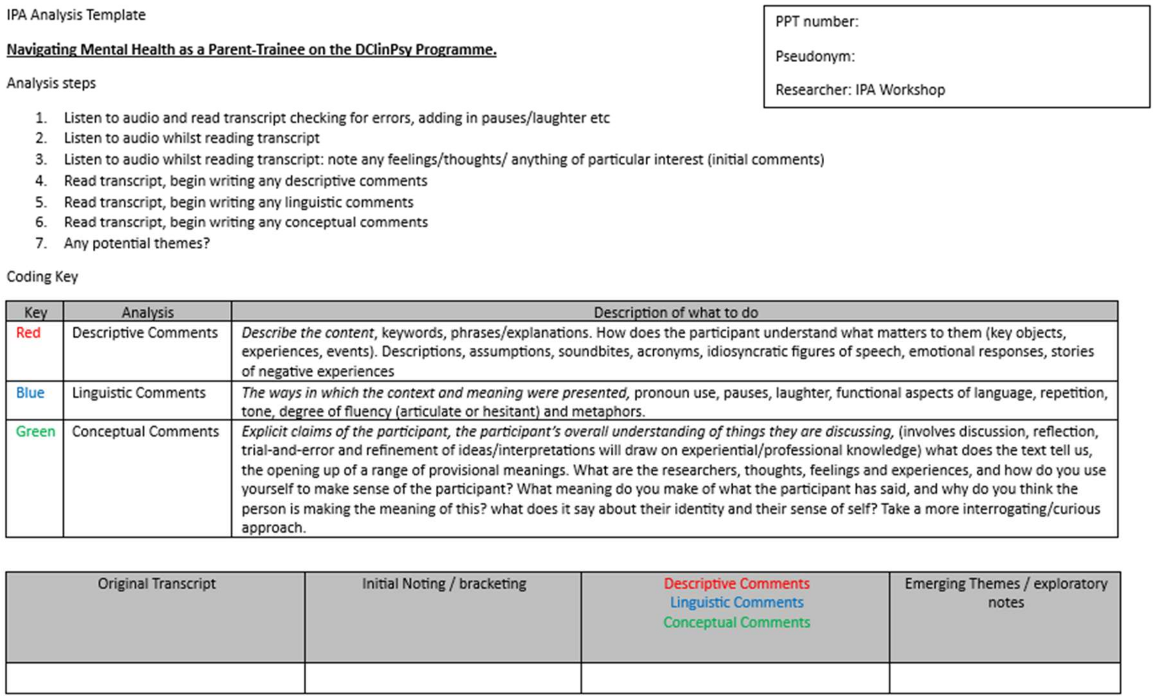
If you have any queries concerning this document, please contact:
Principal researcher: Emma Mooneapillay (em22acd@herts.ac.uk)
Principal supervisor: Dr Rebecca Adlington (r.l.adlington@herts.ac.uk)

Appendix Q – Pre-interview demographic questionnaire

First name and surname	
Age	
University Course Current year of training	
Gender	Female Male Non-binary Prefer not to say Other – please state _______________________________
Number of children and their age(s)	
Age of child when you first started the course Your age when you started the course	
Relationship status	Married Co-habiting Separated Single Other
Ethnicity – please state	
Type of mental health condition(s)? E.g. depression, anxiety, PTSD… Age when mental health was first experienced?	
Any past intervention? Any current intervention?	
Any adjustments that you wish for the researcher to consider? (e.g., longer interview time, regular breaks, typed interview questions,) please note, that these requests may or may not be filled depending on the researchers' ability to make these adjustments	
Do you wish you wish to see themes of the interview questions before providing your consent?	YES/NO

Appendix R – Example of IPA analysis template



IPA Analysis Template

Navigating Mental Health as a Parent-Trainee on the DClinPsy Programme.

PPT number:

Pseudonym:

Researcher: IPA Workshop

Analysis steps

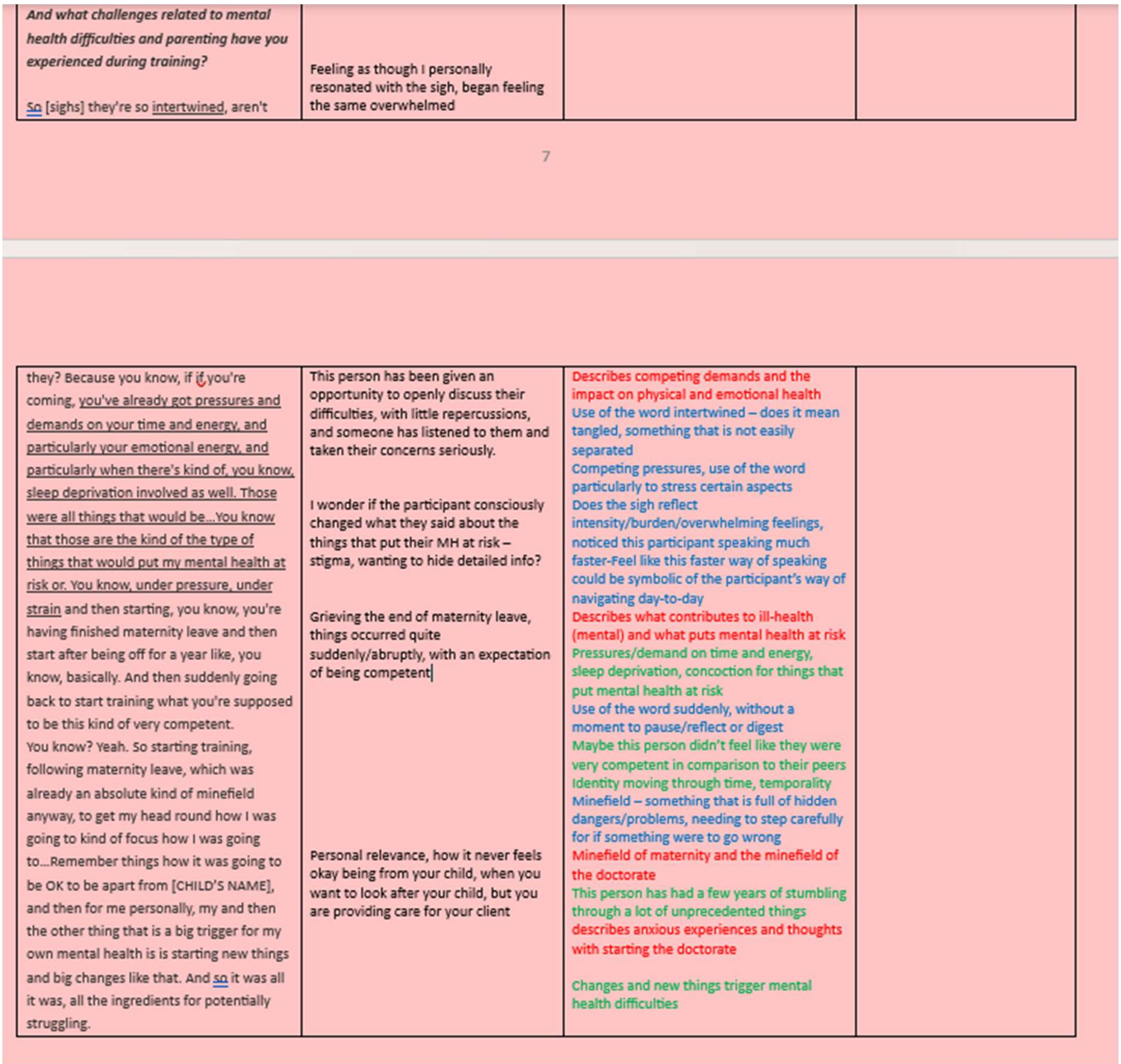
1. Listen to audio and read transcript checking for errors, adding in pauses/laughter etc
2. Listen to audio whilst reading transcript
3. Listen to audio whilst reading transcript: note any feelings/thoughts/ anything of particular interest (initial comments)
4. Read transcript, begin writing any descriptive comments
5. Read transcript, begin writing any linguistic comments
6. Read transcript, begin writing any conceptual comments
7. Any potential themes?

Coding Key

Key	Analysis	Description of what to do
Red	Descriptive Comments	*Describe the content*, keywords, phrases/explanations. How does the participant understand what matters to them (key objects, experiences, events). Descriptions, assumptions, soundbites, acronyms, idiosyncratic figures of speech, emotional responses, stories of negative experiences
Blue	Linguistic Comments	*The ways in which the context and meaning were presented*, pronoun use, pauses, laughter, functional aspects of language, repetition, tone, degree of fluency (articulate or hesitant) and metaphors.
Green	Conceptual Comments	*Explicit claims of the participant, the participant's overall understanding of things they are discussing*, (involves discussion, reflection, trial-and-error and refinement of ideas/interpretations will draw on experiential/professional knowledge) what does the text tell us, the opening up of a range of provisional meanings. What are the researchers, thoughts, feelings and experiences, and how do you use yourself to make sense of the participant? What meaning do you make of what the participant has said, and why do you think the person is making the meaning of this? what does it say about their identity and their sense of self? Take a more interrogating/curious approach.

Original Transcript	Initial Noting / bracketing	Descriptive Comments Linguistic Comments Conceptual Comments	Emerging Themes / exploratory notes

Appendix S – Reviewing anonymised excerpts



And what challenges related to mental health difficulties and parenting have you experienced during training? So [sighs] they're so intertwined, aren't they? Because you know, if if you're coming, you've already got pressures and demands on your time and energy, and particularly your emotional energy, and particularly when there's kind of, you know, sleep deprivation involved as well. Those were all things that would be...You know that those are the kind of the type of things that would put my mental health at risk or. You know, under pressure, under strain and then starting, you know, you're having finished maternity leave and then start after being off for a year like, you know, basically. And then suddenly going back to start training what you're supposed to be this kind of very competent. You know? Yeah. So starting training, following maternity leave, which was already an absolute kind of minefield anyway, to get my head round how I was going to kind of focus how I was going to...Remember things how it was going to be OK to be apart from [CHILD'S NAME], and then for me personally, my and then the other thing that is a big trigger for my own mental health is is starting new things and big changes like that. And so it was all it was, all the ingredients for potentially struggling.	Feeling as though I personally resonated with the sigh, began feeling the same overwhelmed This person has been given an opportunity to openly discuss their difficulties, with little repercussions, and someone has listened to them and taken their concerns seriously. I wonder if the participant consciously changed what they said about the things that put their MH at risk – stigma, wanting to hide detailed info? Grieving the end of maternity leave, things occurred quite suddenly/abruptly, with an expectation of being competent Personal relevance, how it never feels okay being from your child, when you want to look after your child, but you are providing care for your client	Describes competing demands and the impact on physical and emotional health Use of the word intertwined – does it mean tangled, something that is not easily separated Competing pressures, use of the word particularly to stress certain aspects Does the sigh reflect intensity/burden/overwhelming feelings, noticed this participant speaking much faster-Feel like this faster way of speaking could be symbolic of the participant's way of navigating day-to-day Describes what contributes to ill-health (mental) and what puts mental health at risk Pressures/demand on time and energy, sleep deprivation, concoction for things that put mental health at risk Use of the word suddenly, without a moment to pause/reflect or digest Maybe this person didn't feel like they were very competent in comparison to their peers Identity moving through time, temporality Minefield – something that is full of hidden dangers/problems, needing to step carefully for if something were to go wrong Minefield of maternity and the minefield of the doctorate This person has had a few years of stumbling through a lot of unprecedented things describes anxious experiences and thoughts with starting the doctorate Changes and new things trigger mental health difficulties	

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Reflecting at a point if if I really think I'll be able to to, you know, even when the doctorate finishes to come back. And I'm sorry, I think I'm getting emotional now, but to be as I used to be. [SIGH] Because I I feel like. [PAUSE] Once you go through through these difficulties and it's something that it wasn't on my mind, I I'm thinking here of you know how we talk about recovery and what recovery is. And I'm realising that, you know, I think once you've been treat it, it's like a scar that it's not going to go away.		Envisioining the self when the doctorate finishes Becomes emotional, teary, crying Describes the doctorate as a traumatic process, that scares you permanently, questioning will they ever be able to come back to what and who they were before pre-training A loss of identity recovery from the course- the course being a trigger or a perpetuating factor	Doctorate as traumatic Recovering from the doctorate
Because I think, like my my my main concern with all of this probably in the future as I'm saying it's it's not going to be as worse as it was, but it's always going to bring me back to that time you know and and think about the time when I was so low and I was so anxious. In terms that I was having was something that was carrying me, although I was consciously, you know, I was like, oh, I know what		A scar that never goes away The course has been so challenging, that events in the future that are fairly minor, will remind the participant of more trickier times when they were so anxious and low The emotional scars and baggage- are they really known to the course? can they be alleviated somehow to protect people from experiencing this in the future ? they are navigating- but really just stumbling along this path of finding themselves and recovering Carrying the buden of the doctorate and the experience with it Professionally they can understand	