INTRODUCTION

An overview:

The relationship between Disability and stress is well documented and has been studied from many perspectives. Most research has considered the psycho-social impact of Disability on the individual or family (Abelson 1999; Olsson & Hwang, 2002; Roberts & Lawton, 2000; Todd & Jones, 2005; Woolfson & Grant, 2005). Professionals working in the field of Disability are reportedly subjected to higher stress levels, increased caseloads as well as psychological fatigue (Harris, Prater, Dyches & Heath, 2009; Langdon, Yaguez & Kuipers, 2007; Lubinski, 2001). Speech-language therapists, occupational therapists and physiotherapists are amongst individuals who encounter Disability as part of their work on a daily basis. However, there is little research that examines experiences from the perspective of therapists working with Disability who are also mothers to children with developmental disability. What is unique about this situation is that individuals have an insight into Disability from the perspective as a parent and a clinician. In the present study which explored the experience of therapist mothers, four occupied life domains were considered, namely, the mother as a caregiver; the mother to a child with disability; the working mother and finally the role as a therapist working with Disability. Though multiple social roles are associated with positive well-being, there is also evidence that cumulatively high stress levels lead to burnout and ineffective coping mechanisms (Carlson & Perrewe 1999; Langdon, et al., 2007).

In addition, the spillover effect of stress usually affects all occupied life domains (Appel & Kim-Appel, 2008). This has professional implications in terms of how intra-personal boundaries are established in order to adhere to professional guidelines.

This study aimed to understand the experience of professional parents working in the field of Disability while caring for a child with developmental delay.

1. LITERATURE REVIEW

The aim of this section is to understand the challenges and stressors which confront therapists who are mothers to children with developmental disability.

Stress is defined as the collective effect of various demands on the individual as per daily responsibilities while burnout refers to the physical, mental and psychological impact of cumulative life stresses (Gibson, Swartz & Sandenbergh, 2002). Stress and burnout has a significant impact on the calibre of professional services rendered (Harris et al., 2009). The nature of professional-client interactions within the health and caring professions are very sensitive to the psychological well-being of the professional. The professional, as the service provider, is obliged to ensure their own emotional and mental vitality. Failing this, clients may be subjected to unprofessional practices. At the same time professionals may suffer poor job satisfaction, low morale, depersonalization and lower levels of personal accomplishment (Langdon et al., 2007). On a macro-level the outcomes of stress and burnout often result in shortages of professional services available to the broader community (Skovholt, 2001).

For the past fifty years, the notion of disability has undergone radical transformations (Thomas, 2007). At this juncture, disability is viewed by many as a societal response rather than an individual problem. A burgeoning literature offers a range of perspectives all of which acknowledge the role of society in the definition of disability.

One example of the influence that this change in perspective has had is on the powerful documentation and policies produced by the World Health Organization (WHO). According to the WHO's International Classification of Functioning, Disability and Health (ICF) (2001), disability is no longer viewed exclusively as the overall effect of impairment. The ICF has aimed at shifting the focus towards a holistic, quality of life orientated perspective of disability. In this way, disability is acknowledged for the social impact that it has on the individual. Consequently, the ICF implies that professionals working with disability need to adapt treatment and polices in order to reflect the change in definition. More importantly, the ICF draws attention to the social prejudices to which individuals with disability are subjected. It can be surmised that the rational guiding the ICF framework acknowledges the resulting social stress that Disability creates within the individual as well as those within the interpersonal social sphere.

Exploring life stressors requires an understanding of the individuals' lives. For the purposes of this research report four life domains were considered. These were the mother as a care-giver; as the mother to a child with developmental disability; as the working mother and as the professional working with Disability.

1.1. The mother as a caregiver

Care-giving entails extending oneself in order to oversee or assume responsibility for the well-being of an individual, usually a child or a significant adult in the care-givers life (Rogoff, 2003). Generally, parental care-giving refers to the physical care that the child or adult is afforded though strategies for psychological and mental health care are also included (Lubinski, 2001).

Research on parenting has traditionally focused on mothers as the primary care-givers largely due to the socialized differences in female and male role occupation (Barnett, 2008). As a result the parenting experience is seen to be gender biased despite the increasing involvement of fathers in care-giving activities (Fletcher, Vimpani, Russell & Keatinge, 2008; Perala-Littunen, 2007). Further support for the gender bias arises from the proposition that care-giving is central to women's identities (Brannen & Petite, 2008; Perala-Littunen, 2007). As a result women tend to assume responsibility for the majority of the care-giving that is required (Gibson, et al., 2002). Of significance is that the nature of care-giving can be stressful. As a result of demands on time, energy and resources, mothers report limited social recreation and interaction with their spouses as well as having to constantly engage in household obligations (Abelson, 1999). Consequently, they are more prone to the negative health impacts of care-giving such as fatigue, heightened stress levels, avoidance coping strategies as well as emotional and mental burnout (Marin, Holtzman, DeLongis & Robinson, 2007; Ray, 2003).

Acknowledging care-giving related stresses, the recent literature has focused on methods of promoting effective coping skills within care-givers (Marin et al, 2007; St Jonn-Seed & Weiss, 2005). The diversified sources of stress are a result of immense variation in personal beliefs pertaining to child-care practices (Rogoff, 2003). Understanding the stress that mothers experience as care-givers necessitates an understanding of what it means to be a mother. A working definition of motherhood also explains how the mothering identity is conceptualized which is significant to the coping strategies, support mechanisms and degree of role balancing in which mothers engage.

Human parenting is a product of our collective social, cultural, biological and psychological heritage (Rogoff, 2003). These four factors account for the perceptions, attitudes and beliefs that parents hold regarding child-care (Cheah & Chirkov, 2008; McGillicuddy-de Lisi & de-Lisi, 2007). The pattern of interaction between society, culture, biology and psychology of the individual is dynamic and not always proportionate in influence. Additional factors such as child responsiveness, daily living experiences and workload, family structure and needs as well as socio-economic status are but a few factors which tailor the manner in which parenting is exhibited (Ray, 2003).

Maternal parenting or Motherhood has become a broadly defined and contested term. The criteria which define motherhood have changed dramatically over the last few decades (Landsman, 2000). In many societies the shift in socio-economic factors has expanded the social roles in which women previously engaged. In addition to the role as a nurturer, child-minder and home-maker, women were slowly starting to enter the workforce (Barnett & Hyde, 2001). This transition gave rise to the term “working mother”, which has challenged the traditional definition of motherhood (Hanson & Lynch, 2004; Rogoff, 2003).

The challenges of motherhood are also redefined as per evolving social expectations and norms. Being a mother no longer assumes common genetic material between child and parent nor does it imply that the biological mother has to care for her child (Perala-Littunen, 2007). The advance of reproductive technologies, adoption rights of non-biological mothers, re-establishing of nuclear families and the contentious definition of caregiver versus parent raised new issues in terms of the mothering responsibilities (Landsman, 2000).

Despite the ambiguity, the core concept of motherhood remains the presence of a child or children, usually cared for by an influential female figure (Hanson & Lynch, 2004). Cross-cultural psychologists maintain that the mother's ability to carry out child-rearing practices is embedded in parental cultural belief systems or ethno-theories (Cheah & Chirkov, 2008; Bornstein, Hahn, Haynes, Belsky, Azuma, Kwak, Maital, Painter, Varron, Pascual, Toda, Venuti, Vyt & de Galperin, 2007). As child-rearing is a dynamic, bi-directional relationship, it follows that maternal reactions to child-rearing would also be rooted in ethno-theories. This is the essence of understanding the stressors and coping strategies that mothers employ.

In many of the world's societies, the onset of motherhood is seen as the cultural entry into adulthood if not the next stage of adulthood (Rogoff, 2003). It is premised on the underlying responsibility that is associated with caring for a child. To this end the importance of socio-cultural systems as a source of understanding parenting has most commonly been explained by the independence or individualism and the interdependence or collectivism models of parenting (Cheah & Chirkov, 2008; Borke, Lamm, Eickhorst & Keller 2007; Bornstein et al, 2007; McGillicuddy-deLisi & de Lisi 2007). The models explain the extent to which the individual is immersed within collective community and subsequent intra-personal skills that each situation fosters. The independence model focuses on the development of the individual. The aim of this model is to maximize individual strengths. Parenting concentrates on fewer children with a huge emphasis on tailoring of specific needs. Autonomy of the individual regarding decision making, competitiveness, achievement and self reliance are highly regarded personality traits.

In contrast the collectivism model is concerned with the social interdependence of the unit, namely the family. Each individual is likened to a building block who contributes to the functioning of the larger structure. The interdependence model focuses on developing the individual in manner which allows the larger social unit to function efficiently. As a result, there tends to be more emphasis on sharing workloads, pooling of resources and compensating for the limitations of others. In this way, the individual still develops his or her abilities but in a different direction from peers within the independence model.

It is widely acknowledged that most of the world's societies embrace aspects of both these models. The central issue remains the extent to which each orientation is evident within a particular grouping of people. Cheah and Chirkov (2008) compared European and Aboriginal maternal cultural practices in order to ascertain the level of contrast that each culture exhibited. Results indicated that both cultural groups listed similar concerns regarding child care practice such as individual achievement, financial independence, autonomy, respect to others, religious affiliation and cultural/community development. However, the differences between cultural practices were evident in the extent to which each goal was prioritized. The strongest predictor of cultural practice was the changing social demographic factors that the mothers experienced.

In attempting to explain the daily experience of mothering, Ho, Bluestein and Jenkins (2008) discuss an Integrative Model of Culture. The model assumes the traditional values outlined by the independence and interdependence models while taking into account the broader context in which the society exists. Variables such as racism,

prejudice, social class, economic and psychological segregation, prejudice are also examined. The implications of this model are firstly the enormous intrapersonal variability that exists amongst parents. The idea of a shared system of beliefs would seem a superficial explanation of what parenting actually entails. Social position and socio-economic status emerge as key factors in the type and level of parenting a child is afforded. It becomes more difficult to define parenting yet alone mothering. Rather researchers have to understand what it means to be a parent in light of complex, dynamic social environments coupled with highly individual experiences, beliefs and needs. Although previously characterized by time-honoured, cultural and religious conventions, individuals are experiencing greater freedom in living out their own definitions of what it means to be a mother. In the process of creating new identities, certain aspects of the maternal archetype still hold strong (Perala-Littunen, 2007). Ironically the evolving face of motherhood presents itself as a double edged sword which can in itself be a daunting experience. Change is often accompanied by uncertainty or stress and the dynamic, interactive nature of parenting is such that it is inevitable that external factors bring about stress. Such challenges redefine the roles, expectations and obligations that a mother is to fulfill (Barnett, 2008). No doubt, this may be highly stressful for mothers, in addition to caring for other individuals. The socio-cultural challenges of motherhood are often accompanied by mixed emotions (Ray, 2003). Significantly, the mother's emotional state coupled with stress often leads to psychological distress (St. Jonn-Seed & Weiss, 2005). Rouge-Maillart, Jousset, Gaudin, Bouju and Penneau (2005) revealed that psychological-social stresses such as lack of social support, economic difficulties, desire to achieve, family stress and unrealistic expectations of motherhood were attributed as

causal factors to maternal neonaticide and filicide. Maternal psychological health is seen to have repercussions on the family at large.

While the confluence of ethno-theories may have explained diverse socio-cultural expectations that mothers face when raising their children it also reflects the immense pressure and different roles that the mother now has to assume. In some cases managing multiple roles such as provider, nurturer and wife has proven to result in high levels of psychological stress (Carlson & Perrewe, 1999). However, in other cases this has proven to be the opposite (Barnett, 2008; Nordenmark, 2004). It has become evident that mothers who demonstrate secure attachment as children, parental self-efficacy and better social support are better able to juggle multiple roles (Quimby & O'Brien, 2006; Rogoff, 2003). This comes down to the consolidation of early ethno-theoretical explanations and socio-demographic factors. Early consolidation of the self be it in individualism, collectivism or combination cultures result in better internal working models which formulate psychological resilience.

To this end, it is apparent that the evolving face of motherhood brings about unique yet challenging expectations of the individual. Taking up mothering duties consequently unveils an infinite number of possible stresses which the mother has to survive.

1.2. The mother to a child with developmental disability

Rossetti (2001) defines developmental disability as anything that interferes with the child's ability to develop according to normative expectations. Referred to as special-needs parenting, the earliest and possibly most significant stress factor that

parents are faced with is the diagnosis of the developmental delay (Sen & Yurtsever, 2007; Ray, 2003; Seiler, 2002). Mothers are reported to assume blame for the disability, tracing back to incidences or events during pregnancy that could have precipitated the onset of the prevailing disability. During this time, parents find themselves searching for answers whilst simultaneously acknowledging the impact of the disability on the child and the family (Landsman, 2000). Moreover, many parents mourn the loss of the hopes, dreams and ambitions for their child that may inevitably be brought about by the disability. Parents often pass through various stages of grief prior to accepting their child's condition (Sen & Yurtsever, 2007). These stages range from initial shock to denial, depression, feelings of guilt, indecisiveness, anger and shame. Each of these stages can be stressful to the parent and can manifest as difficulties in family relations, domestic issues and work. The negative spill-over into other life domains exacerbate the emotional difficulties that parents face which could be detrimental to all family members.

For many parents, an additional source of emotional distress is exacerbated by the lack of information pertaining to their children's disability (Brannen & Petite, 2008; Ray, 2003). Parents have reported utilizing avoidance coping mechanisms to counter the effects of lack of information. Consequently there is a need for effective professional support structures for parents (Spratt, Saylor & Marcias, 2007; St. Jonn-Seed & Weiss, 2005).

Another source of stress for special-needs parenting is the high level of care that children with disability require (Kenny & McGilloway, 2007; Roberts & Lawton, 2000). Not only are they subject to the care-giving demands that non-special needs parenting requires but also the demands imposed by the presenting disability (Abelson, 1999). As a result parents engage in constant care-giving. The care

required ranges from activities of daily living (bathing, dressing, feeding, toileting) to behavioural and or educational (stimulating, pacifying, behaviour management, dealing with delayed or deviant behaviour patterns) and life skills (safety, independence, social behaviours). The more attention and monitoring of care that is required the more exhausting the task tends to be (Sen & Yurtsever, 2007). The care-giver, being integral to the intervention process, also assumes the responsibility of monitoring developmental progress and implementing intervention measures within the home context (Brannen & Petite, 2008). Consequently, parents of children with Disability report that care-giving has a negative impact on their physical and emotional health.

Parental stressors and coping are also influenced by the outcomes of various disabilities. The more severe the disability, the more care the child requires. Robert and Lawson (2000) document that those parents of children with autism found the behavioural and cognitive deficits to be more difficult to manage in comparison with intellectual deficits. Furthermore each stage of development brings about changes which require different types of parental input and care. According to Cuskelly (2006); Ansberry (2004); Walden, Pistrang and Joyce (2000), many children with disabilities grow up without ever developing full autonomy and independence. As a result many parents have to care for their disabled children into adulthood and beyond. MacDonald & Callery (2008) report that long-term care of the child often results in parental fatigue and burnout. As a result there is need for respite care towards parents (Abelson, 1999).

Despite the high levels of stress, parents display resilience and positive attitudes (Lindblad, Holritz-Rasmussen & Sandman, 2007; Davies & Hall, 2005; Roberts & Lawton, 2002). There is an emergence of strong themes such as acceptance, joy, balancing of good and bad times (Lassetter, Mandeco & Olsen-Roper 2007). Mothers try to maintain as normal a life as possible while caring for their child (Todd & Jones, 2005). Maintaining a sense of normality is important for personal well-being as well as their social interactions. Landsman, (2000) revealed that mothers of children with disabilities maintained stronger and resilient identities in the face of other obstacles in their lives. Seiler, (2002) reports that the experiences of caring for children with developmental disability results in parents advocating for meaningful life opportunities for their children. Eventually, these parents aim for their children to be socially integrated within the community at large. The root of such parental desires stems from surviving the parenting ordeal, collaboration with others as well as increased knowledge about the presenting disability. This reflects the sociological impact that Disability has on the family at large. On an individual level, the ability to turn a difficult situation into a positive learning experience highlights parental resiliency. For many mothers, re-establishing their own lives is a pro-active measure which ensures the survival of themselves, the child with developmental disability and the family at large (Brook, Garcia & Fleming, 2008). Most often, these mothers seek an identity outside the home, which inevitably leads them to the working environment.

1.3. The working mother

Research examines how mothers balance their own lives in relation to care-giving responsibilities (Carlson & Perrewe, 1999). One of the ways in which they

accomplish this is by working. Many parents maintain that work is a necessity from a financial and psychological well-being perspective (Barnett, 2008). It is a form of self-care which enables them to adopt a new identity, allowing them time away from the stresses of the home environment. Apart from the psychological relief, many women are purely career orientated individuals who ambitiously strive for personal growth. Such individuals often occupy multiple roles, namely the role as a mother, wife and employee (Nordenmark, 2004). From a psychological standpoint working mothers report that they contributed positively to their children when they were away from them (Appel & Kim-Appel, 2008). It gave them a much needed break which they ordinarily would not get (Kenny & McGilloway, 2007). The overall effect of role balancing may have a significantly positive impact on the mother, allowing her the opportunity to socialize with women in similar predicaments which in itself is supportive (Comer and Stites-Doe 2006; Guendouzi, 2006; Barnett & Hyde, 2001).

While there are positive outcomes to employment, there are also negative results. Mothers who work are required to balance work and family which is a stressful yet common experience (Brandon, 2007; Elliot 2003; Kagan, Lewis, Heaton & Cranshaw, 1999). Finding the balance stems from work and family demands competing for time and energy resources from the individual, termed the work-family conflict (Appel & Kim-Appel, 2008; Barnett, 2008; Winslow, 2005; Carlson & Perrewe, 1999). The work-family conflict is indifferent to situational differences in profession, disability, social or family support and finances. Mothers balancing work and family life often have to make greater personal sacrifices while being subjected to high levels of physical, emotional and mental stress (Elliot, 2003; Ray, 2003). In addition, the work and family obligations may suffer setbacks (Guendouzi, 2006; Morris & Coley, 2004). The nature of stress is such that more often than not it cannot

be contained within a particular domain. As a result, the stress in one domain tends to accumulate within the individual and spill-over into other domains (Appel & Kim-Appel, 2008). The significance of such a pattern potentially results in burnout.

One of the reasons why mothers of children with disabilities work is due to the financial demands that the child with disability incurs (Kagan, Lewis & Heaton, 1998). Apart from everyday living expenses, professional services, specialized equipment, medication and special school or daycare facilities need to be taken into account. As a result children with disability are more likely to live in middle to lower socio-economic conditions (Sen & Yurtsever, 2007).

Although working alleviates part of the financial pressure which mothers may face, there is also gender bias towards care-giving which may compromise their position in the workforce (Brandon, 2007; Comer & Stites-Doe, 2006; Barnett & Hyde, 2001). Even highly successful career women in egalitarian relationships are likely to assume greater family responsibilities compared to their husbands or male colleagues (Comer & Stites-Doe, 2006). As a result, mothers tend to opt for employment with flexible options which allow them to maintain their domestic lives (Elliot, 2003). Work flexibility comes with the price of possibly stunted career growth and lower salary packages.

Generally, working women have to maintain the work-family balance (Carlson & Perrewe, 1999). While they may be intrinsically motivated to sustain the associated stresses, many a time they find the balancing act to be exhausting. Working mothers to a child with developmental disability have to contend with the stressors of Disability. At this point, engaging in multiple roles is more demanding of the

individual and often results in higher stress levels (Brook, et al., 2008). Bearing this in mind, the working therapist who is a mother to a child with developmental disability is considered in terms of the professional engagement with Disability on a daily basis.

1.4. The therapist working with disability

Speech therapists, occupational therapists and physiotherapists are trained to work with people presenting with disability (Physiosa, 2008; OTASA, 2005; SASLHA, 2001). These individuals emerge from their training with clinical and theoretical knowledge regarding the assessment and intervention of Disability. Two important points to bear in mind are that firstly, therapists are career orientated women and secondly their training ensures that they are highly capable to address issues of disability. Most therapists are women. For these women being in the work place constitutes more than financial gain or psychological well-being. These are career women who are usually drawn by individual goals, ambitions and desires within their respective fields (Comer & Stites-Doe, 2006; Elliot, 2003). Like other working mothers, therapists would aim to integrate their dual role, namely as specialist skilled workers as well as nurturers. Flexible working options are necessary to balancing the two roles (Barnett & Hyde, 2001). For therapists, this option is available in most clinical or academic settings. The option of flexible work is associated with psychological rewards and work-family facilitation.

As professionals, therapists are obliged to adhere to ethical guidelines as stipulated by the respective professional boards. Professional guidelines ensure that the clients' interests are protected and that the integrity of the disciplines are maintained (Lubinski, 2001). In South Africa, these professional bodies governing speech-

language therapy, occupational therapy and physiotherapy are The Health Professions Council of South Africa (HPCSA, 2008), South African Speech Language and Hearing Association (SASLHA, 2001), Occupational Therapy Association of South Africa (OTASA, 2005) and The Society of Physiotherapists South Africa (Physiosa, 2008). Generally, professional rules of engagement are based on the principles of beneficence, non-maleficence, autonomy, justice, veracity and fidelity (Irwin, Pannbacker, Powell & Vekovius, 2007; Nelson, Summers & Turnbull, 2004). The South African professional organizations have dutifully engaged these principles in devising guidelines pertaining to ethical conduct and professional competencies. A review of the professional guidelines pertaining to three therapeutic disciplines revealed that professional responsibilities geared towards ensuring clients and communities interests as well as healthy interactions amongst colleagues. For the former two entities, issues included are maintaining confidentiality, adhering to boundaries governing professional relationships, appropriate provision of services and usage of equipment. The therapist has to respect the clients' rights at all times. Therapists are encouraged to maintain good relations with clients by being empathetic, compassionate, respecting clients' wishes while affording them services of a high quality that is well suited to their needs. There is also a social responsibility which the professional has to implement. This includes not misleading or misrepresenting consultations or the nature of the profession as well as providing correct information about the profession. Therapists are discouraged from befriending clients, assisting them with chores or acting as their advisors or confidants. Though professionals are duty bound to implement professional guidelines, their behavior may result in them being portrayed as impersonal and unable to understand the clients' experiences (Bingham, 2003). This can lead to

negative interactions between parents and professionals especially in cases where parents are emotionally vulnerable and looking to the professional for supportive information. Parents may feel more comfortable if the professional is a parent, perceiving that the professional has a degree of personal insight into their situations (Das, 2006).

A review of the professional guidelines revealed that there is very little attention drawn to the psycho-social well-being of professional therapists (HPCSA, 2008; OTASA, 2005, SASLHA, 2001). What this means is that the impact of professional and personal issues on the individual has not been acknowledged. Rather, the ethical guidelines seem to downplay the importance of self-care and preservation of professionals in relation to effective service delivery. Paradoxically there has always been a need for professionals to separate personal and professional life issues in the interests of their clients (Nelson, et al., 2004). The significance of the relationship between personal and professional issues as it occurs within the individual has been recognized by the psychological professions. The American Psychological Association provides insightful guidelines which govern professional behavior (Knapp & VandeCreek, 2006). For example professionals who experience personal tragedies should alter their lives and seek necessary psychological assistance so as not to inflict any harm or possible damage onto their clients. Furthermore, the principles of transference, counter-transference and projecting ones' emotional states onto others are discussed in relation to the effect on clients. Speech therapy, occupational therapy and physiotherapy approach Disability from a largely physiological perspective. This shifts the goalposts of professional guidelines and expectations which may explain why emotional interactions are downplayed. Also

the Allied Health Professions' association with the medical fraternity inevitably draws on the medical model of interaction with clients despite best efforts to engage the sociological models of professional-patient interaction (Thomas, 2007). As a result, very often there are 'grey areas' of professional conduct which cannot be accounted for. A further concern is the effect on the professional-client boundary. Boundaries refer to the professionals' relationship between the therapist and the client (Knapp & VandeCreek, 2006). A boundary crossing occurs when a professional deviates from professionally stipulated behaviour whereas a boundary violation refers to professional malpractice which could potentially harm the client. No doubt, there is a very fine line that distinguishes the crossing from the violation. Taking the nature of the therapeutic relationship with Disability into account, professional-personal issues within the therapist has the potential to cause the greatest harm to the client.

1.5. The parent-professional relationship

Apart from professional guidelines, professionals inherently bring their experiences, knowledge and even personal expectations to the parent-professional relationship (Skovholt, 2001). Professional and parent collaboration is a fundamental principle to any intervention programme concerning individuals, especially where children presenting with developmental disability are concerned. The term collaboration implies equal participation of both the family and the professional (Seiler, 2002). Parent-professional collaboration where children with developmental disabilities are concerned is known to have a high success rate (Morrow, Quine, Loughlin & Craig, 2008). As a result, professionals are continuously attempted to better this collaborative process (Schmidt, Thyen, Chaplin, Mueller-Godeffroy, Bullinger & the European DISABKIDS Group, 2008). For parents a large part of the discrepancies

that arise stem from a lack of information about their children's condition and understanding their experiences in raising a child with disability (Marin et al., 2007). However, part of this entails predicting outcomes for the child, which could be an unreasonable request from the therapist. The opposite may also hold true, with many therapists having expectations of the level and type of involvement that the parents engage which often may not materialize (Das, 2006). An example may be that therapists expect parents to be interactive and share information, to oblige the implementation of therapy protocols or offer input regarding joint decision making. The professional may make assumptions about parents' emotional states, ability to cope, personal issues as it relates to everyday living, the depth of parental knowledge or even the appropriateness of caring mechanisms that are in place. Marshall and Goldbart, (2008) report that professionals often may not acknowledge parents as the experts on the children as well as the level of knowledge that they have subsequently acquired about the disability that the child presents with. Professionals who do not understand the experience of raising a child with disability may mistake certain parental behaviours for faulty parenting (Ong-Dean, 2005). In the same instance, parents who sense that professionals do not fully understand the depth of their emotional states or personal experiences may not trust the professional or the professional body at large (Chen & Boothroyd, 2006). In addition Morrow et al., (2008) and Knowles, Griebsch, Bull, Brown, Wren and Dezaleux, (2007) indicate that while parents and professionals do agree to the same concerns regarding quality of health of the child being cared for, priority of needs differ. Professionals seem to attach more concern to long term objective functions (such as generalizing behaviours to everyday living) whereas parents prioritize the emotional state of the child in relation to target behaviours (such as emotional stress

associated with implementing target behaviours to everyday living). Here we see the surfacing of rudimentary attachment behaviour between parent and child which highlights the source of differences in professional and parental perspectives of the child concerned.

Nevertheless, the priority of both parents and professionals is to further the child's level of functioning. In order to do so, it is essential that the space between parents and professionals is bridged. Taking professional and parenting issues into account, therapists who are mothers to children with disabilities have a dual perspective on Disability. In theory they would be the best source of information regarding effective parent-professional collaboration.

1.6. The therapist mother

At first glance, it would seem logical that therapists who are mothers to children with disability are the most suited to care for their children considering their level of skill and knowledge pertaining to Disability. However, this may not be the case. Therapists are first and foremost mothers who may be subjected to the same emotions and stresses of parents to children with a disability. As working mothers they may be confronted with work-related stresses as well as the existing gender bias towards care-giving. The consequences may be depleted intra-personal resources and an increase in the work-family conflict. A further contribution is that the simultaneous engaging in the role of mother and the therapist may result in inconclusive results pertaining to their children. There are also the intra-personal and external psycho-social expectations of professional parents to be able to treat their children (Lubinski, 2001). In a report pertaining to parents of children with disability, Ong-Dean (2005) reports that historically, professionals have been blamed

for disorders such as infantile autism in their children due very high expectations of their children to succeed. Such expectations were assumed to stem from their professional knowledge. Although such theories have been discarded, it is plausible that many professional parents may have high developmental expectations of their children.

Clearly the role as a parent is different to the role as a professional. To this end, it brings into question how therapist mothers balance the obligations that are associated with each role. It may be that therapist mothers keep their roles as separate as possible in order to avoid unethical or unprofessional behaviour. However, this may lead to professionals assuming an altered sense of identity, which may be more harmful to clients in general. The point at which the role as a parent and professional merge is critical as it determines the clinical outlook adopted by the therapist. The significance of the professionals' sense of identity is that ultimately it impacts on the manner in which professional guidelines are implemented.

Unfortunately, the literature on professional-parent role balancing is scarce. There were only two studies which could be found which dealt directly with parent-professionals raising a child with disability. The first was a study conducted by de Steiguer, Erin, Tapor and Turnbull (2008), where ophthalmologists reported significant success within their profession based on increased motivation to assist their visually impaired children. However, it emerged that most ophthalmologists entered the profession subsequent to their child's visual impairments. This is in contrast to the participants in this study who were established clinicians prior to the birth of their children with developmental disability. The second study as conducted

by Das (2006) reports on parent-professionals who raise a child with disability with specific interest as to how the role of parent and professional are interconnected. Due to limited literature on the relationship between the two roles, he considered psycho-social issues and gender as it affected the individual within each role. Much of the literature documenting professionals' coping with disability stem from texts which are not peer reviewed. Individuals such as Cheri Florence, a Speech-Language Pathologist and Marion Stanton (Stanton, 2002), a special needs teacher are examples of professional mothers raising a child with severe disability. Their texts are based on their experiences as parents trying to raise their children and offer practical suggestions regarding treatment, support networks, everyday care, schooling issues and legal rights and benefits that the child is entitled to. As the texts are aimed at the general public such women have been highly influential in terms of offering support and encouragement for women in similar predicaments especially considering their professional backgrounds. These women have also made significant contributions to their individual professions and are fine examples of the success of role overlap and merging as a professional and a parent.

Therefore therapists who are mothers to a child with disability are in a unique situation that has yet to be explored. The aim of this study is to understand the unique life experiences and emotional processes that these women undergo in balancing their roles as a parent and as a professional. In addition the study seeks to understand the effect that role balancing has on these individuals. Following on from this, the knowledge contribution of therapists who are mothers to children with disability is vital to the interpersonal relationship and collaboration between families and professionals. It broadens our knowledge of coping and stress faced by

professional parents. In addition actualization of intra-personal professional issues can result in supportive measures being implemented for such individuals. Improved knowledge of risk factors that we face as clinicians can ultimately enhance our clinical and professional competence and could be a learning curve for future generations of therapists.