Parenting experiences in the context of poverty and austerity

Jane Ellis

Supervised by:

Professor Rhiannon Corcoran

Dr Sarah Robertson

Dr Michael Galbraith

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Thesis overview

A poster affixed to the Humanities corridor wall of my secondary school read: ‘politics is everything’. Almost two decades later – and coming to the end of my clinical psychology training – I hold firm the principle that socio-political contexts are vitally important in understanding and supporting human development, emotions, relationships, health, and wellbeing. This is a view shared by multidisciplinary researchers of the social determinants of health (Marmot, 2010, 2020; Wilkinson & Pickett, 2009; World Health Organization, 2008). Poverty is a well-established social determinant of health, and its effects are particularly harmful when experienced in early childhood (Center on the Developing Child, 2007; Fell & Hewstone, 2015; Gutman, et al., 2015; Wickham, et al., 2016). Poverty does not exist in a vacuum, but rather emerges in the context of an inequitable distribution of resources and access to public services, often resulting from public and economic policy decisions (Duffy, 2020; Joseph Rowntree Foundation, n.d.). In the UK context, the austerity programme has been one such policy decision that has been linked to increased poverty and inequalities (Marmot, 2020). Psychologists Against Austerity have argued that clinical psychologists have an ethical and professional duty to examine and speak out about the negative impact of austerity on mental health (McGrath, Walker, & Jones, 2016). My clinical interests lie in preventative and early intervention work with parents and babies. Nurturing positive parent-baby relationships can have a long-lasting impact on babies’ social, emotional, and cognitive development (Gerhardt, 2014). I therefore sought to understand more about the socio-political contexts to parenting babies and young children from parents’ own perspectives.

In this thesis, I aim to make a novel contribution to the research landscape through two chapters:

Chapter 1: A systematic review examining the experiences of parents in poverty. In this chapter, I undertake a quality appraisal and thematic synthesis of the qualitative literature to

understand the ways in which parents of young children perceive poverty impacts their parenting and parent-child relationships.

Chapter 2: An original empirical research project, which explores parenting experiences in the context of austerity and a cost-of-living crisis. In this chapter, I present a narrative inquiry of parents' stories of caring for a baby in this context.

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Chapter 1

Parents' experiences of the impact of poverty on parenting young children: A systematic review and thematic synthesis.[1]

Chapter word count: 10,161

[1] I prepared this chapter for publication in the Journal of Child & Family Studies, which adheres to APA 7 style (Appendix I). The word count has been extended to provide sufficient detail for examination.

Abstract

Background

Poverty is a major social issue in the UK. Experiencing poverty in early childhood can negatively impact children's healthy development. There is a history of locating this in deficient parenting rather than in adverse environments and systems. Parents in poverty contend with multiple challenges, which makes building and maintaining positive relationships with their young children more difficult. This systematic review sought to understand parents' own experiences of the impact of poverty on parenting and the parent-child relationship.

Methods

Social Sciences Citation Index, CINAHL, MEDLINE, PsycINFO, ProQuest Public Health Database, and ProQuest Dissertations were searched in December 2022. Studies were included if they were qualitative, involved parents of young children (under 8), and explored parents' subjective experiences of poverty and parenting. The search included articles published in English, and after 2007, following the global financial crisis. Papers were quality assessed. Thematic synthesis was used to analyse the data.

Results

The search yielded 2461 unique records, of which 47 were retrieved for full-text screen. 16 papers met eligibility criteria for review. The majority of these took place in the US (*n*=11). The outcomes of these papers were synthesised, and five themes were constructed: 'impoverished communities'; 'parental wellbeing'; 'the parent-child relationship'; 'the early years support landscape'; and 'gendered parenting'.

Conclusions

Parents' experiences of poverty were multi-layered. Social and economic policies intensified parents' hardship and support structures were often experienced as absent or unhelpful. This review found evidence that contradicts pathologising and blaming narratives, emphasising instead how parents necessarily adapt parenting strategies to cope with adverse environments and experiences.

Background

Poverty in the UK

An estimated 14.5 million people in the UK are living in poverty, representing 22% of the population (Department for Work & Pensions [DWP], 2023). Around 4.2 million of these are children, totalling 29% of the child population (DWP, 2023). The UK is among the top 20 richest countries in the world, making it one of the most unequal countries in the Global North (Organisation for Economic Co-operation and Development [OECD], 2023b; 2023c). While not new phenomena in the UK, poverty and inequalities have increased since 2010, which has been directly linked to the austerity programme implemented by the coalition and successive Conservative governments (Joseph Rowntree Foundation, 2022; Marmot, 2020; Thomson, Niedzwiedz, & Katikireddi, 2018). In the period 2010-19 the government introduced widespread cuts to local government, the welfare state, public sector pay, and housing. Foodbank use has increased from just under 26,000 in 2008/09 to 2.9 million in 2022/23 (Trussell Trust, 2023). All forms of homelessness have increased since 2010 (Department for Levelling Up, Housing & Communities [DLUHC], 2023).

At the time of writing, the UK is experiencing a 'cost-of-living crisis', in which many households are unable to afford to heat their homes or afford essentials due to a rapid fall in real disposable incomes (Hourston, 2022). While the 'cost-of-living crisis' is a global phenomenon, the UK has been one of the worst affected wealthy countries (OECD, 2022). This has been attributed to the aftermath of Brexit and austerity measures, since public sector employees' pay decreased in real terms between 2009 and 2021, and unemployed people in the UK receive less income support than other OECD countries (Dhingra, et al., 2022; Hall, 2022; OECD, 2023a; Office for National Statistics [ONS], 2022a). The cost-of-living crisis has affected people on low incomes and living in deprived areas most significantly (Centre for Cities, 2022). Following a brief reprieve during the Covid-19 pandemic, the austerity agenda has been re-introduced in 2021/22, which, combined with the cost-of-living crisis, is forecast to deepen poverty and inequalities even further (Hall, 2023; Marmot, 2020).

The impact of poverty in early childhood

The harmful impacts of poverty and inequalities on both physical and emotional wellbeing have been well-established (Fell & Hewstone, 2015; Gutman, et al., 2015; Wilkinson & Pickett, 2018). Poverty has particularly deleterious effects when experienced in early childhood, widely considered a crucial period in children's lives for social, emotional, and cognitive development (Center on the Developing Child, 2007; Cooper & Stewart, 2013; Shaefer, et al. 2018; Sobowale & Ross, 2018; Wickham, et al., 2016). The first years of a child's life is a period of rapid brain development during which the foundations are laid for future health and wellbeing (Center on the Developing Child, 2007; Gerhardt, 2014). Both positive and negative early experiences have a cumulative and lifelong impact on a child's development (National Scientific Council on the Developing Child, 2014; Gerhardt, 2014). The Adverse Childhood Experiences (ACEs) literature has demonstrated that experiencing multiple traumatic events in childhood, such as abuse, witnessing domestic violence, or having a parent with significant drug or alcohol use, leads to a range of negative outcomes for health and wellbeing across the lifespan (Bellis, 2014; Felitti, et al., 1998). Growing up in poverty and inequalities increases the likelihood of experiencing ACEs and magnifies their impact (Asmussen, et al., 2020; Lacey et al., 2020).

Parenting & the parent-child relationship

Given that immediate family context and relationships are highly influential for babies and young children, parenting is often considered to be a mediator between poverty and child outcomes (Burgess, et al., 2006; Dickerson & Popli, 2016; Kaiser, et al, 2017). Research has linked economic hardship to the adoption of 'negative' parenting practices, such as high control and low warmth (Holmes & Kiernan, 2013; Kaiser, Pollmann-Schult, & Song, 2017). The family stress model proposes that economic pressure affects the quality of the co-parent relationship, which in turn impacts on child outcomes, for example, cognitive development, emotional regulation capacity, and school achievement (Conger & Elder, 1994; Knitzer &

Perry, 2009). Decades of attachment theory literature have suggested the importance of at least one secure, responsive relationship with a consistent adult for good child mental health and future health and wellbeing outcomes (e.g., Bowlby, 1988). In this way, the parent-child relationship is understood to be able to buffer some of the disadvantage associated with poverty (Center on the Developing Child, 2007; Gerhardt, 2014; Sobowale & Ross, 2018). Sensitive and warm parenting to a 'good enough' level can provide the consistency and emotional containment that young children need to develop essential capacities for coping with stress and adversity such as emotional and behavioural regulation (Center on the Developing Child, 2007; Winnicott, 1973).

However, social, cultural, and environmental factors are key for providing the conditions and resources necessary for parents to build and maintain positive early relationships with their babies and young children (Gerhardt, 2014). Parents living in poverty contend with a multitude of disadvantages including a lack of access to employment and services, social exclusion, deprived neighbourhoods, inadequate housing, a lack of access to green space and recreational facilities, and poor physical and emotional health (La Placa & Corlyon, 2015; ONS, 2020). For parents from minoritised ethnic backgrounds these challenges are often magnified, in conjunction with discrimination and racism, at individual and structural levels (ONS, 2020, 2022b; DLUHC, 2020a, 2020b, 2020c). The 'Pair of ACEs' model extends the original ACEs literature, adding a sociocultural context, and demonstrating how poverty and other systemic inequalities, described as 'adverse community environments', are often at the root of adverse childhood experiences (Ellis & Dietz, 2017).

Less is known about parents' subjective experiences of poverty, how it impacts on their parenting, how they cope, and what could help. Understanding this further could support interventions to improve outcomes for children later in life.

The current review

To the best of our knowledge, no other paper has systematically reviewed qualitative research exploring the experiences of parents of young children living in poverty and their perspectives on the impact of this on their parenting and the parent-child relationship. Focusing on qualitative literature will offer an in-depth understanding of the lived experiences and realities of parents in poverty.

Aims

Through a thematic synthesis and quality appraisal of the qualitative published evidence this review seeks to understand:

- What are the experiences of parents of young children living in poverty and experiencing inequalities?
- What is the impact of poverty and inequalities on parenting and the parent-child relationship?
- What are the implications for clinical practice and policy?

Methods[2]

Definition of terms

Poverty. The broadest definition of poverty, according to the United Nations (2010) was used in recognition that it is a complex phenomenon that cannot be captured by one measure, and to maximise the number of studies included in the review:

> *Poverty has various manifestations, including lack of income and productive resources […]; hunger and malnutrition; ill health; limited or lack of access to education and other basic services; increased morbidity and mortality from illness; homelessness and inadequate housing; unsafe environments; and social discrimination and exclusion.*
>
> (United Nations, 2010)

[2] The review protocol was registered on PROSPERO, no. CRD42022380783.

Parent. For the purposes of the review, a parent is understood as an adult caregiver with primary parenting responsibility for a child.

Early childhood. The age range constituting early childhood is contested and varies between countries and organisations (United Nations, 2006). The review used the definition of early childhood adopted by UNICEF and the United Nations: from birth to 8-years-old (UNICEF, 2022; United Nations, 2006).

Search strategy

The review question was developed using the PEO framework, where population (P) were parents, exposure (E) was poverty, and outcome (O) was parenting and the parent-child relationship (Moola, et al., 2015).

The search strategy, as shown in Table 1, was developed iteratively from scoping searches, and in consultation with an evidence review expert at a local NHS Trust and the primary supervisor.

Table 1.

Search strategy.

Poverty	Perspectives	Parenting
poverty OR austerity OR deprivation OR deprived OR disadvantage OR precarity OR precarious OR "financial hardship" OR "economic hardship" OR low-income OR "low income" OR poor OR impoverished OR inequality OR inequalities	experience OR story OR stories OR narrative OR reality OR realities OR perspective OR perception OR view	parenting OR "parent-child relationship"

The following databases were searched: Social Sciences Citation Index, CINAHL, MEDLINE, PsycINFO, ProQuest Public Health Database, and ProQuest Dissertations (doctoral only). Reference lists of eligible papers were searched. Peer-reviewed journal articles and doctoral

dissertations were considered. Other grey literature and unpublished papers were excluded due to variation in information available about sampling techniques and methodology in these sources, which would hinder the quality assessment process.

The search included studies from Global North countries (typically understood as economically developed democracies, defined for the purposes of this review as OECD membership), published in English, and after 2007, reflecting the period following the global financial crisis (OECD, n.d.). Only studies in which a primary focus is parents' experiences of poverty (or related concepts, e.g., low income, homeless) and the impact on parenting were included. Therefore, only studies that included an explicit, relevant aim or research question were included. The original search was run December 2022 and subsequently re-run prior to the final analysis in May 2023. One further study was identified from hand-searching at this stage.

Data extraction

Identified records were exported into EndNote, where duplicates were automatically excluded. I screened all titles and abstracts of the search items generated, applying the inclusion criteria. All relevant details (title, author[s], publication year, language, country, journal, and abstract) of the papers meeting inclusion criteria were exported to an Excel spreadsheet.

I then screened the full papers for suitability, in collaboration with my primary supervisor (RC). A peer researcher independently screened 20% of the full-text papers. In cases of disagreement, we discussed the studies and reached a decision about inclusion or exclusion. The reason for exclusion at the full-text stage was recorded. A hand-search of the included papers' reference list was carried out and any relevant studies were screened.

Data was extracted from the final included studies into the Excel spreadsheet. Information on sample, setting, method, analysis, and main findings were extracted.

Quality appraisal

A peer researcher and I appraised the papers using the Critical Appraisal Skills Programme (CASP) Qualitative Studies Checklist (CASP, 2018). This tool was selected given it is the most commonly used appraisal tool for qualitative research, was designed for health-related research, and is endorsed by Cochrane and the World Health Organisation (Long, French, & Brooks, 2020).

Data synthesis strategy

Thematic synthesis was used to construct an overall understanding of parents' experiences of poverty and the impact on parenting and the parent-child relationship presented across the studies. This method was developed specifically to address questions about people's perspectives and experiences and so was considered to fit with the aims of this review.

Thomas and Harden's (2008) method for thematic synthesis was applied:

- free line-by-line coding of the findings of primary studies;
- the organisation of these 'free codes' into related areas to construct 'descriptive' themes;
- and the development of 'analytical' themes (Thomas & Harden, 2008, p. 4).

This was carried out in collaboration with the research team. The extracted data was exported into NVivo to aid analysis.

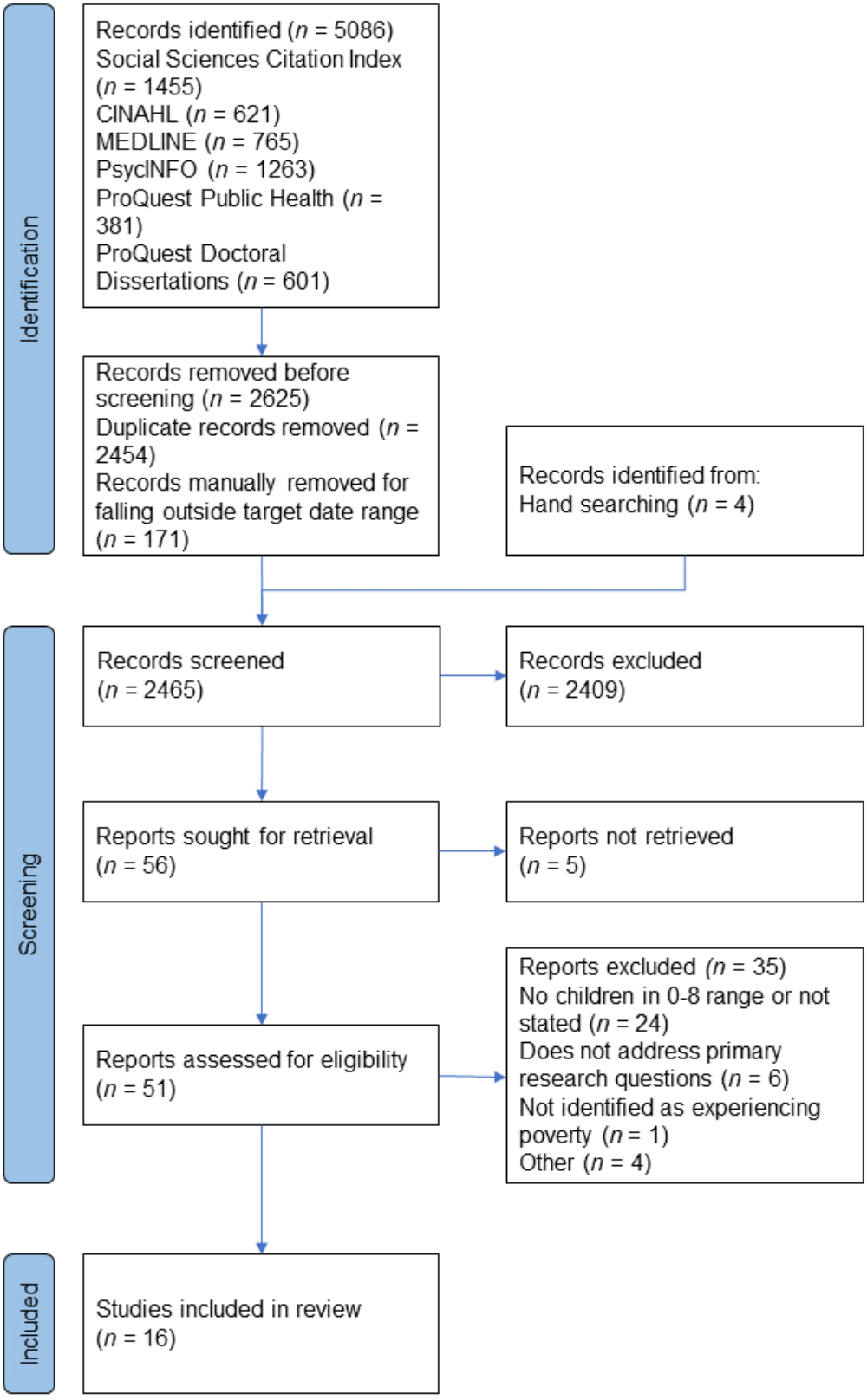
Results

Results of the search

Searches of electronic databases and hand searching returned 2465 unique records, as demonstrated in the PRISMA diagram in Figure 1 (Page, et al., 2021). Following a title and abstract screen, 51 full-text papers were retrieved. A more detailed full-text screen yielded 16 papers to be included in the review.

Figure 1.

PRISMA diagram.



Characteristics of included studies

The 16 primary research studies were reported in 13 journal articles and three doctoral theses. A summary of included papers is provided in Table 2. Two of the papers (3 and 16) used the same dataset. Studies predominantly took place in the USA (*n*=11), with the remaining in Australia (*n*=2); the UK (*n*=2); and Canada (*n*=1). Of the 274 primary caregivers who participated across the 16 studies, 225 were mothers (82%); 37 were fathers (14%); and 12 were grandparents (4%).

Quality appraisal outcomes

Studies were assessed and rated against the 10 CASP criteria and accompanying prompt questions (see Appendix II). Studies fully meeting criteria received an outcome of 'Yes' and two points, those partially meeting criteria received 'Can't tell' and one point, and those which did not meet criteria received 'No' and no points. For example, several papers scored 'Can't tell' for criteria 3 because their research design appeared appropriate given the aims, but this was not addressed in sufficient detail. Outcomes of the quality appraisal are shown in Table 3. Most of the studies were rated 'High' (*n*=9) or 'Medium/High' (*n*=6) quality. One was rated 'Medium' quality. No studies were excluded at this stage, but quality ratings were implicitly considered when prioritising and organising the results section. Implications of the quality appraisal will be further addressed in the discussion section.

Table 2.

Characteristics of included studies.

#	Reference	Setting	Sample	Method	Analysis	Summary of findings
1	Anthony, Vincent, & Shin (2018)	USA	19 parents (16 mothers; 3 fathers), ≥1 night in a homeless shelter African American (*n*=17), White (*n*=2). ≥ one child under 6.	Semi-structured interviews	Thematic analysis (TA)	Parents reported multiple difficult emotions in their children. Parents talked about the disempowering experience of parenting while in shelter.
2	Beasley, et al. (2022)	USA	70 primary caregivers (38 mothers; 20 fathers; 12 grandparents) Hispanic/Latino (31%); European American (27%); African American (19%); Native American (10%); Asian American (6%); Multi-Racial (7%). ≥ one child under 8.	Focus groups	Content analysis	Families experiencing poverty and related risk factors experience challenges in the realm of child safety, education, and racism/prejudice.

3	Cho, Kleven, & Woods-Jaeger (2021)	USA	11 low-income parents (10 mothers, 1 father). Black/African American (*n*=7); Black or African American and White (*n*=2); Native Hawaiian/Other Pacific Islander & White (*n*=1); White (*n*=1). Children's ages: 1-6.	Semi-structured interviews	TA	Healthy, supportive parenting goals and values are hampered by challenging interactions with various levels of the socioecological system.
4	Franz (2016)	USA	5* single Latina mothers in poverty. Puerto Rican American (*n*=3); Mexican (*n*=2) Dominican American (*n*=1). Children's ages: 0-6. *original sample size was 6 but one parent's data was excluded as no child in 0-8 range.	Structured interview	Existential phenomeno-logical method	Mothers wanted to give their children a better experience than they had, and described the effort required to balance the roles of nurturer and disciplinarian. Mothers found social programmes unhelpful. Context impacted on parenting decisions.

5	Jamison, Ganong, & Proulx (2017)	USA	11 low-income, unmarried couples (11 mothers, 11 fathers). White (*n*=14); African American (*n*=7); Asian/Pacific Islander (*n*=1). Children's ages: 3 months-8 years.	Interviews	Grounded theory (GT)	Unmarried couples aspired to be good co-parents, but the stress of living in poverty and the challenges of parenting young children led some to experience family strain or crisis.
6	Kistin, et al. (2014)	USA	30 low-income mothers with trauma history. Black (*n*=14); White (*n*=8); Hispanic/Latino (*n*=8). Children's ages: <5.	Interviews	Interpretative Phenomeno-logical Analysis (IPA)	Repetitive child behaviours were the most stressful, and mothers commonly coped by taking time away. Harsh discipline was used.
7	Kuskoff, et al. (2022)	Australia	17 low-income mothers. Ethnicity not reported. Children's ages: <5.	Interviews	IPA	Resources provided through the [housing] programme enabled mothers to care for their children in ways that aligned with their parenting beliefs and aspirations.

8	Marcil, et al. (2020)	USA	26 mothers, mostly single, experiencing financial strain. African American/Black (*n*=19); Other (*n*=4); White (*n*=2); Asian (*n*=1). Children's ages: <5.	Semi-structured interviews	Existential phenomeno-logical method	Financial strain resulted in forced trade-offs, compromised parenting practices, and self-blame, which contributed to significant mental health problems.
9	Matthews (2021)	USA	16 parents who lived in shelter (15 mothers; 1 father). White (*n*=6); Black (*n*=4); Hispanic (*n*=3); Multiracial (*n*=3) Children's ages: 1-7	Semi-structured interviews	GT	Shelter context limited parental agency and compromised parents' ability to uphold parenting values and strategies.
10	McManus & Suizzo (2020)	USA	3 mothers. Mexican American (*n*=1); Alaskan Native (*n*=1); African American (*n*=1). Children's ages: 1-3.	Semi-structured interviews	TA	Mothers felt they needed more money, time, opportunities for self-care, and validation.

11	Romagnoli & Wall (2018)	Canada	10 low-income mothers. White (*n*=10). Children's ages: 0-6.	Semi-structured interviews	GT & critical feminist analysis	Intensive mothering expectations and mandated programmes were experienced as prescriptive and regulative. Meeting basic needs is potentially more effective policy direction for improving child and maternal well-being.
12	Smith, et al. (2015)	Australia	13 mothers experiencing intergenerational poverty. Ethnicity not reported. Preschool-aged children.	Semi-structured interviews	GT	Parents described role as guiding children to become 'good' people, teach them skills and provide routine. Whilst parenting was hard and lonely, it was seen as a private matter and parents avoided seeking help.
13	Stack & Meredith (2018)	UK	11* single mothers. Ethnicity not reported. Children's ages: 9 months-8 years. *original sample size was 15 but four parents' data was excluded as no child in 0-8 range	Semi-structured interviews	TA	Participants described food and fuel poverty and made sacrifices to ensure children's basic needs were met. Isolation, anxiety, depression, paranoia, and suicidal thoughts were described. Psychological services unable to meet contextual needs.

14	Swick & Williams (2010)	USA	4 single homeless mothers. Black (*n*=3); Dominican Republic (*n*=1). Children's ages: 2-7.	Open-ended interviewing	Narrative analysis	Barriers to effective parenting were a lack of financial resources and a loss of self-control. Mothers focused on taking care of basic needs and made greater efforts to keep children happy.
15	Townsend (2012)	UK	6 mothers. Ethnicity not reported. Preschool children.	Focus group & semi-structured interviews	GT	Ecological support (including community facilities, employment and social support) was important for parents' functioning.
16	Woods-Jaeger, et al. (2018)	USA	11 low-income parents, histories of ACEs (10 mothers; 1 father). Black (*n*=7); Black & White (*n*=2); White (*n*=1); Native Hawaiian/ Other Pacific Islander & White (*n*=1). Children's ages: 6 weeks-5 years.	Semi-structured interviews	GT	A potential intergenerational cycle of ACEs was identified, along with key factors that can break that cycle, including parent aspirations to make children's lives better and parent nurturance and support.

Table 3.

CASP quality appraisal outcomes.

Paper	1. Was there a clear statement of the aims of the research?	2. Is a qualitative methodology appropriate?	3. Was the research design appropriate to address the aims of the research?	4. Was the recruitment strategy appropriate to the aims of the research?	5. Was the data collected in a way that addressed the research issue?	6. Has the relationship between researcher and participants been adequately considered?	7. Have ethical issues been taken into consideration?	8. Was the data analysis sufficiently rigorous?	9. Is there a clear statement of findings?	10. How valuable is the research?	Score*	Overall rating**
Anthony, Vincent, & Shin (2018)	Can't tell	Can't tell	Can't tell	Yes	Yes	No	Yes	Yes	Can't tell	Yes	14	Medium/High
Beasley, et al. (2022)	Yes	Yes	Yes	Yes	Can't tell	No	Yes	Can't tell	Yes	Yes	16	Medium/High
Cho, Kleven, & Woods-Jaeger (2021)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	18	High
Franz (2016)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	20	High
Jamison, Ganong, & Proulx (2017)	Yes	Yes	Can't tell	Yes	Yes	No	Yes	Yes	Yes	Yes	17	High
Kistin, et al. (2014)	Yes	Can't tell	Can't tell	Yes	Can't tell	No	Yes	Can't tell	Yes	Yes	14	Medium/High
Kuskoff, et al. (2022)	Yes	Yes	Can't tell	Yes	Yes	No	Yes	Yes	Yes	Yes	17	High
Marcil, et al. (2020)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	20	High
Matthews (2021)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	20	High
McManus & Suizzo (2020)	Yes	Yes	Can't tell	Yes	Can't tell	No	Yes	Yes	Can't tell	Yes	15	Medium/High
Romagnoli & Wall (2012)	Yes	Yes	No	Yes	Can't tell	No	No	Can't tell	Yes	Can't tell	11	Medium
Stack & Meredith (2018)	Yes	Yes	Can't tell	Yes	Can't tell	No	Yes	Can't tell	Yes	Yes	15	Medium/High
Smith, et al. (2015)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	20	High
Swick & Williams (2010)	Yes	Yes	Yes	Yes	Yes	No	Yes	Can't tell	Can't tell	Yes	16	Medium/High
Townsend (2012)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	20	High
Woods-Jaeger, et al. (2018)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	18	High

*Score
Yes = 2 point
Can't tell = 1 point
No = 0 point

**Quality rating
17-20 = High
13-16 = Medium/High
9-12 = Medium
5-8 = Medium/Low
0-4 = Low

Thematic synthesis

Through thematic synthesis five themes were constructed: ‘impoverished communities’; ‘parental wellbeing’; ‘the parent-child relationship’; ‘the early years support landscape’; and ‘gendered parenting’. Table 4 summarises the themes and sub-themes.

Table 4.

Summary of themes & sub-themes.

Themes	**Sub-themes**	**Papers referenced**
Impoverished communities		1, 2, 3, 4, 5, 7, 9, 10, 12, 14, 15, 16.
	Living contexts	1, 2, 5, 7, 9, 14.
	Adverse community environments	2, 3, 4, 9, 15, 16.
	Intergenerational cycles	3, 4, 10, 12, 15, 16.
Parental wellbeing		2, 4, 5, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16.
	The stresses and strains of economic deprivation	4, 5, 8, 9, 10, 11, 12, 13, 14.
	Self-sacrifice	4, 7, 8, 10, 11, 13, 15.
	Self-blame	2, 4, 8, 9, 10, 11, 13, 15, 16.
The parent-child relationship		1, 3, 4, 6, 7, 8, 9, 11, 12, 14, 15, 16.
	Parent-child relationship difficulties	1, 6, 9, 15.
	Managing difficulty in difficult circumstances	1, 3, 4, 6, 8, 12.
	A ‘good enough’ relationship as a buffer	1, 3, 4, 7, 8, 9, 11, 12, 14, 15, 16.
The early years support landscape		2, 4, 5, 8, 9, 10, 11, 13, 14, 15.
	Support is absent	2, 4, 8, 9, 13.

	Support is present but unhelpful	2, 4, 9, 11, 13, 14, 15.
	Support is present and helpful	4, 5, 8, 10, 11, 13, 15.
Gendered parenting		2, 4, 5, 9, 12, 15.

Impoverished communities

Prevalent in parents' accounts was a sense of their parenting being impacted by the social contexts associated with impoverished communities. This theme has three sub-themes: 'living contexts', reflecting families' more immediate social context; 'adverse community environments', reflecting the wider community contexts; and 'intergenerational cycles', representing the temporal dimension.

Living contexts

Three papers (1; 9; 14) explored parents' experiences of homelessness and living in temporary homeless shelters, environments which were experienced as removing parental agency. Parents reflected on how shelter rules and expectations led to a sense of parental disempowerment and conflicted with parents' values and parenting styles. Two studies (1; 9) highlighted the rule for parents to always be with children. This was experienced as impractical and developmentally inappropriate, with parents highlighting the importance of independent play, socialising with other children, and the benefit of alone time for parental wellbeing. It caused difficulty when parents were required to complete jobs as a requirement of their shelter stay while also caring for young children in settings that were not appropriately equipped:

You tell them sit down. Give them toys […] and you go and come back. But […] they don't know this. They can just jump off the bed […] And then when they get injured. Like 'oh! the mother, she's negligent, she's not paying attention!' [...] There's nothing for […] us to help us keep them safe while we doing our chores.

(9, p. 62)

This also speaks to parents' worries of what children might be exposed to while staying in a shelter:

We're used to it just bein' us. There's a lot of people. Lots of kids. Lot of different parenting. […] And my son seein' other kids' behavior and it's like, 'Oh they're doin it!' […] 'Maybe I can do it.' Well. 'Nope. We're not doin' it that way […] That's not what WE do.

(9, p. 50)

Inadequate housing was constructed as a barrier to effective parenting and providing safe and secure environment for their children. One mother talked about health fears regarding a longstanding leaky roof and the tenancy manager failing to resolve it. Parents reported difficulties in finding secure affordable housing (5; 7). One study directly linked a lack of appropriate housing to mother's involvement with child protection services:

For two years I tried to fight for [my son] and it has been hell until [housing support programme] walked into my life and gave me that security. And then was like, 'Here, have a house.' And I have been able to have my son.

(7, p. 3992)

Parents constructed safe and secure housing as vital for parental wellbeing, child wellbeing and the parent-child relationship (5; 7). One mother reflected on how being able to access secure housing had enabled her to focus more on her baby in the absence of stress and worry about finding suitable housing. Another mother described the link between her own sense of security provided by safe accommodation impacted positively on her babies' wellbeing:

It's the security of it. Apart from the support, I think my main one is security. I feel secure and my babies are secure.

(7, p. 3992)

Adverse community environments

Parents constructed their environments as challenging and unsafe. Parents described fears around risks to their child's physical and emotional wellbeing posed by their community environments; for example, violence, child kidnapping, drive-by shootings, speeding cars,

exposure to negative influences, and distrust of police (2; 3; 4). Parents highlighted the racism and structural inequalities that impacted them growing up and that continue to impact their communities and children now (2; 3). Other parents observed the more limited access to resources and opportunities due to these inequitable systems for parents from minoritised ethnic backgrounds (3).

There was a sense of adapting behaviour and parenting in the face of adverse environments. Parents described how these physical and psychological threats influenced their parenting towards more restrictive and controlling practices. One parent discussed restricting outdoor play:

I don't know if the kid died, but he got shot, that's the point. And so I told [my child] […] that's why I don't like them playing outside…

(2, p. 7)

Parents focused on keeping their children '*off the streets'* generally, with some putting effort into indoor activities to try to prevent them from leaving the house (4, p. 87).

Intergenerational cycles

Closely linked to the previous theme, many parents were cognisant of an intergenerational element to adversity in their communities. One mother appositely summed up this sentiment as follows:

A kid sitting in the window for her whole childhood, looking out the window because it's too dangerous to go outside . . . I sat in the window like every single day. Now it's my kids sitting in the window because I'm afraid for them to go outside because it's so bad.

(16, p. 774)

Parents observed that intergenerational community trauma can lead to survival-focused parenting practices, such as hypervigilance and 'over-protectiveness' (3; 4; 16). One parent explained how her own experiences led to her to be vigilant for potential threats:

Just be aware of what you went through. Be aware of what you went through and keep your eyes open for certain signs. So that if you see it, you can prevent it.

(16, p. 778)

Parents made the link between how they were parented in adverse contexts to how they parent their own children now (3; 4):

They're overprotective . . . When things happen to parents it's like maybe they just don't never want their kids to do nothing […], go nowhere. Just like always have their kids in their eyesight because they'll never know, like, this happened to me when I was a kid . . . It's really hard to just trust anybody.

(3, p. 280)

Often these practices appeared to conflict with parents' values and intentions in supporting their children's growth and learning in a developmentally appropriate way but were deemed a necessary adaptation to adverse environments (3). One such adaptation for some parents was encouraging responsibility and self-reliance in their children from an early age.

I hold my daughter to a higher standard for several reasons […] because of my ACEs. I want her to be able to survive even if I can't hack it or […] something takes me from her. […] So I have taken away some of the world's natural expectations of a five-year-old . . . I've made her so responsible for herself that, that way she's not completely self-reliant on me already.

(3, p. 280)

While many parents recognised the challenging parenting contexts of their own parents, many were also critical of their own upbringings, and expressed a desire to break these cycles and give their own children a better experience than they had (4; 10; 15; 16).

I didn't have an advocate, nobody spoke for me I was basically there by myself with the teachers. When we were in school we didn't have our parents that were there to back us up consistently. […] I'm going to be his advocate. I don't care what it takes, but he's going to be successful. (4, p. 88)

In this way, parents were directly linking their own experiences of being parented to how they parent their own children.

I parent them the way I wanted to be parented when I was younger and a little bit more better.

(4, p. 88)

Parental wellbeing

Parents related the impact living in poverty has on their emotional health and how this in turn affects their parenting. This theme has three sub-themes: 'the stresses and strains of economic deprivation'; 'self-sacrifice'; and 'self-blame'.

The stresses and strains of economic deprivation

Parents described how stressful financial insecurity is and how this impacts their parenting. Acute struggles with money took a significant toll on parents' wellbeing, leading to feelings of overwhelm, powerlessness, depression, anxiety, and suicidal ideation (4; 8; 9; 13).

I was so anxious about everything [...] There was a spell when basically the boys went to bed [...] and then I just collapsed sobbing on the sofa and then went to bed. I couldn't sleep because my head was just in turmoil [...] It just can feel really overwhelming sometimes.

(13, p. 237)

Parents felt that financial insecurity and other related concerns compromised their parenting (8; 9; 10; 12; 14).

It's just, you know if I had a little bit more money, I feel like I would be a little bit more at ease and I could be a better mom.

(10, p. 246).

Another mother, who was homeless, described the limitations in her capacity to be a responsive parent and the kind of mother she wanted to be, referring to this as '*the ugliest feeling in the world*' (9, p. 53). Many parents reflected on how money worries deprived them of being with their children. For some parents, this represented a physical absence due to having to work long hours or pursue further education to earn more money (10). For others,

this was more of a psychological absence, with parents commenting on the mental energy taken up by money worries (8; 9; 10; 12; 13; 14).

I was a lot more involved in the activities related to financial security during maternity leave. [...] I just feel like this took away from me the moments that I could have spent with her. I just feel like I missed out.

(8, p. 587)

Self-sacrifice

Many parents made sacrifices to put their children's needs first in strained contexts (7; 8; 11; 13; 15). Often this self-sacrifice was to the detriment of their own wellbeing.

I barely eat, and if I do, it's like a bowl of cereal at nighttime, and it's just because I'm dizzy. I have to make sure they have their formula, they have their baby food, and they have clothes [...] . . . when it comes down to me, it doesn't really matter.

(8, p. 587)

Another mother explained her efforts to facilitate her partner safely returning to their home even after he had been violent towards her because this would maximise their financial resources and benefit the children (7). Parents were cognisant, though, of the importance of self-care in parenting and of the potential negative impact neglecting their own needs could have. One mother reflected that she needed to:

Make herself a priority, respect herself, be happy, and be her own person before she can be a good mom.

(10, p. 247)

Another mother recognised that when she was able to take some time out to herself, facilitated by a supportive co-parent, she was able to be more responsive and patient with her baby (15).

Self-blame

Parents appeared to internalise blame and guilt for their challenging situations and believed they had a personal responsibility to resolve them. One parent noted the guilt they harboured

over what they perceived as parenting shortcomings and how this in turn further impacted their parenting:

The things that I put my children through, I feel like they don't deserve to be put in time out because I feel like they've been punished enough. [...] I'd be like just do whatever you want because I felt like I put them through so much they deserved to do whatever they want. That's parenting out of guilt.

(16, p. 778)

An absence of containment, structure, and limits could in turn have an unintended negative impact on children's development of self-regulation and could increase their stress. Another parent identified that blaming herself for her financial difficulties and the parenting modifications her situation necessitated negatively impacted on her emotional wellbeing:

I get depressed [...] and I would [...] just hide out in my house. And I have a hard time reaching out for help [...] because I look at [it] *as a sign of weakness and failure, so I'd rather just try and figure it out on my own. . . [...] I felt like a failure. I felt like I was undeserving of* [my kids] *and their love [...] and they deserved better and more. I think the stress of not being able to make sure they had everything they needed, maybe* [I was] *not as present as I should have been.*

(8, p. 588)

Parents' accounts revealed a sense of needing to be self-reliant to the extent that they resisted accepting help from others. Parents reported feeling ashamed when they were unable to take care of themselves and their children without help and resisted seeking help from family or assistance programmes due to feelings of personal responsibility (4, 8, 10). Indeed, some parents eschewed the '*welfare mom'* identity and criticised those they knew who '*live off the government'* (4, p. 94, 99; 11). This points towards an internalisation of dominant narratives in western capitalist societies comparing those who 'work hard' to those who 'scrounge' off the state. Other parents highlighted prejudice and judgement they have experienced for being a low-income (and young) parent (2; 11; 13). One mother felt judged for not being able to afford developmentally-focused books for her baby (11). One paper reported counter-narratives of

resistance, wherein some mothers reported being able to reject society's preconceived notions of them as young, low-income parents (11).

The parent-child relationship

Parents talked about the impact of poverty on the parent-child relationship. This theme has three sub-themes: 'parent-child relationship difficulties'; 'managing difficulty in difficult circumstances'; and 'a "good enough" relationship as a buffer'.

Parent-child relationship difficulties

Some parents seemed to be experiencing significant difficulties in the parent-child relationship due to their challenging contexts. Some appeared to struggle to understand and manage their children's challenging behaviours.

I hit rock bottom with him, and now it seems like I really can't bring him back. […] I felt like he lost respect for me because we wasn't in our home … and he's still out of control now … he mad about something…

(1, p. 12)

As this quote implies, parents appeared to feel a sense of being out of control and disempowered in the face of their children's behaviours (6; 9). This was heightened when children used physical means of communicating distress:

She likes to hit me. And only me. She doesn't usually hit her friends. Or her daddy or grandma. [...] And we don't know why. [The nurse] said there is not a lot that we can do about it right now because [...] she isn't quite understanding that it's not ok to hit because other friends do hit her.

(9, p. 54)

This sometimes resulted in parents attributing intentionality to their young children's challenging behaviour (6, 14). Some parents described children deliberately 'misbehaving':

I think he does it on purpose, everybody does. I'm like, you need to stop doing that, little man! You can't do that!

(6, p. 5)

Another parent expressed that their baby cried '*for no reason'* (15, p. 47). This suggests that in their adverse situations, parents' capacity to reflect is reduced, limiting their understanding of their babies' emotions and perspectives. This was also implied by a parent who wondered whether her two-year-old may have 'bipolar disorder':

I also have bipolar and I'm wondering if that is another thing he might have because his moods switch so quick and it's like a firecracker set off or he'll be fine and happy. [...] He'll go from happy to yelling at me. [...] He has a little bit of a anger problem. [...] When he gets frustrated, he'll start hitting himself in the face. [...] He'll pinch or bite me.

(9, p. 70)

Managing difficulty in difficult circumstances

Some parents reported using some potentially harmful strategies for managing their children's challenging behaviour. For some parents, physical punishment was constructed as an undesirable but necessary tool to regain control (1; 4; 6).

It's not that you want to strike your child […] you just want your child to stop. You just want your child to know, I say no and, again, no means no.

(6, p. 5).

Other parents presented it as an impulsive and last resort measure, which generally happened when they felt pushed to their limit and other methods had failed. Still other parents explained their use of physical punishment as a means of preparing their children due to fears for their future and the outside world (3). Some parents identified a need to remove themselves from a situation to avoid responding violently towards their children (6). However there appeared to be times when the length of the unsupervised separation seemed unsafe given their child's young age or the separation was used as a punishment (6).

A ‘good enough’ relationship

Despite their ongoing hardship, many parents were aware of the importance of the parent-child relationship, its ingredients, and its potential to buffer adversity in childhood.

Just having that bond with your child that nobody else can have, [...] simple things like if they get scared of something they run to you [. . .] the basics, making sure he’s clean, his room is tidy and he has clean clothes [. . .] you know that somebody’s a good mom if you can tell that their kids like want to be around them.

(11, p. 283)

As this quote also suggests, parents identified the ever-changing balance in early childhood between the need for safety and comfort and the need for independent exploration (3). One mother summarised:

[I]t is knowing that children are in early stages of learning on their own . . . We have to teach them to be strong as they learn on their own because […] at that age, they will take off on their own not knowing […] what’s safe and what’s not safe.

(3, p. 277)

A similar trade-off was identified in the need to be an authority figure to their children, but not at the expense of their relationship.

When I say no, it’s no […]. When I tell you sit down, it’s sit down. Stop, it’s stop. I’m the mom and you’re the child. […] That’s how I and my mom was. But […] it was different because at one point I was scared of her. I don’t want my daughter to be scared of me. (4, p. 89)

Parents recognised open communication and ‘being with’ children in their emotions as key components of a good parent-child relationship during adversity. One mother reflected on how honesty and clarity about living in a homeless shelter had been helpful for them to manage their difficult feelings (9). Another parent reflected on the importance of expressions of love and containing children’s emotions for them in difficult times (16). These parents were able to mentalise and understand their child’s perspective despite ongoing challenges. Parents who were more able to do this took measures to mitigate the potential negative impact their difficult

situations may have for their children; one parent spoke about taking her six-year-old daughter to visit a homeless shelter before they lost their home, so she knew what to expect. (9)

The early years support landscape

The role of support and social connections was constructed by parents as either buffering adverse contexts and facilitating their parenting or as exacerbating parenting difficulties if absent or poor. This theme was thus constructed into three sub-themes: ‘support is absent’; ‘support is present but unhelpful’; and ‘support is present and helpful’.

Support is absent

Many parents described experiences of not getting the right support, either in their own social networks or from institutions and systems. Parents highlighted difficulties accessing affordable, high-quality childcare, particularly out of school hours and specialist care for children with disabilities (2). For one parent, the consequence of a lack of childcare support was such that she could not maintain her job and care for her three children and thus she became homeless (9). Parents who had been homeless reported that shelters were not child- or family-friendly and were not equipped to understand or cater for their specific needs (9).

They assess us as adults and as moms, [...] but they need to look at the kids too and kind of assess them and be like, ‘Ok, this kid needs more help because of this’.

(9, p. 99)

Other parents recalled experiences of reaching out for help but not getting it (4; 9).

Many parents bemoaned the inadequate benefits available to them as not covering their various outgoings and financial responsibilities (8). Some parents described their experiences of losing out on vital benefits due to punitive eligibility criteria; for example, losing resources from assistance programmes following a raise or taking on more hours. Another parent explained how she received sporadic child support payments from her ex-partner, which was just enough to render her ineligible for subsidised childcare (4). Pregnancy was associated

with financial difficulty, especially when maternity pay was inadequate or in some cases non-existent (8).

Some parents had limited social support, in particular lone mothers and parents who had been homeless (4; 12; 13). A vicious cycle was identified wherein social isolation exacerbated their financial struggles, which in turn increased their isolation due to a lack of time, money and emotional resources (13).

Support is present but unhelpful

Some parents recalled experiences of services being unhelpful and inappropriate. Parents highlighted the inflexible and impractical nature of support offered to them, for example offering appointments only during work hours (4). Another mother described how she was eligible for an education programme that would open the opportunity for higher earnings, but was required to work to qualify for the programme and no childcare was available (4). Similarly, other parents highlighted unreasonable demands and expectations that support services placed on them. One mother reflected:

People think 'that girl's not spending enough time with her kids because [...] she's working all of the time', well, if that girl wasn't working all the time she wouldn't even have her kid!

(11, p. 282)

Another mother recalled how she was unable to complete the requirements of her parenting programme given she worked full-time and had four young children to look after without support, leaving her feeling frustrated and that she was being set up to fail (4).

Some parents criticised the content of advice or education they were offered. One mother questioned the value of a parenting programme that focused principally on babies' cognitive development and overlooked their emotional wellbeing:

It's like they're trying to raise these little like geniuses [. . .] and to make the economy grow almost, but it's like, sure your baby's going to be smart and stuff, but is he going to feel

secure? Is he going to feel loved? Is he going to feel pressured? Is he going to feel like he has to do these things to be accepted?

(11, p. 283)

Another mother expressed that she felt the parenting advice given to her was often based on middle class ideals and advantages (11). Some parents reported finding early childhood professionals judgemental and that they made assumptions about them and their parenting. One mother recalled being made to feel like a '*bad mom'*, describing the experience as '*humiliating*' and like she was being '*put under a microscope'* (4, p. 97). Other mothers echoed this, expressing they wished professionals dispensed with negative stereotypes, showed them respect, and tried to understand their challenges (4; 14).

It is like no one takes no time to talk to me. Sometimes I get an attitude when I get real depressed and no one says, 'Why you have so much anger, talk to me.' They would be like, 'oh, she has her attitude, then goodbye.' That is how it has always been in my life. I never had nobody […] be there for me and listen.

(4, p. 100)

This sometimes appeared to lead to a lack of trust and a barrier to seeking help, reinforcing parents' beliefs that only those with shared backgrounds could understand and help them (4).

You don't know who you can trust. They don't really know about you and at the end of the day they go home to they house and they white picket fence and leave you where you're at. What do they know about helping you? Or they say they gonna help and do nothing.

(4, p. 99)

Some parents felt the mental health interventions they were offered were either medicalised (e.g., offering antidepressants) or individualising (e.g., cognitive behavioural therapy [CBT]); both serving to pathologise what they saw as contextually located distress:

He [GP] then referred me to, what I was told was counselling, but ended up being CBT [...] It was a complete waste of time. [...] The stresses and things I was feeling was not due to any habits that needed changing. It was due to [...] my life being completely turned upside down.

(13, p. 239)

Support is present and helpful

Parents who had strong social support constructed this as mitigating some of the parenting challenges induced by hardship (5; 8; 15). Sometimes this was for emotional support and social contact (4; 5; 15).

> *I think that as human beings everybody feels better by being in company and around people…I think it's important for me and for the children.*
>
> (15).

Many parents saw children's centres as a critical resource in alleviating some of the pressures on their parenting. Some parents accessed vital material support from centres, such as nappies and grocery vouchers (11). The crucial advisory and signposting role of children's centres was highlighted by parents (12; 13); one parent reported that she '*wouldn't have dreamt'* of asking for help from a food bank if the children's centre had not raised it (13, p. 237).

For many parents, children's centres represented opportunities for social contact for them and their young children (15). For some, particularly lone parents, attending programmes with a crèche provided their only opportunity for social time away from their children, which was presented as important for their own wellbeing (11).

Gendered parenting

The gendered nature of parenting and experiences of poverty featured in many parents' accounts. Most parents in the studies included were mothers, often without a co-parent. The absence of the father is often assumed but sometimes directly addressed. In one study, the mothers felt that the lack of a male presence or role model made disciplining their children, particularly boys, more difficult since female authority is not respected in the same way (4). In many cases, mothers assumed caregiving responsibilities either in the absence of a co-parent, or a father who was not engaged in parenting tasks (4; 12; 15).

Many parents highlighted stereotypes and societal expectations about mothers and fathers, positioning fathers as providers and less competent caregivers than mothers (2; 5). In the context of economic deprivation, when fathers were unable to provide, this could impact on their mental wellbeing and lead to a disengagement in parenting, leaving caring responsibilities to mothers and causing tension in the co-parenting relationship (5). The intersection of race and gender was raised by one father, who explained:

Being an African American, people already look at you and say, 'Hey, you're not gonna be there for your child'. It's like a stereotype.

(2, p. 8)

These roles were reinforced structurally in a shelter context where families were separated; this was harmful for both mothers and fathers since women were solely responsible for childcare and men were excluded (9).

Discussion

Summary of main findings

This is the first systematic review of qualitative evidence to examine the impact of poverty on parenting and the parent-child relationship from the perspectives of parents of young children. The experiences of 274 parents as explored in 16 papers were thematically synthesised. The review has illuminated that parents experienced poverty impacting their parenting and relationship with their young children at the individual, family, community, and societal levels.

Poverty at a community level threatened parents' ability to keep their children physically and emotionally safe. Unsafe environments necessitated adaptations to parenting, such as increased control, restriction, and hypervigilance, which were at once contextually appropriate and capable of impacting children's healthy development. Parents observed how these parenting practices and relational difficulties were passed down the generations due to

structural inequalities. This is demonstrated in the 'Pair of ACEs' model, which depicts how 'adverse community environments' such as poverty, racism, poor housing quality, and community violence are at the root of 'adverse childhood experiences' (ACEs) such as emotional abuse, parents with mental health difficulties, and neglect (Ellis & Dietz, 2017). Persistent exposure to these adverse experiences in childhood is connected to emotional and behavioural difficulties in childhood and health and wellbeing challenges across the lifespan (Anda, et al., 2006; Ellis & Dietz, 2017).

Poverty at the individual and family level was detrimental to parents' emotional wellbeing. It jeopardised parents' abilities to parent in sensitive and responsive ways, since the stresses and strains of financial hardship culminated in physical or psychological absences. Many parents made significant sacrifices to prioritise their children's needs, which affected their wellbeing in the absence of opportunities for self-care. Daly & Kelly (2015) and Gillies (2005) emphasised the commitment of parents on low incomes to be 'good parents', including going without to provide for them, and striving to protect their children from hardship, but how this was constrained by lack of access to resources, and social and cultural capital. Parents experienced guilt and blamed themselves for their financial situations, which often led to a resistance towards seeking help. Sometimes this impacted on parenting and therefore in turn potentially on child outcomes; for example, a guilt-induced lack of limit-setting or taking the lead may not offer the containment and structure young children need for development of emotion regulation capacities (Gerhardt, 2014).

In the context of acute strains on their emotional resources, and a potentially limited repertoire of coping mechanisms due to their own adverse experiences, challenges in the parent-child relationship were evident for many parents. Some parents struggled to understand their young children's challenging behaviours, or to support them to communicate in different ways. At times, this appeared to lead to a misattribution of malicious intention towards their young children's behaviours and communication, suggesting their reflective functioning capacity was

constrained by the limited emotional resources left over in the context of dealing with adversity. Some parents used harmful strategies for managing young children's challenging behaviours and their emotional responses to this, for example, physical punishment or unsupervised separation. Reflective functioning or mentalising capacity is considered a key facilitator of secure parent-baby relationships but has been found to be compromised when parents experience high stress or mental health difficulties, such as those caused by poverty (e.g., Sadler, et al., 2013; Sleed, Slade, & Fonagy, 2018).

At the same time, many parents seemed to be aware of the importance of the parent-child relationship and its potential to moderate the impact of adversity. These parents understood the necessary balance between meeting developmental needs for safety and comfort, and for independent exploration and discovery. They valued open communication and identified their role in 'being with' children in their difficult emotions. There was a sense that even in the face of significant adversity, with the right support networks (professional or personal), many parents were able to provide 'good enough' parenting (Winnicott, 1973). Attachment theory literature has demonstrated the importance of secure, responsive, and attuned early relationships for babies and young children, positing that they have stress-buffering potential (e.g., Centre on the Developing Child, 2007; Gerhardt, 2014).

Parents were unequivocal that support and social connection was vital for facilitating their parenting. Early years services, such as children's centres, were a critical resource for practical and material support, and for increasing parents' social contact. Parents with strong social networks relied on these for emotional support, which was beneficial to their own wellbeing. When support was absent or unhelpful, this exacerbated parenting challenges. State financial support was inadequate in covering parents' daily living expenses, and the cost of good-quality childcare was prohibitively high. Many parents' experiences of support services were poor. For some, support offered was inflexible or impractical, betraying a lack of understanding of the context of their lives. Others experienced early childhood professionals

as othering, judgemental and critical of their parenting, which could lead to a disengagement from seeking help.

There is a long history of demonising parents on low incomes and blaming poor child outcomes on 'bad' parenting (Cooper, 2020; Shildrick, MacDonald & Furlong, 2016). The results of this review challenge this narrative, portraying instead parents who have experienced trauma, racism and discrimination, social isolation, and ongoing economic hardship. For many, their own experiences of being parented were beset by similar adversities. What emerged was not deficient parenting, but rather parenting that was adapted to the adverse circumstances in which parents found themselves.

Strengths and limitations

The number of reviewed studies was relatively large for a review of qualitative studies, which may counterbalance any methodological limitations associated with one qualitative approach (Sandelowski, Docherty, & Emden, 1997). The collective sample was ethnically diverse, which is an important strength, given that figures suggest that people from minoritised ethnic backgrounds are disproportionately impacted by economic hardship, unsafe neighbourhoods, inadequate housing, and inequitable access to services (DLUHC, 2020a, 2020b, 2020c; ONS, 2020, 2022b; Raleigh, 2023; Weinstein, et al., 2017).

The collective sample comprised overwhelmingly mothers or female-identifying caregivers. This is a strength since women still assume most childcare tasks and responsibilities, including 'invisible' work such as cognitive and emotional labour – even when in paid employment – and most lone parents worldwide are mothers (Daminger, 2019; Reich-Stiebert, Froehlich, & Voltmer, 2023; Woessmann, 2015). However, it provides less insight into the experiences of fathers, whether involved or not, in the care of their children. Enhancing fathers' role in the care of their children is a feminist concern, and is beneficial for fathers, mothers, and children alike (Doucet, 2017). Future research should endeavour to include the perspectives of fathers

and male-identifying caregivers, including perceptions of the barriers and facilitators to greater involvement in childcare activities.

The experiences of same-sex or other LGBTQIA+ parents were not explored in any of the studies. This is a significant omission given the social stigma and oppression faced by the LGBTQIA+ community, which future research should seek to rectify.

Most of the studies were based in the USA. Although qualitative research does not prioritise generalisability of results, the dominance of USA-based studies does mean the experiences are situated in an, albeit heterogeneous, American context.

While over two-thirds (69%) of the studies were rated 'high' quality, there were notable quality criteria that several of the studies failed to meet. For example, 11 papers did not include consideration of the relationship between researcher and participants. Reflexivity is considered crucially important to ensuring rigour in qualitative research, since the researcher is not positioned as an objective observer but an active participant themselves in constructing the data (Dodgson, 2019). Six papers did not contain enough information to ascertain whether the research design was appropriate to the aims, which leaves doubt around whether other methods may have been better suited for addressing their research questions.

Recommendations for future research

Future research should consider exploring overlooked stories in parenting literature, such as those of LGBTQIA+ communities and fathers, and how these intersect with experiences of poverty.

Given the paucity of studies exploring experiences of parenting young children in poverty in local UK contexts, this would be a valuable future direction of study. This would contribute to

our understanding of how continued austerity measures and the current cost-of-living crisis are affecting families.

Implications

The results of this review have several relevant implications for practitioners, including clinical psychologists, and policymakers in early years services.

Tailored and flexible support

Parenting support, whether group or individual, should be trauma-informed and developed as far as possible with and for the parents local to their service and their specific needs, including those from minoritised ethnic backgrounds (Ishimaru, 2014; Osman, et al., 2021; Sheller, et al., 2018). This is likely to require more flexibility and clinical judgement than that afforded by rigid adherence to programme manuals or protocols. In this way, practitioners can model the kind of attuned and responsive behaviours they are encouraging parents to emulate with their children. This is especially important given many of these parents may have limited experience of relationships of this kind. This may involve peer support, for which there are several models and can be tailored to the needs of the community (Moran, 2020). For example, this could involve a birth companion for asylum seeking women, or one-to-one or group emotional support for socially isolated new parents (Birth Companions, n. d.; Moran, 2020). A narrative review found that peer support interventions for marginalised and disadvantaged parents was generally well received, with an emphasis on flexibility and matching peer supporters based on cultural background, ethnic group, religion, or language (Kåks & Målqvist, 2020). The importance of adequate and ongoing training and supervision has been highlighted as key for the safety and quality of peer support (e.g., Barlow & Coe 2012; MacLeish & Hann, 2019).

Contextual approach

Practitioners should not seek to assess or modify parenting practices in isolation but situate these in parents' wider social contexts. Parenting programmes should avoid narratives that

pathologise parents and view them as individually responsible for child wellbeing; this might also involve interventions targeted around reducing guilt and shame (Wall, 2010). Parents want to feel their stories are heard and their contexts are understood by practitioners who are not judgemental (Aguilar-Gaxiola, et al., 2012). Parenting support should involve acknowledging and where possible working alongside parents to address contextual factors; for example, linking in with housing providers, benefits support agencies, and local children's centre support schemes (Lucas, 2011).

Reflective practice & supervision

Working with parents experiencing marginalisation and difficulties in the parent-child relationship is emotionally taxing work. Much like parents need support from their network for good parent-child relationships, to 'be with' parents in their distress, practitioners need to feel well-supported. Clinicians should be supported to practise cultural humility; a lifelong commitment to reflexivity, curiosity, and learning from and with clients (Tervalon & Murray Garcia, 1998). Masters, et al. (2019) developed a clinician tool designed to support this process, the '5Rs of cultural humility', which aims to 'bring more awareness into clinical encounters', of the clinician's own identities and biases, and the client's individuality (Masters, et al., 2019, p. 628). Robust clinical governance structures which embed regular specialist clinical supervision, and reflective practice are necessary.

Policy reform

Practitioners must collect evidence on and speak out about the various ways parents are oppressed by social and economic policies evident in our clinical practice. For example, routine outcome monitoring should include data on the impact of socioeconomic marginalisation on wellbeing. This kind of data and research findings can be taken to commissioners to influence funding decisions and shape service design. We must advocate for policy change in directions which redistribute wealth and channel funding towards preventative and early years services. This might involve joining campaign groups such as

Psychologists for Social Change, a branch of which developed a briefing paper collating evidence on the psychological impact of austerity (McGrath, Griffin, & Mundy, 2016). It could involve direct lobbying of politicians such as MPs and councillors and working in partnership with colleagues in public health and local authorities.

Conclusion

This systematic review and thematic analysis found that parents in poverty perceived myriad challenges to their parenting. Parents experienced poverty operating at multiple levels which at times jeopardised their ability to parent in ways which aligned with their values, and which cultivated positive parent-child relationships. Social and economic policies and structures were understood to exacerbate parents' hardship, and support structures which could mitigate some of this disadvantage were often absent or unhelpful. This review rejects the pathologising narrative of 'bad' parents and instead emphasises the resilience of parents in these contexts who can adapt their parenting strategies to work within toxic parenting environments. It is imperative that parenting interventions acknowledge parents' social context and offer a flexible and adapted approach. Clinical psychologists should use their power and resources to join the growing movement advocating for social and economic policy reform.

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Chapter 2

Parents' stories of caring for a baby in the context of austerity and a cost-of-living crisis.[3]

Chapter word count: 14,169

[3] I prepared this chapter for publication in the Journal of Social Policy & Administration, which adheres to APA 7 style (Appendix III). The word count has been extended to provide sufficient detail for examination.

Abstract

Background

Austerity measures implemented since 2010 have been linked to increased poverty and inequalities. Experiencing poverty in early childhood puts this critical period for babies' healthy social, emotional, and cognitive development in jeopardy. Parents' capacity to provide sensitive, warm, and responsive care is compromised in environments in which their ability to meet basic needs is under threat. Concurrently, austerity measures have served to reduce the support available. While a growing body of evidence points to the damaging effects of austerity for family wellbeing, limited research has explored parents' own experiences of austerity in the UK context.

Methods

Ten parents with babies participated in narrative interviews, which followed the Biographical Narrative Interpretative Method. This involved a single question followed by further prompts dependent on the stories participants told. Interviews were audio recorded, transcribed, and analysed.

Results

Themes, important events, and experiences within individual stories are shared diagrammatically, followed by the telling of a meta-narrative. Three sub-narratives were constructed: 'Small government, big problems'; 'It takes a village'; and 'The personal is political'. Results indicated that parents and thus their babies are harmed by the financial precarity induced by austerity measures and a contraction of public services, and by austerity discourses.

Conclusions

Hearing the stories of this marginalised group has provided insight into their experiences and needs. Implications for clinicians and policymakers are discussed, advocating for relationally-informed, socially-contextualised approaches to clinical work, the delivery of services, and the development of policy.

Introduction

A time of unique opportunity and vulnerability

Babies are born 'ready to relate'; they recognise and seek out human faces and show a preference for their caregivers' voices (Carnevali, et al., 2022; Sullivan, et al., 2012). Attachment theory posits that secure attachments develop when caregivers respond sensitively and predictably to their babies' needs (Bowlby, 1988). Securely attached babies and children treat their caregiver as a secure base from which they can explore and learn, and a safe haven to which they can return to seek comfort and protection when feeling threatened or afraid (Waters & Cummings, 2000). Patterns of relating in early life are thought to form a template or 'internal working model' for future relationships (Sherman, Rice, & Cassidy, 1999). This instinct to seek proximity to caregivers is necessary for survival, but also for cognitive and emotional development. Babies' brains demonstrate high neural plasticity, meaning they adapt and change in response to experiences and stimuli (DeMaster, et al., 2019). The everyday interactions between baby and caregiver enable the brain to create neural pathways. As Siegel puts it: 'human connections create neural connections' (Siegel, 1999, p. 85). For this reason, the period from conception to age two is considered a sensitive period for development, often termed the '1001 critical days' (Parent-Infant Foundation, n.d.). These early relationships and experiences lay the foundation for a range of later developmental outcomes, including self-confidence and self-worth; curiosity for learning; platonic and romantic relationships; emotion regulation; and emotional wellbeing (National Scientific Council on the Developing Child, 2004).

When caregivers are unable to respond to their baby's needs in a sensitive and predictable way, babies can develop insecure attachments (Ainsworth, et al., 1978). Babies develop alternative strategies to maintain proximity to their caregiver, which have been linked to a range of poorer outcomes in later life, including in relationships and emotional wellbeing (Asmussen & Brims, 2018; Fearon, et al., 2010; Newman, Sivaratnam, & Komiti, 2015). In the

absence of a secure attachment figure, experiencing stress during infancy, such as that caused by poverty and other adversity, can damage developing brain architecture (Center on the Developing Child, 2007). In this way, the parent-infant relationship can be seen as the 'conduit through which infants experience environmental risk factors' (Zeanah & Zeanah, 2009, p. 8).

Decontextualised development

Attachment theory can be criticised for being westernised, sexist and heteronormative, as well as rigid and deterministic in its attachment style categories (Cleary, 1999; Cox, 2006; Duschinsky, 2021, Grossmann & Tan, 2020). Specifically, messaging around the primacy of the mother-baby dyad arguably serves to undermine the role of fathers and same-sex parents; reinforce sexist discourses confining mothers to the domestic sphere; and negate a more collectivist approach to family and childrearing, in which babies are more likely to have multiple attachment figures (Cleary, 1999; Crespo, 2012; Wray, 2015). Its decontextualised approach leaves it vulnerable for co-option by neoliberal ideologies, which 'treat the emergence of the self-sufficient individual as a process which occurs naturally in families and does not require health, social or political resourcing' (Duschinsky, et al., 2015, p. 189).

There is renewed impetus to recognise the importance of early childhood from policymakers and public figures (e.g., Centre for Early Childhood, 2023; Department of Health & Social Care [DHSC], 2021). The Adverse Childhood Experiences (ACEs) literature has demonstrated that childhood exposure to multiple 'adverse experiences', such as being abused or witnessing domestic violence, leads to negative outcomes for health and wellbeing across the lifespan (Bellis, 2014; Felitti, et al., 1998). Efforts to reduce the incidence and impact of ACEs have moved up the policy agenda (Finkelhor, 2018). The wider socio-political context to early childhood and parent-baby relationships, though, is often overlooked (McEwen & Gregerson, 2019; Taylor-Robinson, Straatmann, & Whitehead, 2018).

This thesis assumes the core tenets of attachment literature that babies need to feel safe and secure in their early relationships with caregivers who can provide sensitive and responsive parenting to a 'good enough' level (Winnicott, 1973). It presupposes that general patterns of behaviour develop in response to interactions with caregivers, akin to the secure and insecure attachment styles, but that these are dynamic and can evolve across time and contexts (Crittenden, 2007). It takes a contextualised approach to attachment, understanding that these relationships do not develop in a vacuum, but in relational, systemic, political and historical contexts. Bronfenbrenner's ecological systems theory emphasised the importance of these different levels of influence on babies' and children's development (Bronfenbrenner, 1977). This thesis will not only consider parent-baby attachments, but also parents' systems of attachment with, for example, political institutions, support networks, and healthcare systems. A major macro-system influence for over a decade has been the government's adoption of 'austerity', the context and significance of which will be outlined in the following section.

The age of austerity

Following the global financial crisis of 2007/08 and their accession to power in 2010, the UK coalition and successive Conservative governments embarked on a journey towards systematically reshaping the role, scope, and size of the welfare state. Initially positioned as an economically prudent strategy to address the budget deficit, welfare state retrenchment formed part of an ideological pursuit of 'a leaner, more efficient state' (Cameron, 2013; Taylor-Gooby, 2012). Since 2010, an unprecedented range of measures have been introduced, representing the biggest and most prolonged cuts to public spending since the Second World War (Crawford, 2010). The cost of the austerity programme to public expenditure has been estimated at £540 billion across 2010-19 (Calvert Jump, et al., 2023). Under welfare reform, cuts to working-age benefits totalled more than £30 billion between 2010-19 (Timmins, 2020). This included a benefits 'freeze'; local housing allowance cuts; disability benefits changes; local council tax relief variability; a two-child cap for child benefit; and an overall cap on benefits (Beatty & Fothergill, 2016). The reforms extended welfare conditionality, by reserving benefits

for those working or seeking work, and raised eligibility thresholds for parents of young children, unemployed and disabled people (Barford & Gray, 2022). A system of sanctions was introduced to enforce the new system, including withdrawal of support as a penalty for missed appointments and other transgressions (Barford & Gray, 2022). Funding for local authorities has been cut by 49.1% in real terms over the period 2010-18, which translates into a reduction in real spending power of 28.6% (National Audit Office, 2018). At the same time, demand for services has increased; for example, homelessness services and adult and children's social care (National Audit Office, 2018). Between 2010-19, the NHS's annual budget increase was reduced by an average of 1.4% compared to the usual annual increase of 3.7% since its creation (NHS Confederation, 2022). Public sector pay has reduced in real terms by 4.3% since 2009, with some occupations facing worse cuts (Office for National Statistics [ONS], 2022). These retrenchments are interlinked and compound each other.

The effects of these austere policies have been profound, far-reaching, and long-lasting. While poverty and inequalities in the UK are not new phenomena, austerity measures served to reverse progress and made these problems more entrenched (Marmot, 2020; Stubbs, et al., 2021). Austerity has worsened the social determinants that impact on mental and physical health in the short, medium, and long term (Marmot, 2020). The Psychologists Against Austerity campaign group identified five 'austerity ailments', which encapsulate the psychological cost of austerity: humiliation and shame; fear and distrust; instability and insecurity; isolation and loneliness; and being trapped and powerless (McGrath, Griffin, & Mundy, 2016).

Increasing inequalities

Analysis by the Equality and Human Rights Commission (EHRC) has demonstrated that welfare reform has been regressive; those in the lowest two deciles lost approximately 10% of their net income, increasing to 20% among those with children (Bourquin, Norris Keiller, & Waters, 2019; Portes & Reed, 2018). The EHRC found that the negative impacts of welfare

reform are felt most acutely for disabled people, lone parents, women, and children (Portes & Reed, 2018). Women are more likely to work in public services and women of colour are both more likely to be employed in the public sector and in low paid, temporary work, regardless of educational qualifications (Emejulu & Bassel, 2017; NHS England, 2021; Skills for Care, 2022; Department for Education, 2023). Moreover, women are disproportionately impacted by reduced social security and public services as they are more likely to be on a low income, have a disability, and have caring responsibilities (Women's Budget Group, 2021).

Families with babies and young children have been especially impacted by austerity measures due to welfare reform and cuts to early intervention and preventative services. Child poverty has increased under austerity, especially for larger families and families with lone parents (Cribb, et al., 2022). There has been a 62% reduction in council early years spending, leading to the closure of between 500 and 1000 Sure Start children's centres since 2010 (Smith, et al., 2018). Many centres have reduced timetables and facilities (Smith, et al., 2018). Between 2014/15 and 2017/18 the number of children accessing children's centres fell by 18%, with the greatest decline in the most deprived areas (22%) compared to more affluent areas (12%; Action for Children, 2019). It is estimated that there has been a reduction of 30% in the health visiting workforce (First 1001 Days Movement, 2022). This can be linked to government funding decisions; the public health grant has been reduced by 26% since 2015/16 (Finch, & Vriend, 2023). In 2022, 18.6% of babies and 27.7% of toddlers missed out on their respective reviews (Office for Health Improvement and Disparities [OHID], 2022; First 1001 Days Movement, 2022). As Marmot stated: 'austerity will cast a long shadow over the lives of the children born and growing up under its effects' (Marmot, 2020).

Crisis begets crisis

During the Covid-19 pandemic, austerity measures were paused, with an expansion of emergency government spending and borrowing (Brien & Keep, 2023). Austerity left the nation's health and public services ill-prepared to withstand the pressures and toll of Covid-19

(Arrieta, 2022; Blackburn, 2020; Marmot, 2020). The inequalities in health and healthcare access deepened by austerity meant that people from minoritised ethnic backgrounds and people living in deprived areas were more likely to be infected with and die from Covid-19 (Arrieta, 2022). As the UK emerges from the Covid-19 crisis, we have found ourselves in a 'cost-of-living crisis', in which many households are unable to afford to heat their homes or afford essentials due to a rapid fall in real disposable incomes (Hourston, 2022). While the 'cost-of-living crisis' is a global phenomenon, the UK has been one of the worst affected wealthy countries (OECD, 2022). This can be attributed to the fragile foundations established by a decade of austerity cuts, and the impacts of Brexit (Dhingra, et al., 2022; Hall, 2022). Families with young children are one of the most significantly impacted groups; the Joseph Rowntree Foundation (JRF) found that a third of families with a pre-school child cannot afford vital everyday items (Parker, 2021). The austerity agenda has been re-introduced in 2021/22, which, combined with the current 'cost-of-living crisis', is forecast to further deepen poverty and inequalities (Hall, 2023; Marmot, 2020).

Parenting in austere environments

Parents need to be sufficiently internally and externally resourced to enjoy their relationship with their baby, be present and attuned to their baby's needs (Gerhardt, 2014). In other words, parents too need to feel safe and secure in their adult relationships and environments to provide their babies with safety and security. Chronic stress associated with financial hardship and structural inequalities, in conjunction with unsupportive or absent relationships, can deplete these resources (Gerhardt, 2014). The 'Pair of ACEs' model depicts how poverty and other systemic inequalities, described as adverse community environments, are often at the root of adverse childhood experiences (Figure 2; Ellis & Dietz, 2017). Austerity could be seen as creating the conditions for adverse community environments, providing fertile ground for these roots to grow.

Figure 2.

'Pair of ACEs' model. Adapted from Ellis & Dietz (2017).

Feeling the austere

Austerity scholars have highlighted the importance of exploring the everyday landscapes of austerity, since viewing it only at the macro-political level renders invisible its consequences on our collective mental ecologies (Hitchen & Shaw, 2019). Studies examining the affective experience have identified a sense of accepting hardship as necessary and 'diminished expectations' of the state, thereby localising a level of blame and responsibility within the individual (Bhattacharyya, 2015, p. 32). There is a long history of blaming parents for their hardship and children's poor outcomes, but this has intensified under austerity with narratives of 'problem families' (Cooper, 2020; Lucas, 2011; Shildrick, MacDonald & Furlong, 2016).

Successive Conservative governments have viewed parenting primarily as the job of individual families, which can be seen in the language around the child poverty agenda (Gentleman, 2015).

The UK government does not scrutinise the cumulative impact of austerity measures at a population level, nor the localised impact on communities (Aldridge & MacInnes, 2014; Barford & Gray, 2022). A growing body of research, however, has concluded that austerity measures have worsened a range of indicators with well-established links to poorer emotional and physical health outcomes (Beatty & Fothergill, 2016, 2017; Barford & Gray, 2022; World Health Organisation, 2008). Austerity discourses have also been linked to a further shaping of the collective mindset towards individual responsibility and self-reliance, which inculcates feelings of shame and self-blame, known to be corrosive to emotional wellbeing (Duncan & Cacciatore, 2015; Kim, Thibodeau, & Jorgensen, 2011).

The current study

This study seeks to contribute to the body of evidence by hearing parents' stories of caring for babies in the context of austerity as well as how it shapes their internal worlds. It aims to understand how austerity is lived but also how it is felt.

Aims

- To hear the stories of parents caring for a baby in the context of austerity and a cost-of-living crisis.
- To understand how austerity shapes parents' external and internal worlds.
- To construct a collective narrative of parents' stories situated in a socio-political context.
- To develop recommendations to inform service provision and practice at the secondary prevention level, and influence policy and decision-making at the primary prevention level.

Method

Epistemological position

This study assumes a social constructionist perspective, viewing knowledge and realities as socially constructed and situated. It does not presuppose the existence of one 'reality' or 'truth' that can be uncovered by an objective researcher. Rather, it seeks to construct knowledge at the interface between participants' social contexts and internal worlds: how do participants experience socially-mediated events and processes, and what meanings do they ascribe to them?

Design

This study used a qualitative narrative inquiry design. Narrative inquiry is concerned with experiences as expressed through individuals' lived and told stories (Creswell & Poth, 2018). It is interested in the wider context in which the narrative is constructed, comprising an 'exploration of the social, cultural, familial, linguistic, and institutional narratives within which individual experiences were, and are, constituted, shaped, expressed and acted' (Clandinin, 2013). Narrative analysis is well-suited to this study since it is inherently socially and politically situated and aligns with the epistemological positioning of the research (Czaniawska, 2004). Moreover, the collaborative and empowering approach in narrative analysis is appropriate for a group who often experience their stories and voices being dismissed and shamed (McGrath, Griffin, & Mundy, 2016). It is an opportunity to re-frame and 're-story' some of the pervasive social narratives that shame and blame and locate 'problems' in individuals rather than in systems and structures.

Sample

Ten participants were recruited through purposive sampling. Participants volunteered on the basis that they were struggling financially, which was self-defined, and guided by the questions on the recruitment flyer (Appendix IV). The other inclusion criteria were having a baby under

two-years-old, and the ability tell their story in English; however, we offered the possibility of an interpreter. Narrative inquiry does not prioritise generalisability, but, rather, seeks to generate rich and in-depth data to offer insight into the subjective lived experiences of participants (Padgett, 2012). This sample size was judged by the research team to be sufficient to generate rich enough data and meet the research aims of exploring individuals' stories and developing collective narratives.

Participants were recruited through a combination of methods: through a third-sector parent-baby relationship service (*n*=6); word of mouth or flyers (*n*=3); social media (*n*=1). All resided in the north-west of England, either in city A (*n*=8) or city B (*n*=2). I briefed colleagues at the service and provided physical and digital copies of the recruitment flyer and participant information sheet (Appendix V). Colleagues at the service informally shared information about the study with families in clinical sessions and group events. Interested parents were given the option of contacting me themselves or having their contact details passed on for me to contact them. I shared the flyer on my Twitter page. I approached local community services (for example, children's centres) and administrators of relevant Facebook groups (for example, parenting groups) to request sharing of the flyer on their social media pages.

Participant demographics

The majority (*n*=8) of participants identified as White British. One participant identified as Black African and one as White Other. Nine participants identified as women and one as a man. All participants identified as heterosexual. All participants were biological parents and primary caregivers of their babies. The mean age of participants was 32 (range 23-46) and the mean age of their babies was 11 months (range 2-18 months). Four parents were lone parents and six were co-parenting. One parent had a learning difficulty.

Setting

Participants were recruited between December 2022 and April 2023 in the north-west of England. City A and city B are two of the most deprived local authority areas for unemployment, income deprivation and indices of deprivation (Centre for Cities, 2023; Ministry of Housing, Communities & Local Government, 2019; ONS, 2021). On a per capita basis, city A has seen the largest cuts of any local authority under austerity; a £441 million reduction in spending equating to £816 decrease per resident (Centre for Cities, 2019).

Ethical considerations

The study received ethical approval from the University of Liverpool Research Ethics Committee (reference 10662; Appendix VI). This followed careful deliberation of the following ethical issues raised by the research.

Informed consent

An ‘easy read’ participant information sheet was developed to enhance accessibility in recognition of potential variability in literacy levels in the target population. All participants attended a telephone pre-interview meeting in which I explained the purpose and rationale of the research and what participation would involve. Participants were given opportunities to ask questions before signing consent forms (Appendix VII).

Coercion

The possibility for coercion was minimised by recruiters holding in mind the inherent power imbalances, discussing these in supervision, and making it clear that participation was voluntary and would not affect their care under the parent-baby service or any other support agency.

Anonymity

Participants were informed before the interviews that direct quotes would be used in the write-up of the thesis, but that these would not include any personally identifiable details. Participants were given the option of providing their own pseudonyms; three did so and I chose the remaining seven.

Distress

In recognition that the interviews could be emotive and cause some distress for participants, the following actions were taken:

- Participants were reminded of their right to leave the interview or have a break, as well as their right to request their data be removed from the study up until two weeks post-interview.
- Participants were given a debrief form (Appendix VIII) with signposting to support.
- I emphasised to participants who attended with their baby (*n*=7) that whenever or however they needed to take care of their babies' needs took priority over the interview.
- Distress and disclosure protocols were developed to be followed if required (Appendices IX and X). Some participants experienced mild distress during their interviews, and I followed the distress protocol, but none wished to terminate the interview. The disclosure protocol was not required.

Location

A flexible approach to interview setting was taken. Interviews took place in participants' homes (*n*=4); over video call (Zoom; *n*=3); in children's centres (private room booked in advance; *n*=2) and in my car (*n*=1). To protect my safety, the University lone working policy was followed, and a risk assessment was developed and approved by the Institute of Population Health.

Data storage

Data were stored in line with University of Liverpool data protection procedures.

Remuneration

Participants were paid £15 Amazon vouchers for their time and any travel expenses were remunerated.

Interview procedure

At the beginning of the interview, participants completed a brief demographics form (Appendix XI). The narrative interview then began, which followed the biographical narrative interpretative method (Wengraf, 2001). The interviews thus took the following structure: first, a single question aimed to prompt narrative (SQUIN); second, follow-up question prompts called particular incident narratives (PINs; Appendix XII). The follow-up questions were unique to the individual and the story they shared following the SQUIN. I applied this approach flexibly and adapted where necessary; for example, providing more scaffolding in stage one for a participant with learning difficulties.

Interviews lasted on average 60 minutes (range 46-73 minutes), were recorded on encrypted devices and later transcribed by University administrators. Post-interview, I recorded initial impressions as a voice note to capture my immediate emotional responses and contextual information (Phillippi & Lauderdale, 2017).

Analysis

Narrative inquiry is perhaps best understood as an approach to data analysis, rather than a single method with specified steps (Josselson, 2011). The researcher is afforded the flexibility and creativity of drawing on a range of analytical tools as befits the data gathered. Analysis in this study took place in four stages.

Stage one: Attention to narrative

I immersed myself in the data, reading and re-reading the transcripts while listening to the audio recordings. Following this, summary stories were constructed from each transcript, a process which involves condensing full-length narratives into briefer ones to facilitate the narrative analysis process (Petty, Jarvis, & Thomas, 2018).

Stage two: Thematic narrative analysis

Themes were then inductively constructed from the core stories. NVivo software aided this process and I adapted Braun & Clarke's process for thematic analysis: familiarisation, coding, creating themes, reviewing themes, and interpreting themes (Braun & Clarke, 2006).

Stage three: Narrative mapping

To aid the transition from themes to a meta-narrative, and to situate participants' experiences and meaning-making in wider socio-political contexts, a process of narrative mapping took place, which borrows from the structural tradition of narrative analysis (Reissman, 2008). Aspects of participants' core stories were mapped into columns of actions, participants' evaluations, and my interpretations (Mattingly, 2007). An excerpt can be found in Appendix XIII.

Stage four: Constructing a meta-narrative

Transcripts and core stories were reviewed again, and I used both themes and the narrative mapping outputs to construct an overarching meta-narrative. This focused on maintaining individual stories while attending to the layered contexts of participants' experiences. The meta-narrative highlighted commonalities and distinctions between narratives and consisted of sub-narratives and sub-plots (Polkinghorne, 1995).

Quality

In line with the epistemological positioning of this research, which holds space for multiple truths, quality in narrative research relates to ‘trustworthiness’ rather than ‘truthfulness’ (Reismann, 2008). The following steps were taken to ensure quality:

Triangulation

The research supervisors, who collectively have expertise and experience in qualitative research methods and the research area, reviewed sections of transcripts and contributed to the refining of themes and constructions of meta-narratives.

Methodology training

I attended training on narrative analysis delivered by the Social Research Association.

Expert by experience consultation

The process of narrative mapping was supported by an expert by experience, who had previously received support from a specialist parent-baby service. She provided analytical commentary on excerpts of participant transcripts, thereby constituting a form of member checking.

Audience validation

The research is being presented at the 2023 Cost of Living Conference at Liverpool Hope University, attended by primary intended users and readers, including practitioners, commissioners, academics, and policymakers (Patton, 2002).

Reflexivity

To further enhance rigour, I have held in mind my positionality throughout the research process. It is important to locate myself as a middle class, White British & Irish, female-identifying trainee clinical psychologist studying at doctoral level. I do not have experience of

caring for a baby or of significant financial hardship. I was conscious of the power differentials inherent in the interview setting as someone to whom society assigns greater power and resources based on my ethnicity, class, educational level, and profession. I tried to minimise this by affording as much flexibility and choice as possible, by offering participants the freedom to tell their stories in whatever way they wished, and by making my language accessible and jargon-free.

In my close family history is an incidence of an abuse of institutional and political power, resulting in immense relational trauma for members of my family, the effects of which I have later come to understand through my clinical psychology training as intergenerational trauma. This undoubtedly influenced the early conceptualisation of the research idea and questions. I have previously used mental health services, which informs my critical approach to current service structures and provision and motivates me to advocate for social change.

Results[4]

Parents' stories of caring for their babies were diverse and varied, reflecting the heterogeneity of participants' experiences and contexts. Their stories are shared here in three ways. First, important events and experiences in parents' stories are highlighted in Figure 3. Second, key themes are constructed and interpreted in Figure 4. Third, the telling of a meta-narrative is presented in text form. The meta-narrative is divided into three sub-narratives: 'Small government, big problems'; 'It takes a village'; and 'The personal is political'.

[4] **Content warning.** We all have our own experiences of being parented and of being babies; some readers may also be parents. The material presented and discussed tells emotive and difficult parenting stories which may be difficult to read.

Section 1: Events in a timeline of experiences.

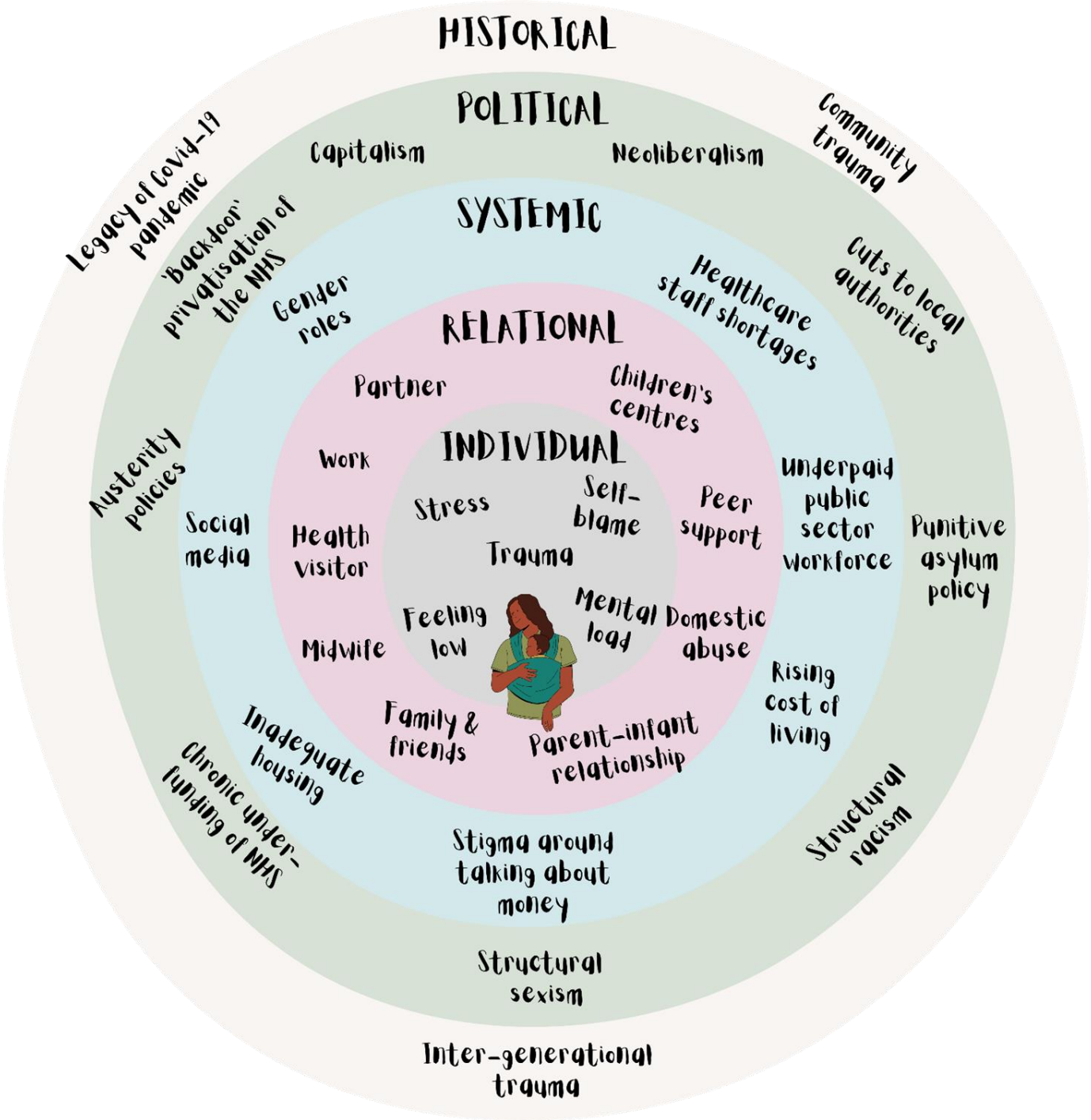
Figure 3.

Events in a timeline of experiences.

Section 2: Key influences on experiences.

Figure 4.

Key influences on experiences. Adapted from Bronfenbrenner (1977).



Section 3: The meta-narrative

Small government, big problems

This sub-narrative captured the political context to parents' stories of caring for their babies. Parents' stories connected an uncaring and diminished welfare state to economic deprivation, poor parental wellbeing, increased inequalities and unsafe living environments. This is aptly summarised by one parent as follows:

They know how much it costs to raise a family and to pay the gas and electric. They're all aware that it's going up, so why does the money that we get paid not go up? […] They've gotta realise they're putting us into financial hardship. The government doesn't care.

(Catherine, M3)[5][6]

Welfare does not meet needs

The scaled-back welfare state featured as an antagonist in parents' stories. Assuming the role of an absent, neglectful parent, social welfare was depicted as not meeting parents' basic needs.

Universal Credit is paying for the rent and the bills, it's not paying me for the food, not paying me for the glasses, I'm walking around with Sellotape on them, it's not paying for my dentist…

(Cristina, M12)

Catherine's story highlighted the punitive elements built into the benefits system, insensitively withdrawing support at the time her family needed it the most:

Because we're on Universal Credit, you have a month without money, where your claim's changing, so it was just pressure after pressure… […] Can we pay the gas and electric if we're not getting any money this month?

(Catherine, M3)

[5] All names are pseudonyms.

[6] Mother is indicated by 'M' and father by 'F'. Baby's age (in months) is indicated by a number. E.g., 'M3' represents a mother of a 3-month-old baby.

Many parents' stories presented restricted paternity allowance as an obstacle to fathers supporting their partners and spending time with their babies:

Obviously as I'm self-employed, if I don't work, I don't get any money. So I did have two weeks off, and then I was back to work.

(Ben, F17)

Matt had two weeks paid, but he ended up taking four weeks overall, so he took two weeks holiday. And especially after the caesarean, like physically I was not back to being able to do a lot. And he would've taken more if it had been paid.

(Kate, M12)

Anna highlighted shared parental leave as 'real positive' in her story, crediting it for facilitating a close relationship between her partner and their baby, as well as a more equitable division of the mental and physical load of childcare responsibilities. However, Anna lamented:

Even the fact that shared parental leave is not available to men who are self-employed [...] It's outrageous.

(Anna, M18)

Negotiating rising costs

In the absence of a social welfare system that met their needs, parents were left unprotected from the threats of the hostile economic climate. The profound stresses and strains associated with caring for a baby in this context permeated parents' stories, starting in pregnancy:

You don't really think about the money side of it straight away, [...] we were just like really happy, but then things start dawning on you

(Ben, F17)

Financial precarity left parents with feelings of insecurity and powerlessness around their limited capacity to cover their outgoings, and their inability to save and plan:

It was just money on top of money, and it's like, where does it all go, where? [...] And then what do you do when you've got no savings? How can you save, when you've got so much to get?

(Laura, M2)

Many parents' stories depicted the significant cognitive and emotional load associated with planning and worrying about money and bills:

Money comes back into it all the time [...] You're thinking, well I'll have to pay that, pay this… [...] In your mind constantly, always worrying.

(Emma, M8)

It's constant anxiety, it's always there. [...]Every morning we're straight to the machines, is it gonna go off today?

(Catherine, M3)

Parents highlighted health implications for both them and their babies. Many parents relied on food banks, but identified the lack of availability of fresh, nutritious foods available. Delina's story emphasised the cultural significance of family time spent cooking and eating fresh food and how this was compromised:

We are African people, you know, we're not so used to eating food from the can. A lot of these food banks, [...] all their food is in a can. [...] Food is very important to us, [...] it's always a thing of going to buy fresh food, you know, to cook ourselves, we like to cook. Yeah, that's like family time to us.

(Delina, M12)

Hannah described her worries about her baby's development with more limited access to nutritious foods:

It's her future and she needs the nutrition now. […] Going to the food club, I wouldn't necessarily get the same kind of nutrition, it would be [...] the more unhealthy food… But when you're in a pinch, it is what it is… You eat.

(Hannah, M4)

Two parents described part of their reason for breastfeeding as financially-motivated due to the high cost of formula and its unavailability in most food banks. Emma's guilt around struggling to breastfeed was heightened:

That added pressure of the financial side of baby milk, cos I struggle to breastfeed, [...] that was hard for me. So emotionally, I felt really stuck, [...] I was beating myself up that I couldn't do it.

(Catherine, M3)

Moreover, two parents linked their hardship to them stopping breastfeeding:

With all the depression […] and just being stressed all the time. I started having a bit of beer, and I was just feeling it was unsafe to give my son milk that was having beer. So I just decided to stop breastfeeding him.

(Delina, M12)

There were just so many things[…] We had to move house because the old flat had a horrendous mould problem, so that was like a rush…[...] Then working as well. And I'm sure that's why my breast milk dried up, because I was just so stressed that time.

(Anna, M18)

Parents and babies suffered the consequences of having a cold home because they could not afford to have the heating on:

I feel sorry for Finn, I'm having to, like wrap him up in his pyjamas and his housecoat just so he's warm. […] I get angry when he's not wearing his housecoat, and his pyjamas, because Finn, it's freezing, […] You just feel really rubbish.

(Laura, M2)

Delina highlighted the impact of this for asylum seekers or migrants from countries with warmer climates to the UK:

The cold is a big deal [...] The way you are feeling cold, the way I'm feeling cold, it's not the same, because I come from a tropical place, so when I'm feeling cold, I am really feeling cold.

(Delina, M12)

Laura further highlighted the unequal impact of the cost-of-living crisis:

The price of sanitary towels have gone up, [...] you're more or less being punished for being a woman. [...] I've got bras that are too small for me, and I haven't got the money to get new

bras [...] Absolute nightmare. Obviously when you're pregnant, your breasts enlarge… [...] You've got to pay to cover your boobs, because they're known for being sexualising.

(Laura, M2)

Living the austere

Parents' stories illustrated the lived realities of austerity measures on their local environments and illuminated their struggles to find a suitable place to live due to the scarcity of social housing and the reluctance of private landlords to rent to people on benefits.

I looked for quite a while, but nobody would take me [...] being on maternity, having Universal Credit, [...] because you don't have a job. I've been trying to get a council house [...], but [...] there's loads of people in hotels and stuff, there is no council housing.

(Cristina, M12)

Parents highlighted shortcomings with their housing alongside a powerlessness to improve their situation. While their landlords would often not provide suitable accommodation or fix issues, parents could not afford the expense of moving.

I'm looking on moving, because I've got mould and damp in the house currently, so it's a health risk for the children […], then it's the flooring, the blinds again, […] basic things just to make it liveable. It's hard. And then the cost of even moving house.

(Laura, M2)

Parents identified structural barriers to navigating their local environments due to the shortcomings and expense of public transport.

I struggle to get around, because bus fares are going up now, aren't they?

(Danielle, M18)

It's even hard to get on a bus with the two children, because we have a double pram, […] if there's two prams in there, you can't get on, so you're having to wait ages for another bus. It's hectic.

(Laura, M2)

Kate highlighted the decline of freely available and safe public spaces for families:

There's less and less public spaces that you can just go, without being expected to, [...] pay, for the privilege of going inside of it, [...] Libraries are closing…

(Kate, M12)

Unequal impacts

Parents' stories depicted the disproportionate impact of austerity on those already disadvantaged by society. Parents who had been through significant trauma - survivors of domestic abuse, survivors of trafficking seeking asylum, and care leavers - endured further suffering because of strained systems and limited support. Upon escaping an abusive relationship, Catherine described how she was let down by the lack of services available to protect and support her while pregnant and homeless:

I had to flee domestic violence. And then I was put in a worser position doing that. I had no home then. I had nowhere to go to. I was just put in a hotel. [...] Being pregnant and in that environment, I was vulnerable. [...] It was hard to be there. [...] I spent most of me pregnancy just locked in a room the whole time. It's ridiculous.

(Catherine, M3)

Catherine's account points to a reduction in the funding and services available to support domestic abuse survivors. For Cristina, this gap appeared to be filled by a third-sector domestic abuse support service:

She helped me with food vouchers and stuff like that. [...] They gave me vouchers to buy Mateo clothes, and toys for Christmas. [...] I at least had some food on the table.

(Cristina, M12)

Delina's story of the asylum support she received echoes this. Delina explained how state asylum support covered the bare minimum:

It just helps you have a roof over your head. You are warm, and you're going to get money on Monday to get you through that week. Otherwise, really, the biggest help to help you mentally, [...] is this charity organisations.

(Delina, M12)

In Delina's story, most of her support came from third-sector organisations. In Delina's case, as a survivor of trafficking, the Salvation Army approached her directly, but she explained how otherwise proactivity and connections are necessary to access support, which can result in inequitable access.

It takes a village

This sub-narrative captured the systemic and relational contexts to parents' stories of caring for their babies. Parents' stories depicted how important support networks are for buffering the adverse effects of financial hardship. At the same time, parents' experiences demonstrated how austerity has reduced the quality, availability and consistency of support to parents at all levels of the system.

A secure base

Strong social support conferred material, practical and emotional benefits to parents, which seemed to mitigate against some of the challenges associated with financial hardship. Parents who had strong co-parenting relationships credited their partners for helping them to manage in difficult times:

Luckily I've got my partner, you support me, don't ya? In any way you can. Which is good. But say if I didn't have me partner, then I'd be struggling. Struggling even more.

(Laura, M2)

If I didn't have Richard I think I'd be a bit lost to be honest. I think I'd be very stuck without Richard and his family.

(Catherine, M3)

Family support was depicted by parents as important in relieving some of the parenting pressures at no financial cost:

I couldn't have a baby far away from those kind of support structures, I think they're really important [...] Going round to my parents', [...] it just gives you that chance to rest a bit, which is all you need.

(Kate, M12)

Parents also valued peer support they gained from networks of other parents, validating each other's parenting stresses and offering informal support:

I've made a friend locally [...] and we've formed quite a close bond, which is lovely, the true ins and outs of motherhood, like a real friend, […] it's nice to have that soundboard.

(Hannah, M4)

For many parents, children's centres formed a part of their support network. They were portrayed as providing warm, welcoming environments where parents felt safe. They facilitated social connection, a sense of belonging and helped to build social networks. Parents described children's centre staff as a resource for advice and practical support. Parents valued the free and universal nature of children's centres:

I've been accessing free services through Home Start Centre, doing classes there and the children's centre, just because [...] times are tight [...] The stuff that you can get [...] is absolutely fabulous. I've been very grateful for that.

(Emma, M8)

Parents' stories depicted children's centres as welcoming environments, where parents felt looked after and supported:

Your partner's gone back to work [...] you're in the house all day with the baby, someone else to make you a juice and some toast is so nice.

(Kate, M12)

I feel very supported there, I know each of the staff members, and it is a very lovely centre. […] It's just a very nice, warm environment to be in.

(Laura, M2)

The practical support offered by children's centres was highlighted by parents as a key benefit, particularly in times when less support is available for families:

The only place I know where we can get help if we do hit really hard times is the children's centre. They'll give you a voucher. [...] [Our practitioner] *was well aware that I won't go and*

ask for help. [...] So when she was coming out [...] she used to just leave vouchers on the side.

(Catherine, M3)

Catherine's highlighted how through developing a relationship with her, the practitioner was able to identify support needs that may have otherwise gone unnoticed. Parents' stories emphasised the role of children's centres in connecting parents and supporting the development of peer support networks:

That's what was really good about, like, meeting other mums at the children's centres, I thought I was, like, the only person, and then you talk to everyone, it was literally like an emergency C-section support group.

(Kate, M12)

However, some parents' stories illustrated the impact of cuts to children's centres, both in terms of a reduction in numbers of centres and in their offering. Emma described how her local children's centres are over-subscribed, with the few drop-in sessions and bookable sessions filling up rapidly. As a result of this Emma has had to drive to children's centres on the other side of the city, disconnecting her from local parent networks, and causing her to incur more expense. Laura lamented how she is not able to go to her local children's centre now that she has a two-year-old and a new-born, as classes cater for certain ages, and there is no crèche provision. Laura explained the impact of this for her and her children:

It means Finn is having to miss out on going to the children's centre, which he's been going to since he was six months. [...] It's sad because I'm just stuck in the house now.

(Laura, M2)

Shaky foundations

For parents who had neglectful or abusive partners the challenges of parenting were intensified:

Feels like it gets too much sometimes. Cos I don't have much help, cos I can't just ring the baby's dad because he's just not to be trusted.

(Danielle, M18)

All of a sudden I had this little baby that I needed to look after, […] being abused at the same time, it's just not easy, I was scared to leave the house, [...] I didn't want to speak to nobody.

(Cristina, M12)

Cristina described how the controlling behaviours of her former partner had meant that she moved over 200 miles away, disconnecting her from established support networks and isolating her. Delina portrayed a 'complicated relationship' with her children's dad, who she 'can't really rely on' but financial hardship compelled her to stay:

You can't just say, ah, you treat me so bad, or I'm not happy, just go. [...] If I say that, one of the days I want to go and work maybe a bit extra, I don't have money, [...] who's going to take care of the kids? So you've just got to stay in that situation.

(Delina, M12)

Catherine's story depicted the isolation and loneliness experienced by many care leavers:

With growing up in care and stuff like that, I don't have a family. I don't have one. I'm on me own and this is how I have been since I was this big […]. I've always been on my own.

(Catherine, M3)

The emotional consequences of this lack of support were evident for parents, who reported feeling overwhelmed, anxious, and depressed.

Healthcare: Inconsistently meeting needs

Parents' stories of healthcare throughout their parenting journeys thus far depicted neglectful, inattentive care; a lack of warmth and compassion; and an absence of consistent, joined-up services. Parents situated this in the context of over-burdened and underfunded public services and did not blame healthcare staff themselves. Some parents had positive experiences with healthcare services, but in general there was a sense of a systemic failure to recognise and invest in the importance of relationships.

Feelings of neglect & abandonment

Five parents described having traumatic births, including three emergency Caesarean section deliveries. Some parents directly linked their traumatic experiences to poor care from healthcare staff, describing often inattentive and neglectful care.

I had the most horrendous experience with the birth which left me with PTSD [...] It was pretty dreadful care. I was left, like, haemorrhaging for hours and hours on my own. [...] With like no one really checking on me. That whole experience was incredibly traumatic.

(Anna, M18)

The nurses were like, can you stop screaming please. […] I'm having a baby. [...] I can't help it. I'm in agony here, I've got no pain relief.

(Danielle, M18)

Elena was in a lot of pain, she was basically ignored. She wasn't monitored, [...] it took an emergency Caesarean [...] at the very last minute, and [...] he wasn't breathing when he was born. It could've easily ended tragically.

(Ben, F17)

Kate described how a lack of communication and transparency compounded her traumatic experiences during her emergency Caesarean section:

I didn't even know what was happening really, […] they just kept asking me if I was wearing any metal, and I kept being like, no, what, what are you on about. And then yeah, I woke up and had a baby.

(Kate, M12)

She described how she felt rushed out of hospital by staff the day after her emergency C-section as staff were '*desperate to get people out'.* Two parents' birth stories were described as '*lonely*'. Delina, a survivor of trafficking seeking asylum in the UK, told her story of giving birth alone:

It was very hard. It was lonely because I did not have anyone [...] I gave birth just me and the midwife, nobody holding my hand, no nothing.

(Delina, M12)

Delina's story highlights a not uncommon experience endured by migrant and asylum-seeking women, who have often been disconnected from support networks and likely to be less familiar with the UK healthcare system. Emma recalled feeling abandoned by maternity staff, with little attention paid to her emotional wellbeing. She recalled how in 2012, when she had her first baby, a member of staff visited the maternity ward to check in with mothers and the positive impact this had. Emma reflected *'but it's an expense for people to do that now, isn't it?'*

Many parents experienced an absence of care from health visiting:

Health visitor, I've seen once, but then I got a letter saying basically we're not coming out anymore, but call us if you need us, and I never know when to call.

(Hannah, M4)

Anna highlighted a missed opportunity by her health visitor who did not refer her for psychological support despite Anna's significant distress following a traumatic birth:

I thought, genuinely, I think I've gone mad. I was hallucinating, I didn't know who I was half the time. It was so horrific. And she was like, I think you've got PTSD. [...] But she didn't then recommend me to have any therapy.

(Anna, M18)

Parents encountered obstacles when accessing timely primary and secondary level medical care for themselves and their babies. Many parents described significant struggles arranging appointments with their GPs and the frustration this caused. Other parents described the stress caused by delays to consultant treatment following birth complications at an already emotionally demanding time:

I'm waiting for a gynaecology appointment; I had an episiotomy that isn't healing properly. [...] It's now been delayed to April, and I gave birth in July. […] It does feel incredibly frustrating, [...] it's just an added stress that you don't need, [...] I just need to see someone, I just need someone to take this seriously.

(Hannah, M4)

Uncompassionate care

Parents described a lack of warmth and compassion in their interactions with maternity staff, which was linked to a system under acute pressure:

There was no affection either, it was like, blood pressure, done, off you go, […] you felt like you're in the vets [...] you're just left there. [...] They're rushed off their feet.

(Emma, M8)

I don't blame the staff, like, generally for what's going on, [...] we just happened to have, [...] people who are either just beyond caring, [...] not even any kind of filter on what they're saying. It's just, like, terrible.

(Ben, F17)

At the other extreme, Catherine experienced maternity staff as intrusive and unsympathetic when she gave birth while under a child protection plan:

I think it's the lack of understanding, [...] especially when you're under social services. Everything you say, everything you do is monitored. You can't breathe.

(Catherine, M3)

Anna described experiencing a health visitor who appeared quick to pass judgements on Anna's parenting practices without having built a relationship with Anna and her family:

I found her incredibly rude [...] She said it sounds to me like you're doing too much and you should just be spending one on one time with your baby, and I was just like I've literally just met you three minutes ago, what!?

(Anna, M18)

Catherine described her ongoing experiences with her health visitor who appeared to lack compassion and understanding of her challenging situation. Along with her two-month-old baby and partner, Catherine had just been moved from a hotel into an unfurnished house with no carpets, and she described the health visitor setting her the '*unrealistic expectation'* of having carpets laid within two weeks. This was particularly salient for Catherine given that she had grown up in care and had already had two children removed by social services. Social

services and healthcare professionals had held powerful positions of authority throughout her life. Catherine described the emotional impact of this as follows:

It makes you feel really insecure. […] Like you're not providing enough for your child. [...] They don't understand [...] They're very judgemental [...] You feel like you're choking on it when they're here. It wells you up inside. Sometimes I could cry when she's here just off the things that she said.

(Catherine, M3)

Emma's story depicted a similar experience of feeling pressure and judgement from professionals in the early days after her baby was born. She explained how midwives were concerned her baby was not putting on weight and were monitoring this with frequent visits that felt more punitive than supportive and dismissed her experience as a fourth-time mum. Emma described the intense pressure and anxiety this caused her:

I've got that emotional side, [...] I weren't eating, I weren't sleeping [...] and every night I was scared.

(Emma, M8)

Emma contrasted this directive approach to the more collaborative approach of her enhanced midwife who later visited her, listened to her worries, and offered her reassurance:

I just had that more experienced midwife to say to me, [...] baby will feed, baby will be fine, whereas these particular midwives were just like, you need to be doing this.

(Emma, M8)

Anna highlighted the difficult relational dynamics likely to arise when staff are overstretched and stressed and thus unable to provide a containing and warm environment for stressed parents with unwell babies:

They're overworked and at the end of their rope but […] when a baby's involved […] the stakes are really high.

(Anna, M18)

Inconsistently meeting needs

Parents' stories portrayed a lack of a consistent, joined-up approach in healthcare systems for parents and babies and the consequences of this.

You are given a midwife at a certain point in the pregnancy, but then it's not like that's your one person that you deal with. […] Everyone in every different part has got something to say. [...] They've got a different opinion.

(Ben, F17)

Health visiting was presented as a postcode lottery, with inconsistent provision both within individual families' experiences and across localities, as these two contrasting quotes demonstrate:

In the first week, she came round. And she was really good, […] Because I, erm, had a bit of a traumatic birth, I was upset when she came, so she did […] refer me to the peri-[natal] mental health team.

(Kate, M12)

It's coming up to eight months [...] and he's not saw anyone. [...] I rang and was like [midwife name]*'s discharged me, and she was like, brilliant, I'll book an appointment to come and see you to check how you're doing, and I've never heard from her since.*

(Emma, M8)

The uneven provision of health visiting services exposed gaps in care that GPs, not adequately skilled or resourced in this area, were unable to fill. Hannah summed this up as follows:

You don't know whether you should be going to the doctor or the health visitor about it, because a GP, they're exactly that, they're general, [...] they're not specialist.

(Hannah, M4)

Parents' stories thus depicted experiences of feeling 'fobbed off' and let down by GP care:

I went to the doctor and she said "oh, quite scary doing babies, isn't it?" I was like, is it?! [...] She was like we don't have any baby scales, so why don't you stand on scales holding your

baby, and then I'll hold the baby and you stand on the scales again and we'll just subtract it. Like you're weighing a suitcase to go on holiday.

(Anna, M18)

Ben linked this lack of appropriate care to a potential impact on his baby's development:

He wasn't getting the sleep that he needed, which was so important for his development, and it's probably just down to this ear infection. And it took going to casualty after four visits to the GP, to actually have something done.

(Ben, F17)

Feeling cared for

Some parents reported positive interactions with healthcare services, highlighting the relational aspects of their care:

Like the actual midwife, [...] she was ever so nice, she was such a nice lady.

(Cristina, M12)

The health visitor comes […] out for some emotional support for myself. [...] She's lovely. [...] I couldn't've got a nicer health visitor [...] Very understanding, very down to earth.

(Laura, M2)

This demonstrates how key warm and secure relationships are for parents in healthcare settings, and the difference it can make when parents feel cared for and understood.

The personal is political

This sub-narrative captured the individual contexts to parents' stories of caring for their babies. Parents' stories demonstrated how austerity measures and discourses shape their internal worlds and affective experiences.

Locating blame

A common theme in parents' stories was personal responsibility and self-blame, often resulting in a reluctance to share their struggles or accept help. Self-blame and criticism were accompanied by a sense of longing to be able to 'do' and 'be' more:

It's not their fault I'm struggling financially. It's sad, it makes me feel like I'm a failure of a parent, wish I could do more, provide more.

(Laura, M2)

You just wish, maybe, you could do better, or be better. Wish you could provide more, be there more. Be present in a good manner.

(Delina, M12)

For Delina, her guilt was twofold: as well as guilt around not being able to provide more, she felt guilty for the impact money struggles had on her emotional wellbeing:

Half of the time I'm just depressed anyway, because of the way life is affecting me, I find myself not fully acting the way I want to act. I wish I could go out more and just be in a jolly mood.

(Delina, M12)

The impact of consumerism was identified by parents as contributing to these feelings:

There is a greater pressure [to] have all the stuff for the baby, or else […] you're not giving the baby the best start. Even people who don't have the money spend it because they don't want to not do the right thing by their baby. And it's a constant battle… [...] Wanting to save and not spend too much money, but then being sold quite aggressively, these things for them and the baby that 'you need'.

(Kate, M12)

I see people on social media posting how many presents they've got their children under the tree, [...] and I go, ok, right, I wish I could do that, I wish I could do more.

(Laura, M2)

Parents' stories also highlighted efforts to resist these pressures, emphasising that babies' needs for play and stimulation can be satisfied more easily than advertising would have parents believe:

I don't think he would've at this stage, noticed, hopefully, that we're worried about anything, or that he hasn't got everything that he needs because, […] they really don't need a lot, you're just told that they need a lot of things.

(Kate, M12)

He's such a happy lad. [...] Essentially, what he likes to play with is a ball that cost us £3 and the Tupperware.

(Anna, M18)

Then I realise, presents, and buying luxuries [...] isn't going to buy them love. What they need is just a mum to be present, they don't know any different.

(Laura, M2)

Parents' stories depicted an internalised personal responsibility and valorisation of self-reliance.

It's when you've always been so self-sufficient, it's hard to accept that from somebody else.

(Hannah, M4)

I've got that worry… […] I'm gonna have to pay him back […] Because it's my responsibility. This is my house, my children, and I should be doing it. [...] I should be providing for the children […]. I just don't like accepting any help at all.

(Laura, M2)

Linked to this, parents' accounts revealed a stigma around talking about money and sharing financial struggles:

I almost don't want to let people into that side of things, it's like hmm that's my problem, that's my thing. [...] There's something about finances that makes you kind of tighten up a bit inside, and makes you think, oh goodness, I should be doing okay, but I'm not as okay as I'd like to be.

(Hannah, M4)

That's a big thing, I think it's hard for people, and they get embarrassed and won't speak.

(Emma, M8)

One parent referred to people she knew who were receiving benefits 'lazy' as they 'could go to work', demonstrating internalisation of narratives that demonise recipients of state unemployment benefits.

Locating responsibility

Austerity discourses not only led parents to feel responsible for their financial hardship, but also positioned them as personally responsible for changing and improving their situations. This was observed in pressures to return to paid work, which had an impact on parent and baby wellbeing. For parents facing economic deprivation, this was less of a choice and more of a necessity:

I am already looking for flexible opportunities where I can work from home, […] but it's hard to find, [...] If the right opportunity came up, I would come off maternity leave now to pursue that.

(Hannah, M4)

Emma highlighted the conflict this creates, trying to balance meeting material and emotional needs:

I'm torn… I need to get back to work really soon, just to be able to [...] put clothing on their back, and to feed them, but I feel like I'm taking time away from being with the baby.

(Emma, M8)

Cristina's story echoed this difficult balance, describing at once the strength of the bond with her baby - developed in the face of significant adversity - but also how economic deprivation posed a challenge to 'following her baby's lead' and going at his pace:

I don't know whether it's this situation that I've been going through, that me and Mateo will have this bond, like he can't stay without me, or I can't stay without him. [...] There was times I didn't have things to give him to eat, so he would sit there, like, constantly breastfeeding, so that's probably why he's still breastfeeding so much as well still. Slowly, slowly though, I'm

trying to get him [to] *stop breastfeeding because I really want to go and get a job so we can get out of this situation.*

(Cristina, M12)

Other parents' stories depicted similar experiences, with Kate reflecting on the stress caused by a necessary acceleration of the weaning process due to needing to return to work:

If I'd had better pay, or even if SMP was just extended for the full 12 months, I would've taken the full 12. [...] It would've reduced stress in terms of trying to get him [...] on solids properly before I went back.

(Kate, M12)

Anna described the impact on her and her baby when she had to return to work earlier than she would have liked:

I went back to work too early really. I went to work after three months, and I was still trying to breastfeed at that time. It was just an absolute nightmare, it was so stressful, he was so tiny and at that point he just needed me because I was still breastfeeding. [...] I needed to earn money and I'm sort of the main breadwinner in our house.

(Anna, M18)

Emma summarised this shared experience as follows:

That pressure of I've gotta get back to work to bring even more income. But then, you're gonna miss out on bringing your baby up, and I think that first mainly two years of a child's life, […] it changes by the day with them, and now you feel the pressure to watch that growth less because you're gonna kinda have to get back into work.

(Emma, M8)

At the same time, parents' efforts to return to work were also obstructed due to inadequate benefits and the high cost of childcare:

It's that little vicious circle you're in, […] is it worth me going back to work because I'm gonna spend that [on] *childcare.*

(Emma, M8)

Kate highlighted the gendered dimension of the cost of childcare, given the unequal division of unpaid childcare labour.

If you look at the gender pay gap [...] women [...] go part-time because they're doing childcare, and the way that you could probably help that, really, is to make childcare less expensive.

(Kate, M12)

Anna echoed this sentiment, emphasising the structural sexism inherent in childcare provision and parental leave policy, describing it as an '*attack on women'*. Structural inequalities were also highlighted by Delina, who described that as an asylum seeker she was unable to work for a while and can now only work restricted hours even after being granted the right to work. She reflected that this, combined with her outgoings, meant that working barely conferred any financial benefit. Other parents echoed the sentiment that paid work was insufficient to lift people out of financial hardship:

You're working, […] that should be, that used to be enough, to help you manage everything, it's all of a sudden become tighter. [...] You could have four weeks' wage and still not have that money for food, [...] that's what we're up against.

(Emma, M8)

Catherine summed it up by reflecting:

It doesn't matter what you do in the current times, whether you work, whether you're on benefits [...] you are going to struggle either way.

(Catherine, M3)

Discussion

This study aimed to understand parents' experiences of caring for a baby in the context of austerity and a cost-of-living crisis. Analysis of parents' stories has illuminated the myriad ways in which austerity policies shape the experience of caring for a baby, from the micro- to the macro-level. It suggests that parents and thus their babies are harmed by the financial

precarity induced by austerity measures and a contraction of public services, but also by austerity discourses. This section will begin by summarising parents' stories in the context of other relevant research. It will then outline policy and clinical recommendations and consider strengths and limitations. It will finish with reflections on the research process and conclusions.

The welfare state: An absent parent

Parents' stories depicted a neglectful and diminished welfare state that was not sufficient to meet parents' needs in its policies or financial provision. The Universal Credit shortfall is confirmed in analysis by the JRF and Trussell Trust (JRF, 2023). Benefit rates in the UK are not calculated using a systematic estimation of need, but rather out-dated inflation rates (Hobson, Kennedy & Mackley, 2022; Ray-Chaudhuri, 2023). This means that recipients often face real-terms cuts in their benefits payments. Even with an uplift in April 2023, statutory maternity pay (SMP) only represents 47% of the national living wage (Department for Work & Pensions, 2023). UK public expenditure on maternity and parental leave is low compared to other Global North countries, and the 39 weeks paid leave is below the OECD and EU averages (Dunstan, 2023; OECD, 2022). Though the principle of sharing parental leave was valued by one parent, the policy has been widely criticised for failing to promote more equal parenting; around 40% of fathers are ineligible due to being self-employed or temporary workers, and the total yearly take-up is around 2% (Dunstan, 2023; TUC, 2015; Women's Budget Group, 2021). This suggests structural sexism and gender norms continue to govern public policy.

In this context, parents were left feeling abandoned and exposed to harsh economic conditions. Essentials like food and heating were rendered unaffordable, and what most would consider vital to wellbeing, for example, dental treatment, glasses, and highchairs, were positioned as luxuries. Parents found themselves instead relying on food banks, vouchers, and charitable grants. The rising cost of energy bills caused parents significant stress,

jeopardising their ability to provide their babies with warm, comfortable surroundings and clean clothes. The cost of formula was prohibitively expensive for many, increasing the guilt experienced by those not able to breastfeed. Formula is not available in most food banks and Healthy Start vouchers are no longer sufficient (British Pregnancy Advisory Service, 2022; Cosslett, 2022). This is of particular concern given that breastfeeding rates are lower in more deprived areas, which may relate to a lack of access to the power necessary to overcome barriers to breastfeeding in social spaces (Groleau, Sigouin, & D'souza, 2013; OHID, 2022). Parents drew attention to the lack of fresh, nutritious food in food banks, which has implications for family togetherness, cultural traditions, and babies' healthy development. Use of food banks, in combination with increasingly high food costs therefore contributes to diet inequalities, in turn deepening existing health inequalities (The Parliamentary Office of Science and Technology, 2022). Parents' stories highlighted the impact of austerity on their local environments. Parents were often confronted with barriers to comfortable and appropriate housing. They faced obstacles to navigating their own neighbourhoods due to the inadequacy and cost of public transport and noted the decline of public spaces. These experiences serve to decrease feelings of safety and increase a sense of powerlessness. In this way austerity can be seen to shrink people's psychological and physical worlds, limiting opportunities for both parent and baby to engage in new experiences and new places (Hitchen & Shaw, 2019). The stress of financial hardship constituted a significant cognitive and emotional load for parents, who were confronted with multiple difficult decisions and constant calculations. The JRF reported similar experiences in their research, identifying a significant emotional toll for parents (Parker, 2021). It is well-established that insecurity and uncertainty lead to emotional distress (Massazza, 2022).

For parents who had experienced significant trauma and adversity, specialist support services were found lacking. For these parents, among them domestic abuse survivors, care leavers and trafficking survivors seeking asylum, the containing and nurturing support they needed was often absent. Domestic abuse services have suffered given they are funded by local

authorities; many specialist services have had to close, and refuges have reported turning women away (Sanders-McDonagh, Neville, & Nolas, 2016). The UK government's adoption of 'hostile environment' policies, such as denying access to mainstream benefits or UK bank accounts and restrictions on working, have increased poverty for migrants and people seeking asylum, including families with children (Qureshi, Morris, & Mort, 2020; Dickson, 2019). Austerity cuts have accentuated this, with local authorities often unable to comply with their statutory duty to provide for children whose parents have no recourse to public funds (Dickson, 2019; Price & Spencer, 2015). Further, recent analysis has indicated these punitive policies disproportionately impact families from minoritised ethnic backgrounds (Home Office, 2023). Parents who have experienced relational trauma themselves are more likely to experience difficulties in the parent-infant relationship, especially in the context of hardship and the absence of containing and caring support (Gerhardt, 2014).

The hands that hold the hands: Providing a secure base for families

Parents' stories portrayed social support as important for their and their baby's wellbeing due to the range of material, practical and emotional benefits it bestowed. Parents credited strong co-parenting relationships, supportive family nearby and peer support from other parents in helping them to manage stress and share parenting responsibilities. It is well-established in the literature that social support in the postnatal period is instrumental for parent wellbeing, which in turn benefits baby wellbeing (Razurel et al., 2012; Webster et al., 2011). In this way, support networks were seen to mitigate some of the potentially negative impacts of financial hardship-related stress. For parents who were isolated or had abusive or unsupportive figures in their lives, their challenges were amplified. This in turn has implications for the parent-infant relationship: research has indicated that parents with more community support interacted more positively with their babies than those without (Smith, Landry, & Swank, 2000).

Children's centres were a high point in parents' stories. Parents valued their warm, welcoming environments, informative staff, and freely accessible facilities, especially in an age when fewer free and safe public spaces are available due to cuts. Parents emphasised the social benefits of children's centres for both them and their babies, connecting them to other parents and cultivating a sense of belonging. Children's centres, then, can be seen as providing a secure base for parents to be able to offer their babies safety and security. In their relatively short history, children's centres have become an essential local resource for many families (Action for Children, 2019). Parents' stories, though, underlined under-investment in these vital services with parents describing reduced timetables; a move towards booking systems rather than drop-ins; oversubscribed classes; reduced facilities, and fewer centres within walking distance. The government's Family Hubs and Start for Life programme, £301.75 million shared between 75 local authorities to 'join up and enhance' services for families, falls short of rectifying the damaging effects of over a decade of cuts to early years services (DHSC, 2022). The programme lacks funding to address workforce shortages, and does not meet the need for long-term secure funding for preventative and early intervention family services (McBride, 2018).

Doing more with less: Healthcare in an age of efficiency

Parents told stories of accessing healthcare at highly vulnerable and emotive times in their lives: during pregnancy, birth, and when their babies are unwell. Some parents spoke positively about the care they received, but more common were stories of healthcare staff not able to respond to parents' needs in a compassionate way. Parents' birth stories portrayed mothers as commodities on a 'conveyor belt' of care, contending with overcrowded maternity wards, over-stretched staff, and premature discharge. Indeed, the UK has the shortest average hospital stay following childbirth of any other high-income country (Campbell, et al., 2016). This can be understood in the context of significant under-staffing in maternity wards, which is often at levels unsafe both for patients and staff (Powell, Rough, & Lewis, 2022). This has far-reaching implications for quality of patient care and safety as well as staff morale and

wellbeing (Powell, Rough, & Lewis, 2022). Traumatic births have been linked to parent-infant relationship difficulties, which can manifest in different ways, including increased fear around their baby's health, and feelings of disconnection due to enforced separation or memory loss post-partum (Molloy, Biggerstaff, & Sidebotham, 2021).

Significant inequalities in birth outcomes persist for women from minoritised ethnic backgrounds and women living in the most socioeconomically deprived areas: for example, Black women are four times more likely and Asian women twice as likely to die during childbirth than White women; and women from deprived areas are twice as likely to die during childbirth than those from affluent areas (Jardine, et al., 2016; Knight, et al., 2022). Parents' stories highlighted how experiences of maternity care are often unwelcoming and lonely for migrant and asylum-seeking women (Fair, et al., 2020). This can be linked to the systemic racism and xenophobia endemic in institutions and policy and emphasises how austerity policies have most significantly affected marginalised groups (Abed & Kelleher, 2022).

Premature discharge can lead to parents and babies with more complex health needs requiring treatment in the community (Bowers & Cheyne, 2016). However, many parents described postnatal care as inadequate, reporting delays to medical procedures following birth complications and significant difficulties accessing primary care services. Some parents experienced postnatal healthcare professionals as judgemental and intrusive, which served to increase anxiety rather than contain it. Health visiting was constructed as a 'postcode lottery' by parents, highlighting inconsistent provision and a lack of continuity of care. This is symptomatic of a long-standing shortage of health visitors due to austerity measures (First 1001 Days Movement, 2022).

Whose fault is it anyway? Locating responsibility

Austerity narratives shaped parents' internal worlds. Many parents blamed themselves for their difficulties in providing for their babies, the emotional consequences of which were feelings of failure, guilt, shame, and stigma. Parents internalised pressures to be self-reliant and personally responsible for improving their situations. Parents felt pressured to return to paid work before they or their baby felt ready. Neoliberal narratives position parents as individually responsible for providing for children and money struggles as individual household problems, which shifts blame and responsibility away from political structures. This has been conceptualised as a 'double-bind' for parents who are at once pushed into precarious and stressful contexts due to withdrawal of state support and public services while also being held ever more responsible for the wellbeing and outcomes of their children (Jensen, & Tyler, 2012). Parents' stories highlighted stigma around sharing and seeking help for their financial struggles. Not sharing stories limits opportunities for solidarity and collective action.

A disinvestment in relationships

Austerity, then, can be seen as a disinvestment in relationships at all levels: relational structures, relational availability, and relationship quality. Parents felt rejected and abandoned by the state, which shirks responsibility for attuning to their needs and supporting them to provide for their families. Parents are left with limited choices and agency. Healthcare staff are forced to exchange compassion for efficiency and work in ways which compromise safe and warm relationships. Public services and spaces form part of a 'social infrastructure': they foster connection between individuals and communities, which in turn promote community cohesion and are vital community resources (Hitchen & Shaw, 2019). Austerity narrows these opportunities and 'privatises' the experience of parenting. Parents' relationships with themselves become critical and shaming, impacting on their self-worth and lowering their mood. This is in sharp contrast with what babies need to thrive: an 'environment of relationships' is critical for the development of healthy brain architecture (Center on the

Developing Child, 2004, p. 1). This includes their relationships with caregivers, with wider systems, and their caregivers' relationships with their wider systems (Center on the Developing Child, 2004). In this way, austerity can impact babies' development: parents who are frequently stressed, depressed, feeling hopeless, insecure, powerless, and out of control, alongside an absence of nurturing and warm social connections and contact, may struggle to provide responsive and sensitive parenting to a 'good enough' level (Gerhardt, 2014). Parents whose emotional and cognitive resources are consumed by worry and constant decision-making have limited resource left to effectively bond with and care for their babies. This has implications for how babies learn to regulate their emotions, their sense of self, their 'internal working models' for future relationships, and their stress response systems (Center on the Developing Child, 2004; Gerhardt, 2014).

Implications

A major implication of this research is that public policy should be developed, and health and social care systems should be delivered, in ways that are 'relationally informed and can address the social determinants of mental health' (Cobner, Daffin & Brown, 2021). Providing interventions at the individual level can only be one part of the solution. Implications at clinical, systemic and policy levels are suggested below.

Clinical

Clinicians should practise in a way that avoids individualising and pathologising families' emotional distress, focusing on contextualising difficulties and making space for exploring them in a way that minimises shame and blame. This should involve wider activity and joint working to improve parents' economic circumstances (for example, benefits maximisation, housing issues). Supporting these processes, the practice of cultural humility should be nurtured; this comprises clinicians' commitment to self-reflexivity and introspection, continually learning with and from clients (Tervalon & Murray-García, 1998). Masters, et al. (2019) developed a clinician tool designed to support this process, the '5Rs of cultural humility', which

aims to ‘bring more awareness into clinical encounters’, of the clinician’s own identities and biases, and the client’s individuality (Masters, et al., 2019, p. 628).

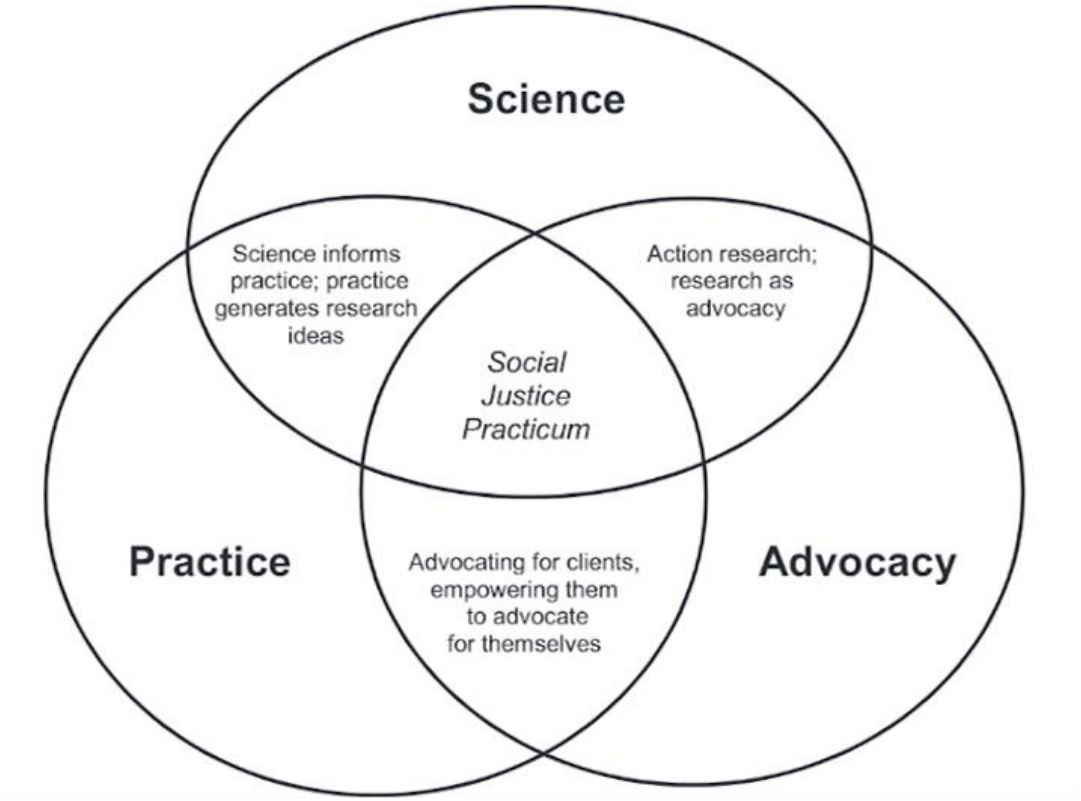
Systemic

Clinical psychologists might feel better equipped and more confident to work in these ways if socio-political contexts and social justice models were covered in greater depth in clinical training (Ballo & Tribe, 2023). The ‘scientist-practitioner-advocate’ model has been proposed for practitioner psychology training (Figure 5), which enhances the traditional scientist-practitioner model by adding a social justice advocate element (Mallinckrodt, Miles, & Levy, 2014). This would integrate multi-disciplinary theories and knowledge into clinical psychology training, including political science, history, sociology (e.g., critical race theory, feminist, and queer theories), and epidemiology. A ‘social justice practicum’ might involve integrating policy, public health, and/or community psychology focused placements into the core clinical placement requirement for trainees. Trainees can be encouraged to conduct research underpinned by social justice values and given training in participatory and action research models. Lancaster University has introduced such placements into their core placement offer; evaluation and learning from this can inform and support other clinical psychology courses (Lancaster University, n. d.)

In services, clinicians can gather evidence for routine outcome reporting on the impact of social contexts on emotional wellbeing to enhance traditional reporting which are often medicalised and individual-based (Collins, 2019). Traditional case formulation in care plans, consultation, reflective practice may be enhanced by adding socially contextualised elements. Clinical psychologists can advocate for working at the community level to address ‘adverse community environments’ (Ellis & Dietz, 2017). For example, Gwent Community Psychology in Wales works in partnership with community organisations and systems to co-construct place-based formulations to understand both collective traumas and assets and to co-develop routes for possible collective action (Cobner, Daffin, & Brown, 2021).

Figure 5.

The Scientist-Practitioner-Advocate Training Model (Mallinckrodt, Miles, & Levy, 2014).



Policy

Redistributive and progressive welfare policies are required for all parents to have their needs met, and to feel safe and secure so that they can do the same for their babies. The concept of universal basic services (UBS) has been proposed, a framework for policy and practice which aims to 'improve and strengthen existing services and to extend universal access to more of life's essentials including social care, childcare, housing, digital information and communications, energy, and transport services' (Button & Coote, 2021). Alongside this, limitations of parental leave should be addressed: SMP should be living wage-based and paid parental leave should be extended for both parents: UNICEF recommends at least six months for both parents (Chzhen, Gromada, & Rees, 2019).

To provide compassionate, relationship-focused, and person-centred care, health and social care staff need to be well-resourced, valued, and supported. This requires investment in public sector workforces, a restoration of NHS funding to at least pre-austerity levels, and additional

funding for local authorities and public health. Specialist parent-infant teams should receive secure and long-term funding; the Parent-Infant Foundation recommends funding jointly between local authority public health budgets, children's services, and children and young people's mental health commissioners in recognition the multisystem approach needed (Bateson, Lang, Hogg, & Clear, 2019).

Strengths & limitations

To the best of our knowledge, this is the first, in-depth qualitative examination of parents' stories of caring for babies in the context of austerity. This study privileges the voices of a section of society whose voices are not often heard, and who are often shamed and blamed. The sample contained a range of different parenting experiences, contexts, and marginalised identities, including care leavers, survivors of domestic abuse, migrants, survivors of trafficking seeking asylum, and lone parents. However, it comprised a predominantly White British sample and did not hear any stories of same-sex or LGBTQIA+ identifying parents. This is a significant omission given these groups have suffered considerably under austerity; this is an important consideration for future research. The sample consisted mostly of mothers, which is both a strength and a limitation. Women have been significantly more affected by austerity than men, make up 90% of lone parents, and undertake more caregiving than men, particularly with children under 5 (Hochlaf, Franklin, & Billingham, 2022; ONS, 2019; Women's Budget Group, 2021). However, it is a feminist concern to involve fathers more in the care of their children, and thus hearing their voices in research is sorely needed.

Reflections

Throughout my clinical training I have contended with feelings of disillusionment and alienation from my chosen profession. When I first had discussions about my nascent research idea, I was met with responses that it was 'too political' and that I needed to make it 'more relevant' to clinical psychology. This was a disorientating experience. In clinical placements I have often

experienced a degree of moral injury working at the individual level in psychological interventions when I could see that the 'problems' were in fact located in systems, inequalities, and political structures: the consequences of over a decade of austerity preceded by years of neoliberal ideology writ large. I have felt disappointed with what felt at times like an unrelenting focus on understanding individual problems and interventions in the teaching curriculum. I remain convinced, though, that clinical psychologists are well-positioned to use their power, skills, and resources not just to find new ways of working in austere services, environments, and ideologies, but to build a case to challenge this. I believe there is motivation and desire for this within clinical psychology; indeed, there are plenty of clinical psychologists who share this view and are working in this way already. But I think this could be further unlocked with a raising of awareness of political contexts in clinical training and a reframing of what it means to work as a clinical psychologist in times of austerity.

I always knew this would be a difficult topic area. Issues of social justice and abuses of political power arouse in me a keenly felt sense of unease, anger, and frustration. Bearing witness to participants' stories was an intensely emotive experience. I was graciously invited into families' lives, and often homes, at a time of acute vulnerability. It felt at once an immense privilege and a responsibility. A responsibility to hear their stories and to ensure their stories are heard.

Conclusion

Stories provide powerful insights into personal experiences. Hearing 10 parents' stories has highlighted the lived and felt experience of austerity while caring for a baby. It has conceptualised austerity's impact as a disruption of parents' attachments through a neglectful welfare state, a healthcare system in crisis, and shrinking public services. Austerity has severed attachments and put others at risk, thereby representing a disinvestment in relationships. Parents, especially those who have experienced trauma and adversity themselves, need safety and security to provide sensitive and responsive parenting to the next

generation. It is imperative that clinical psychologists challenge austerity and collect evidence on its damaging consequences, otherwise we will continue to encounter its transmission as an intergenerational trauma.

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Appendices

Appendix I. Excerpt from the Journal of Child & Family Studies submission guidelines.

Full guidelines can be found here.

Manuscript Style

All manuscripts should follow the recommendations of the 2019 Publication Manual of the American Psychological Association (Seventh Edition). Submissions should be formatted to print out double-spaced at standard 8" x 11" paper dimensions, using a 10 pt. font size and a default typeface (recommended fonts are Times, Times New Roman, Calibri and Arial). Set all margins at one inch, and do not justify the right margin. Double-space the entire manuscript, including title page, abstract, list of references, tables, and figure captions. After the title page, number pages consecutively throughout including the reference pages, tables, and figure legends. Manuscripts should be no more than 30 pages in length, including all tables, figures, and references.

Appendix II. CASP Quality Appraisal Checklist.

www.casp-uk.net
info@casp-uk.net
Summertown Pavilion, Middle Way Oxford OX2 7LG

CASP Checklist: 10 questions to help you make sense of a Qualitative research

How to use this appraisal tool: Three broad issues need to be considered when appraising a qualitative study:

- Are the results of the study valid? (Section A)
- What are the results? (Section B)
- Will the results help locally? (Section C)

The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is "yes", it is worth proceeding with the remaining questions. There is some degree of overlap between the questions, you are asked to record a "yes", "no" or "can't tell" to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

About: These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA 'Users' guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.

For each new checklist, a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.

Referencing: we recommend using the Harvard style citation, i.e.: *Critical Appraisal Skills Programme (2018). CASP (insert name of checklist i.e. Qualitative) Checklist. [online] Available at: URL. Accessed: Date Accessed.*

CASP
Critical Appraisal Skills Programme

Paper for appraisal and reference: .....

Section A: Are the results valid?

1. Was there a clear statement of the aims of the research?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- what was the goal of the research
- why it was thought important
- its relevance

Comments:

2. Is a qualitative methodology appropriate?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- Is qualitative research the right methodology for addressing the research goal

Comments:

Is it worth continuing?

3. Was the research design appropriate to address the aims of the research?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- if the researcher has justified the research design (e.g. have they discussed how they decided which method to use)

Comments:

CASP
Critical Appraisal Skills Programme

4. Was the recruitment strategy appropriate to the aims of the research?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

Comments:

5. Was the data collected in a way that addressed the research issue?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the setting for the data collection was justified
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)
- If methods were modified during the study. If so, has the researcher explained how and why
- If the form of data is clear (e.g. tape recordings, video material, notes etc.)
- If the researcher has discussed saturation of data

Comments:

CASP
Critical Appraisal Skills Programme

6. Has the relationship between researcher and participants been adequately considered?

Yes	
Can't Tell	
No	

HINT: Consider

- If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Comments:

Section B: What are the results?

7. Have ethical issues been taken into consideration?

Yes	
Can't Tell	
No	

HINT: Consider

- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

Comments:

CASP
Critical Appraisal Skills Programme

8. Was the data analysis sufficiently rigorous?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

Comments:

9. Is there a clear statement of findings?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider whether
- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researcher's arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

Comments:

CASP
Critical Appraisal Skills Programme

Section C: Will the results help locally?

10. How valuable is the research?

HINT: Consider

- If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature
- If they identify new areas where research is necessary
- If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Comments:

Appendix III. Excerpt from the Journal of Social Policy & Administration submission guidelines.

Full guidelines can be found here.

3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

Authors are invited to submit original articles (6,000-8,000 words) for publication on subjects within the field of social policy and administration.

Please ensure that your submission is within the word limit. This limit include abstracts, tables and references/bibliography. If you want to include more material, the journal welcomes the submission of additional supporting material that will be hosted online.

The Editors may also invite the submission of review articles.

4. PREPARING THE SUBMISSION

Free Format Submission

Social Policy & Administration now offers free format submission for a simplified and streamlined submission process.

Before you submit, you will need:

- Your manuscript: this should be an editable file including text, figures, and tables, or separate files – whichever you prefer. All required sections should be contained in your manuscript, including abstract, introduction, methods, results, and conclusions. Figures and tables should have legends. Figures should be uploaded in the highest resolution possible. References may be submitted in any style or format, as long as it is consistent throughout the manuscript. Supporting information should be submitted in separate files. If the manuscript, figures or tables are difficult for you to read, they will also be difficult for the editors and reviewers, and the editorial office will send it back to you for revision. Your manuscript may also be sent back to you for revision if the quality of English language is poor.
- The title page of the manuscript, including statements relating to our ethics and integrity policies:
  - funding statement
  - conflict of interest disclosure
  - ethics approval statement
  - permission to reproduce material from other sources
- Your co-author details, including affiliation and email address. *(Why is this important? We need to keep all co-authors informed of the outcome of the peer review process.)*
- An ORCID ID, freely available at https://orcid.org. *(Why is this important? Your article, if accepted and published, will be attached to your ORCID profile. Institutions and funders are increasingly requiring authors to have ORCID IDs.)*

Appendix IV. Recruitment flyer.

What's your story of caring for your baby?

Looking after a baby is hard even at the best of times!

Cuts to public services (often referred to as 'austerity') have impacted on the support available to parents and caregivers.

It has also meant that lots of people are struggling more with money.

We want to hear people's stories of what it's like to care for a baby in these circumstances.

This is a Doctorate in Clinical Psychology research project with full ethical approval (no. 10662).

Please contact Jane Ellis for more information:

07926 073491
0151 795 5546

dclin.babystory@gmail.com

Enter the following URL or scan the QR code
https://qrco.de/bdNnws

SCAN ME

Do you care for a baby who is under 2?

Are you struggling with money? Worried about the cost of living?

We want to hear about your experiences.

Appendix V. Participant information sheet.

UNIVERSITY OF LIVERPOOL

Participant Information Sheet
Version Number 6:04.11.22

What is your story of caring for your baby?

Invitation to take part in a research study

This sheet explains why this research project is being done and what it will involve for you. This will help you decide to take part or not. Please read the information on here carefully. Please ask us if you would like more information or if you don't understand something. You can also discuss this with your friends and family if you want to.

What is this study about?

Looking after a baby is hard even at the best of times! Over the past few years the Government has made cuts to public services. This is often called 'austerity'. This has reduced the support and community services available to parents and caregivers of young children. It has meant that lots of people are struggling more with money. We are now also in a 'cost of living crisis'. We want to hear people's stories of what it's like to be a parent in these circumstances.

Who are we inviting to take part?

We are inviting adults (over 18) who:

- are parents or caregivers of a baby (under two years old).
- feel they are affected by the cost of living crisis and are worried about money.
- can tell their story in English. However, if you are worried that your level of English speaking and understanding isn't good enough, we may be able to get an interpreter to help.

What will happen if I take part?

If you agree to take part, a researcher called Jane Ellis will ask you to share your story in an interview. This will take place at a location and time of your choice. It can be done in a video call (like Zoom). You can start your story wherever you feel it begins. There is no right or wrong way of doing it. Jane will listen to your story and ask you questions about it. This should take around an hour and a half and will be audio-recorded. You will also be asked to fill in a questionnaire on your personal information, such as sexual orientation and ethnicity. This will be anonymous (you won't put your name on it) and you have the option not to answer any of the questions.

What happens to the information I give you?

The interview will be written up anonymously. This means that anyone reading it wouldn't be able to work out it was you or your family. You will be given a made-up name. You can choose this if you want to. I have a duty to try to keep people safe, so if I am worried about anybody's safety I might need to pass on information to the relevant services. I would try to let you know if I had any worries like that.

Are there any advantages or disadvantages to taking part?

You might gain some personal benefits from sharing your story. You will receive a £15 Amazon voucher for taking part, and we will cover your travel costs. We also hope that the results will help other parents and caregivers and their babies. We hope that there won't be any disadvantages from taking part in the study. If you felt uncomfortable or upset during the interview, it is okay to take a break or to stop the interview. We would encourage you to talk to friends, family members and health professionals if needed further support or advice.

What will happen to the results of the study?

Results will be written up for an academic report and may be shared with the research community in presentations and journals. Quotes from some of the interviews will be used in these reports and presentations, but they will be anonymised. No one will be able to identify you or your family in this report. Everyone who takes part in the study will be sent a summary of the results. You will be asked to give either an email address or postal address if you would like this.

Who is organising this study?

This study is being run by researchers at the University of Liverpool and has received full ethical approval (no. 10662).

Do I have to take part?

No, it is your decision if you want to take part in this study. It is okay if you do not want to take part. If you decide to take part and later change your mind you can leave the study at any point. You do not have to explain why. The care or service you receive from PSS or other organisations will not be affected if you take part or not.

What should I do next?

If you are interested in taking part or want more information, please contact Jane on dclin.babystory@gmail.com, 07926 073491 or 0151 795 5546. She will arrange to meet with you either on a video call or in person to answer any questions.

Your data in more detail

The University processes personal data as part of its research and teaching activities in accordance with the lawful basis of 'public task', and in accordance with the University's purpose of 'advancing education, learning and research for the public benefit'.

Under UK Data Protection legislation, the University acts as the Data Controller for personal data collected as part of the University's research. The Principal Investigator / Supervisor (Professor Rhiannon Corcoran) acts as the Data Processor for this study, and any queries relating to the handling of your personal data can be sent to Rhiannon.Corcoran@liverpool.ac.uk.

How will my data be collected?	Voice recording on an encrypted device.
How will my data be stored?	Password-protected files.
How long will my data be stored for?	Audio-recorded data will be stored until it has been transcribed and anonymised, before being destroyed. Anonymised data will be stored until 2032.
What measures are in place to protect the security and confidentiality of my data?	Data will be kept on password-protected devices. Audio data will be transcribed and anonymised.
Will my data be anonymised?	Any information that could identify you or someone else will be replaced.
How will my data be used?	Data will form part of a Doctorate in Clinical Psychology research project looking at caring for babies under austerity.
Who will have access to my data?	Only members of the research team will have access to your data.
Will my data be archived for use in other research projects in the future?	No.
How will my data be destroyed?	Identifiable data will be deleted when it has been transcribed and anonymised. All anonymised data will be deleted by Professor Rhiannon Corcoran in 2032.

What if there is a problem?

Please contact Prof Rhiannon Corcoran on Rhiannon.Corcoran@liverpool.ac.uk and she will try to help. If your problem is not resolved or you have a complaint which you feel you cannot come to us with please contact the Research Ethics and Integrity Office at ethics@liverpool.ac.uk, providing the name or a description of the study and the researcher involved.

If you have any concerns about the way in which the University processes your personal data, it is important you are aware of your right to lodge a complaint with the **Information Commissioner's Office** by calling **0303 123 1113.**

Appendix VI. Ethics application approval.

UNIVERSITY OF LIVERPOOL

Central University Research Ethics Committee A

19 August 2022

Dear Prof Corcoran

I am pleased to inform you that your application for research ethics approval has been approved. Application details and conditions of approval can be found below. Appendix A contains a list of documents approved by the Committee.

Application Details

Reference:	10662
Project Title:	What is it like to care for a baby in the context of austerity and rising poverty?
Principal Investigator/Supervisor:	Prof Rhiannon Corcoran
Co-Investigator(s):	Ms Jane Ellis
Lead Student Investigator:	-
Department:	Primary Care & Mental Health
Approval Date:	19/08/2022
Approval Expiry Date:	Five years from the approval date listed above

The application was **APPROVED** subject to the following conditions:

Conditions of approval

Please note: Any research ethics approval granted will be subject to the University's Policies on research during the pandemic.

Please ensure you are familiar with the latest guidance on conducting research during the pandemic. The guidance is available on the research ethics webpages.

- All serious adverse events must be reported to the Committee (ethics@liverpool.ac.uk) in accordance with the procedure for reporting adverse events.
- If you wish to extend the duration of the study beyond the research ethics approval expiry date listed above, a new application should be submitted.
- If you wish to make an amendment to the study, please create and submit an amendment form using the research ethics system.
- If the named Principal Investigator or Supervisor changes, or leaves the employment of the University during the course of this approval, the approval will lapse. Therefore it will be necessary to create and submit an amendment form within the research ethics system.
- It is the responsibility of the Principal Investigator/Supervisor to inform all the investigators of the terms of the approval.

Kind regards,

Central University Research Ethics Committee A

ethics@liverpool.ac.uk

CUREC-A

Appendix VII. Consent forms.

UNIVERSITY OF LIVERPOOL

Participant Consent Form
Version number 3:12.07.22
Participant to keep

Title of the research project: What is it like to care for a baby in the context of austerity and rising poverty?
Research ethics approval number: 10662
Name of researcher(s): Jane Ellis

Please initial box

1. I confirm that I have read and have understood the information sheet dated 02.11.22 for the above study, or it has been read to me. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that taking part in the study involves taking part in an audio-recorded interview with the researcher, Jane Ellis, which will later be typed up and anonymised. ☐
3. I understand that my participation is voluntary and that I am free to stop taking part and can withdraw from the study at any time without giving any reason and without my rights being affected. In addition, I understand that I am free to decline to answer any particular question or questions. ☐
4. I understand that I can ask for access to the information I provide, and I can request the destruction of that information if I wish within two weeks of my interview. I understand that after this date I will no longer be able to request access to or withdrawal of the information I provide. ☐
5. I understand that the information I provide will be held securely and in line with data protection requirements at the University of Liverpool. ☐
6. I understand that audio recordings will be held securely, typed up and anonymised and then destroyed. Anonymised data will be kept for 10 years before being destroyed by the Principal Investigator. ☐
7. I agree that my anonymised information can be quoted in research outputs such as posters, publications and oral presentations. ☐
8. I agree to take part in the above study. ☐

Participant name	Date	Signature
Name of person taking consent	Date	Signature

Principal Investigator
Professor Rhiannon Corcoran
University of Liverpool
corcoran@liverpool.ac.uk

Student Investigator
Jane Ellis
University of Liverpool
jane.ellis@liverpool.ac.uk

UNIVERSITY OF LIVERPOOL

Participant Consent Form
Version number 3:12.07.22
Researcher to keep

Title of the research project: What is it like to care for a baby in the context of austerity and rising poverty?
Research ethics approval number: 10662
Name of researcher(s): Jane Ellis

Please initial box

1. I confirm that I have read and have understood the information sheet dated 02.11.22 for the above study, or it has been read to me. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that taking part in the study involves taking part in an audio-recorded interview with the researcher, Jane Ellis, which will later be typed up and anonymised. ☐
3. I understand that my participation is voluntary and that I am free to stop taking part and can withdraw from the study at any time without giving any reason and without my rights being affected. In addition, I understand that I am free to decline to answer any particular question or questions. ☐
4. I understand that I can ask for access to the information I provide, and I can request the destruction of that information if I wish within two weeks of my interview. I understand that after this date I will no longer be able to request access to or withdrawal of the information I provide. ☐
5. I understand that the information I provide will be held securely and in line with data protection requirements at the University of Liverpool. ☐
6. I understand that audio recordings will be held securely, typed up and anonymised and then destroyed. Anonymised data will be kept for 10 years before being destroyed by the Principal Investigator. ☐
7. I agree that my anonymised information can be quoted in research outputs such as posters, publications and oral presentations. ☐
8. I agree to take part in the above study. ☐

Participant name	Date	Signature
Name of person taking consent	Date	Signature

Principal Investigator
Professor Rhiannon Corcoran
University of Liverpool
corcoran@liverpool.ac.uk

Student Investigator
Jane Ellis
University of Liverpool
jane.ellis@liverpool.ac.uk

If you would like to be sent a summary of the results, please write your email address or postal address below:

Appendix VIII. Debrief form.

UNIVERSITY OF LIVERPOOL

Debrief Form
Version Number 1:15.02.22

Title of the research project: What is it like to care for a baby in the context of austerity and rising poverty?
Research ethics approval number: 10662
Name of researcher(s): Jane Ellis

Thank you for taking part in this study. We are extremely grateful for your valuable contribution.

The purpose of the study is to hear people's stories of what it's like to care for a baby in a time of cuts to public services, when money is tight, and when there are fewer community facilities and support available.

Data collected will now be stored securely in line with the University of Liverpool's Data Protection policy. If you wish to withdraw your data from this study, you have up to two weeks from today's date as after this time it may not be possible due to your data being made anonymous and analysed. Please let me know by **10th February 2023.**

If you are feeling unsettled, worried, or need further advice following the interview today, here are some sources of support you might find helpful:

- For parenting support: https://www.actionforchildren.org.uk/how-we-can-help/get-parenting-support/
- For a free online parenting programme: https://ypas.org.uk/free-online-parenting-programme-in-liverpool/
- For general information and signposting around mental health difficulties, advocacy, and where to get help: https://www.mind.org.uk/information-support/helplines/
- For self-help mental health support: https://www.talkliverpool.nhs.uk/self-help/
- For urgent mental health support: https://www.talkliverpool.nhs.uk/urgent-help/
- For specialist support via the Citizens Advice Bureau perinatal link worker please speak to one of the health practitioners involved in you and your baby's care about a referral.

If you are currently accessing support from the PSS Growing Together or Parent-Baby Relationships Service, I would encourage you to share any concerns you may have with your clinician.

If there is anything you would like to discuss in relation to this study, please contact me or my primary supervisor, Professor Rhiannon Corcoran.

Jane Ellis, Trainee Clinical Psychologist

Principal Investigator
Professor Rhiannon Corcoran
University of Liverpool

corcoran@liverpool.ac.uk

Student Investigator
Jane Ellis
University of Liverpool

jane.ellis@liverpool.ac.uk

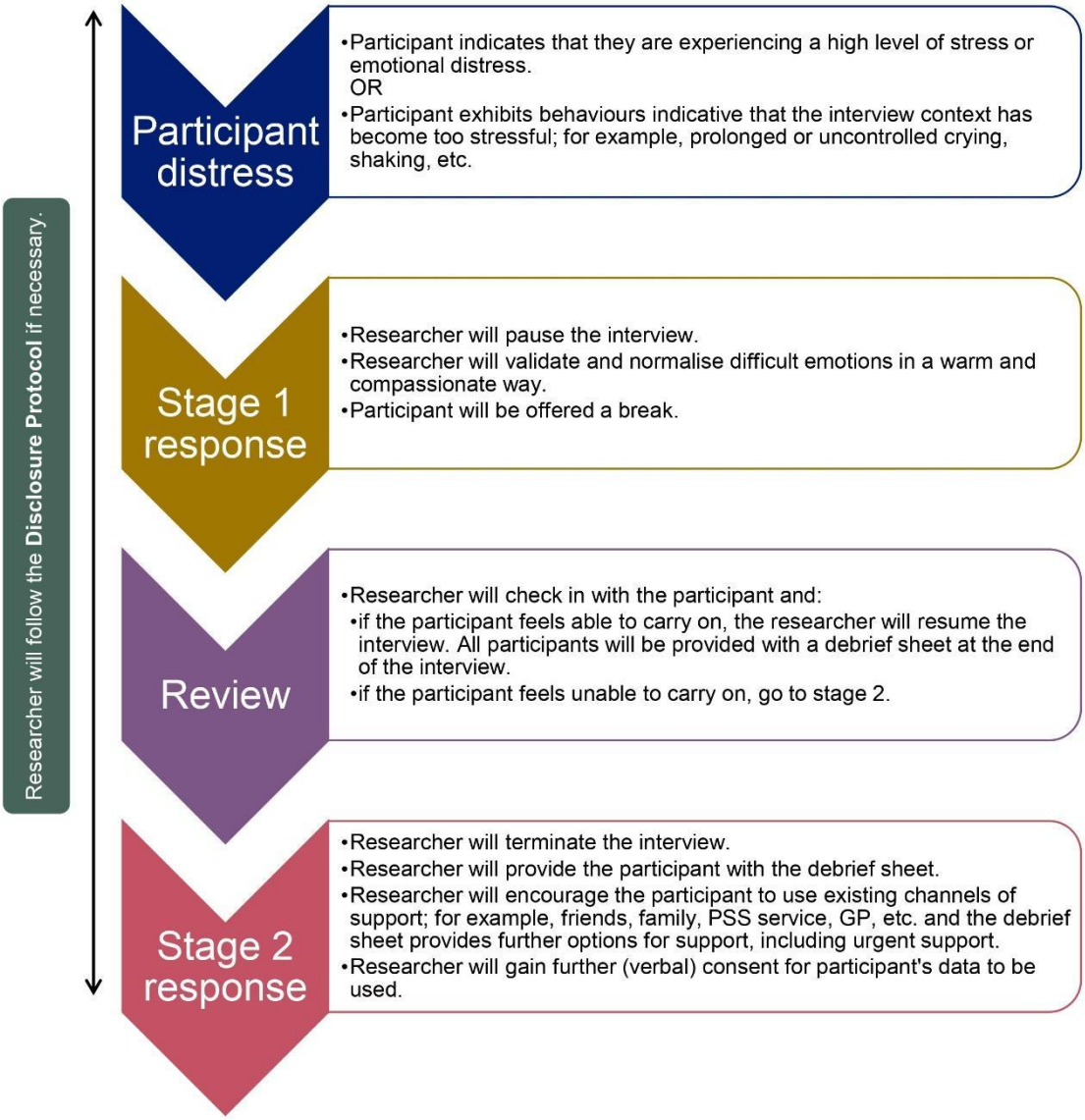
Appendix IX. Distress protocol.

UNIVERSITY OF LIVERPOOL

Distress Protocol
Version Number 3:08.07.22

Distress Protocol

(Adapted from: Draucker, Martsolf, & Poole, 2009; Haigh & Witham, 2015)



Draucker, C. B., Martsolf, D. S., & Poole, C. (2009). Developing distress protocols for research on sensitive topics. *Archives of Psychiatric Nursing, 23*(5), 343-350. https://doi.org/10.1016/j.apnu.2008.10.008

Haigh, C. & Witham, G. (2015). *Distress protocol for qualitative data collection*. Manchester Metropolitan University. https://www.mmu.ac.uk/media/mmuacuk/content/documents/rke/Advisory-Distress-Protocol.pdf

Appendix X. Disclosure protocol.

Disclosure Protocol

1. Harm to other adults

Potential examples that might indicate the risk include but are not limited to verbal disclosure of recent or intended harm to other adults.

Risk management strategy:

- Consider the nature, severity, and immediacy of risk in the context of information given. Consider the grounds for a disclosure to police based on data available. Ensure that the participant is aware that further consultation will take place. Seek supervision.

- Assess the risk, drawing on Galatean Risk Screening Tool (GRiST). Gather additional information. Record participant responses in writing using their own words where possible. Save on the M drive.

    - Where evidence suggests the risk of harm to others, remind the participant of limits to confidentiality.
    - If consent to alert other services is withdrawn, consider whether it is in the public interest to disclose the information with no consent. Seek supervision to weigh up the possible risk of harm to other people if you do not disclose, compared with the possible consequences if you do.
    - If disclosure is required to prevent or report a serious crime, contact the police. Depending on the nature of the disclosure, use urgent or non-urgent contact details. If possible, explain what information will be shared, the purpose of information sharing, and the likely implications.
    - Seek supervision prior to the disclosure if possible.
    - Advise discontinuation of the interview.

The likelihood of disclosure to other services / agencies: very likely. If disclosure is to be made, this would be to the police and on the grounds of public safety. The researcher will need to consider the possible risk of harm to other people if no disclosure is made, compared with the possible consequences if the information is disclosed. Whenever possible, the decision to disclose will be made in collaboration with the individual and clinical supervisor.

2. Safeguarding children and vulnerable persons

Potential examples that might indicate the risk include but are not limited to verbal disclosure indicating safeguarding concerns, e.g., abuse, neglect, exploitation.

Risk management strategy:

- Consider the nature, severity, and immediacy of risk in the context of information given. Consider the grounds for disclosure to social services or the police based on the data available. Ensure that the participant is aware that further consultation will take place.

- Gather additional information. Record participant responses in writing using their own words where possible. Save on the M drive.

- Advise of limits to confidentiality and a statutory obligation to disclose possible harm to vulnerable groups and children. If possible, explain what information will be shared, the purpose of information sharing, and the likely implications.
- If consent to alert authorities is withdrawn, disclose safeguarding concerns without consent. Contact local social services. If there is evidence of harm to a child or a vulnerable adult, contact the police. Depending on the urgency, use emergency or non-emergency contact details.
- Seek supervision prior to disclosure if possible.
- Advise discontinuation of the interview.

Likelihood of disclosure to other services / agencies: very likely. If disclosure is to be made, this would most likely be made on the grounds of public interests (i.e., the interest of a child or vulnerable adult). Whenever possible, the decision to disclose will be made in collaboration with the individual and clinical supervisor.

3. Disclosure of illegal activity

Potential examples that might indicate the risk include but are not limited to verbal disclosure indicating illegal activities. These can include serious crime, such as causing serious physical or psychological harm to individuals (e.g., murder, manslaughter, rape), breaking a law where no victim is easily identifiable (e.g., attempting to drive under the influence, possession of illicit substances) or a series of incidents which combined constitute illegal activity even though one on its own may not (e.g., as sometimes occurs with child neglect).

Risk management strategy:

- Consider the nature, severity, and immediacy of risk in the context of information given. Consider the grounds for disclosure to the police based on data available. Ensure that the participant is aware that further consultation will take place.

- Gather additional information. Record participant responses in writing using their own words where possible. Save on the M drive.

    - Advice of limits to confidentiality and an obligation to report criminal activity.
    - Seek clinical supervision before reporting crime, particularly where:
        - It is unclear whether the crime or harm is sufficiently serious to justify disclosure (e.g., historical damage to property).
        - The risk of serious crime or harm being committed exists, but it is not clear whether the likelihood of it occurring is sufficient to justify the disclosure.
        - The risk of serious crime or harm being committed exists, but it is not clear whether it could be prevented without the disclosure (and thus whether the disclosure is 'necessary').
        - Where harm is less severe but is prolonged (e.g., the impact on a child witnessing domestic violence).
        - The participant has explicitly refused to consent to the disclosure.
        - The benefits and detriments from disclosure are finely balanced.
    - If sufficient evidence exists that disclosure may serve to prevent or detect a crime by an individual or against another identifiable person, report it to the police. If possible, explain what information will be shared, the purpose of information sharing, and the likely implications.
    - If consent to alert authorities is withdrawn, disclose the information without consent.

- Consider the application of the public defence interest, which is separate from, and additional to, the specific statutory requirements for disclosure in relation to crime; e.g., financial assistance of terrorist activity.
- Consider other agencies that might require information sharing; e.g., reporting to the Driver & Vehicle Licensing Centre a person who rejects medical advice not to drive, reporting information to social services where there is a risk of significant harm to a child.

The likelihood of disclosure to other services / agencies: very likely. If disclosure is to be made, this would most likely be defended on the grounds of public interest or public defence interest. Whenever possible, the decision to disclose will be made in collaboration with the individual and clinical supervisor

4. Disclosure of current or historical victimisation

Potential examples that might indicate the risk include but are not limited to verbal disclosure indicating any form of current or historical abuse/ neglect/ witnessing domestic violence; being a victim of violent or non-violent crime.

- Consider the nature, severity, and immediacy of risk in the context of information given. Consider the grounds for disclosure to the police based on data available. Ensure that participant is aware that further consultation will take place.

- Gather additional information. Record participant responses in writing using their own words where possible. Save on the M drive.

    - Advise of limits to confidentiality.
    - Gather more information. Seek to establish whether the participant already reported the crime to relevant authorities and if not, if they wish to report it.
    - Seek supervision to consider the nature and extent of information disclosed and current risks to the public.
    - If enough information is disclosed (including identifiable information) and there is evidence that disclosure would in all likelihood support detection, investigation, and punishment of serious crime and/or to prevent abuse or serious harm to others, disclose to the police and / or social services. Seek consent in the first instance.

The likelihood of disclosure to other services / agencies: likely. If disclosure is to be made, this would most likely be defended on the grounds of public interests. Whenever possible, the decision to disclose will be made in collaboration with the individual and clinical supervisor

Sources

This document was adapted from a disclosure protocol produced for another ethics application which received ethical approval, reference number:

The following sources were consulted for the purpose of this document:

- Department of Health (2010). *Confidentiality. NHS Code of Practice. Supplementary Guidelines. Public interest Disclosure.* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216476/dh_122031.pdf
- Department of Health (2021). *SHARE: consent, confidentiality and information sharing in mental healthcare and suicide prevention*. https://www.gov.uk/government/publications/share-consent-confidentiality-and-information-sharing-in-mental-healthcare-and-suicide-prevention/share-consent-confidentiality-and-information-sharing-in-mental-healthcare-and-suicide-prevention
- Health and Care Professions Council. C*onfidentiality. Guidance for Registrants.* https://www.hcpc-uk.org/globalassets/resources/guidance/confidentiality---guidance-for-registrants.pdf
- British Psychological Society (2017). *Practice Guidelines*. https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/BPS%20Practice%20Guidelines%20%28Third%20Edition%29.pdf
- British Psychological Society (2021). *Code of Human Research Ethics*. www.bps.org.uk/news-and-policy/bps-code-human-research-ethics

Appendix XI. Demographics form.

UNIVERSITY OF LIVERPOOL

Demographics Form
Version Number 2:02.08.22

Please do not write your name on this form. It will be stored separately from any information you provide at the interview and will not be directly linked with your responses in the write-up.

For the following questions you can either:

- write your own response in the box **OR**
- tick the option that you feel best describes you **OR**
- tick 'prefer not to say'.

1. **How would you describe your gender identity?**

Please write your response:	**OR tick one of the following options:**	
	Female	
	Male	
	Trans woman	
	Trans man	
	Non-binary	
	Prefer not to say	

2. **How would you describe your sexual orientation?**

Please write your response:	**OR tick one of the following options:**	
	Bisexual	
	Gay	
	Heterosexual / straight	
	Lesbian	
	Pansexual	
	Prefer not to say	

3. **How would you describe your ethnicity?**

Please write your response:	**OR tick one of the following options:**	
	Asian or Asian British – Bangladeshi	
	Asian or Asian British – Chinese	
	Asian or Asian British – Indian	
	Asian or Asian British – Pakistani	
	Asian or Asian British – Any other Asian background, **please state**:	
	Black or Black British – African	
	Black or Black British – Caribbean	
	Black or Black British – Any other Black background, **please state**:	

Participant Number:

	Multiple ethnic groups – Asian & White	
	Multiple ethnic groups – Black African & White	
	Multiple ethnic groups – Black Caribbean & White	
	Any other multiple ethnic background, **please state**:	
	White or White British – English, Welsh, Scottish, Northern Irish	
	White or White British – Gypsy or Irish Traveller	
	White or White British – Irish	
	White or White British – Roma	
	Any other White background, **please state**:	
	Prefer not to say	

4. **How old are you?**

Please write your response:	
OR Prefer not to say	

5. **If you'd like to, please write below a made-up name you'd like me to use when writing up my report. If left blank, I will choose one for you. *(Please do not write your real name here).***

_____

Appendix XII. Narrative interview guide.

Part 1: Single question aimed at inducing narrative (SQUIN)

I am interested in your story about what it's like to raise a baby during what is often called austerity – when less money is spent on public services, when access to community services might be reduced, and when many families are struggling with money. Your story begins wherever you like and there is no right or wrong way to tell it.

So, when you are happy to, please could you talk to me about your story of caring for your baby in these circumstances, and the events and experiences that are important to you.

Part 2: Particular incident narratives (PINs)

Thank you for sharing your story with me. I've made some notes and have a few questions to ask you based on what you've been talking about. As I said before, you can tell me as much or as little as you feel comfortable with, and you can choose not to answer any of the questions.

- You said […] Can you remember a particular time that happened?
- You told me about […] Can you tell me more about how it felt at the time?
- Earlier you mentioned […] What was important about that?
- Before you said […] What was that like for you in that moment?
- You told me […] What did that mean to you?

Appendix XIII. Excerpt from narrative mapping.

Narrative mapping
Transcript 1

Described action/event	Participant's evaluation	My interpretation
Found out I was pregnant.	Excited but also worried about lack of security of income as had just gone self-employed. Money was a big factor in pregnancy.	Money is a top consideration in parent and baby's story from day one.
During pregnancy finances were tight	Tried to save but was a challenge as unexpected costs pop up. Babies are expensive. Cut 'date nights' with partner.	Worrying about money during pregnancy could cause high levels of stress. Already making sacrifices such as own relationship and self-care.
Support during and immediately post-birth	Initial few weeks after birth were scary. Went from lots of input (midwife, then health visitor) to nothing, and partner back in work.	Felt supported around birth but this was not maintained and it stopped abruptly. Felt abandoned? Daunted by the prospect of looking after newborn baby entirely alone. Cuts and underfunding in NHS.
Contact with early years services	Brilliant support from feeding team. Great to know drop-in service is there should I need it. Home Start classes have been incredible. Filled the gap of statutory (health visitor) services, e.g. with weigh-in clinics. Staff were warm and welcoming. Free face-to-face classes have been great. Great to just sit and chat with other new parents.	Children's centre as: - a secure base for parents to be more able to in turn provide a secure base for children. Being the 'hands that hold the hands' - an opportunity for facilitating social connection, sense of belonging, and building social networks. Home Start children's centres are run by a charity and thus a postcode lottery. Voluntary sector filling the gap of statutory service is problematic.
Support from social network	Partner's family live nearby and are incredibly supportive.	Proximity and availability of family support is important.