A qualitative analysis of the role of the baby in recovery from psychosis after childbirth

A thesis submitted to The University of Manchester for the degree of
Doctor of Clinical Psychology in the Faculty of Medical and Human
Sciences

Section for Clinical and Health Psychology

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Charlene Plunkett

School of Psychological Sciences
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Abstract

Paper one is a metasynthesis of studies exploring mothers’ experiences of recovery from postnatal mental illness. Four databases were systematically searched using key words and index terms to identify the qualitative literature exploring mothers’ experiences of recovery from postnatal mental illness. Fourteen studies met the inclusion criteria and were critically appraised and synthesised. These papers reported the views of 395 women’s experiences of recovery from postnatal mental illness. Five core themes emerged from the synthesis to describe four key processes that facilitate recovery. This experience begins with recognising the problem through crisis and relational distress. Women then go through the process of seeking help which consists of subthemes of accepting help and help to access help. The next process in the in the journey is achieving recovery which includes subthemes of sharing with others like me, coping strategies and noticing recovery. The final process of maintaining recovery consists of incorporating coping strategies into daily life; acquiring a different model of motherhood and processing the experience. The role of the family was interwoven through each stage of recovery. Recommendations were made for professionals who come into contact with this group of women and their families. The review highlighted gaps in the existing evidence and made recommendations for future research. The findings and limitations were discussed with reference to the existing literature.

Paper two explored the role of the baby in 12 mothers’ experiences of recovery from psychosis after childbirth. A thematic analysis of the data identified three core themes that described the role of the baby in the mothers’ recovery. Findings revealed that the baby was central to women’s recovery and could be experienced as both helpful and unhelpful. The baby interacted with the mother; increasing self efficacy and reducing emotional distress. The baby could act as a barrier to recovery by increasing the women’s emotional distress and hindering access to help and self care. The findings recommended that women receive specialist treatment in mother and baby units where they can access interventions that support parent - infant interactions. The findings of the study add to the existing evidence base on recovery from psychosis after childbirth and highlighted areas for future research.

Paper three is a critique of the research carried out in Papers one and two. This paper discussed the rationale for the research design in both papers. Approaches to data sampling and data analysis are reviewed with reference to researcher reflexivity. The search strategy and critical appraisal of techniques of the metasynthesis are also critiqued. Paper three closes with personal reflections and conclusions drawn from both papers.

Charlene Plunkett
The University of Manchester
Doctor of Clinical Psychology
July 2015
Declaration

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.
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I would like to thank Tracey Hepburn for help with transcribing the interviews. I would also like to thank Nadine Santos for help critically appraising studies in the literature review.

Lastly, I would like to give a very special thank you to my friends and family who have supported and encouraged me over the last two years. Especially for all their love and patience which has helped me overcome the challenges of completing the thesis.
Mothers’ experiences of recovery from postnatal mental health problems: A metasynthesis

Paper 1 has been prepared for submission to *Archives of Womens Mental Health* in accordance with the guidelines for contributors (Appendix 1)

Word count (excluding tables, figures and references): 7,166
Abstract
Mothers are most vulnerable to mental health problems during the perinatal period. The aim of this metasynthesis was to understand mothers’ experiences of recovery from postnatal mental health problems. Four databases were systematically searched using key words and index terms to identify the qualitative literature exploring mothers’ experiences of recovery from postnatal mental health problems. Fourteen studies met the inclusion criteria and were critically appraised and synthesised. Five core themes emerged from the synthesis to describe four key overlapping processes that facilitate recovery. The experience begins with recognising the problem identified through subthemes of crisis and relational distress. The process of seeking help is characterised by subthemes of accepting help and help to access help. The experience of achieving recovery consists of subthemes of sharing with others like me, coping strategies and noticing recovery. The process of maintaining recovery includes; incorporating coping strategies into daily life; acquiring a different model of motherhood and processing the experience. The role of the family was interwoven through each of the recovery processes. The findings and limitations are discussed with reference to implications for research and professionals.

Keywords: Mothers, recovery, postpartum depression, postpartum psychosis, metasynthesis
Introduction

Childbirth is associated with increased vulnerability to mental health: a woman is more at risk of developing serious mental health problems in the postnatal period than at any other point in her life (Joint Commissioning Panel for Mental Health: JCP-MH 2012; Robertson et al. 2003). Postnatal depression (PND) and postpartum psychosis (PP) respectively are the most common and the most severe forms of Postnatal Mental Illness\(^1\) (PMI); the onset of symptoms ranges from days to months (Heron et al. 2008). Thirty women in 1000 live births will develop severe PND in the weeks following childbirth (JCP-MH 2012; Wisner et al. 2013) and one to two women in 1000 live births will develop PP (Brockington 1996). While each illness may present with slightly different difficulties and symptomatology, they can both lead to inpatient admissions, at a time when separation may have implications for the attachment relationship between the mother and her baby (JCP-MH 2012). The National Institute for Clinical Excellence [NICE] (2014) recommends that first contact with services in both the antenatal and the postnatal periods should routinely assess current and previous maternal mental health. Thus, a range of services should be accessible to mothers who are at risk of severe PND and PP at the earliest opportunity.

Although PND and PP have been viewed as distinct forms of illness based on biomedical models of evidence (Doucet et al. 2011), mothers prefer more psychosocial explanations about the cause of these illnesses (Baines and Wittkowski 2013; Patel et al. 2013). There is now a growing body of disparate strands of literature exploring both types of mental health difficulty from an experiential viewpoint. Common themes, such as guilt and loss of self, were identified in a review of studies exploring PMI (including depression, anxiety or psychosis) (Robertson et al. 2013). Similarly themes of guilt, coping, dual identities, stigma and the centrality of motherhood were highlighted in a review by Dolman et al. (2013). This review focussed on the experiences of motherhood from preconception to parenting in women with severe mental health problems including PP and PND. However, these previous reviews did not consider the experience of recovery from PMI.

There is no singular definition of recovery within the perinatal literature. However, the experience has been construed elsewhere as an ongoing process for individuals with mental health problems (Pachoud et al. 2010), which is more complex than simply the

\(^1\) Throughout the paper the terms mental health problems or mental health difficulties are used, however the term Postnatal Mental Illness is used to abbreviate to PMI as shorthand for the reader.
reduction of psychiatric symptoms. Individuals may consider themselves to be in the process of recovery by drawing on a variety of strategies unique to their personal experience (Anthony, 1993). A metasynthesis of the experience of PND (Beck, 2002) has described recovery as examples of behaviour or insight that allowed mothers to recognise and meet their own needs. To date, there has been no metasynthesis of the qualitative literature on the experiences of recovery of mothers with PP and PND\(^2\). Hence, the aim of this review is to synthesise the experiences of recovery in mothers with PP and PND to provide a comprehensive account of common experiences and to highlight factors that facilitate this process.

**Method**

The metasynthesis approach, informed by Noblit and Hare (1988), was chosen because it is the most widely used synthesis technique in healthcare research (Bondas and Hall 2007) and preserves the interpretive properties of the qualitative data (Walsh and Downe 2006). The key themes and concepts identified in the qualitative literature were synthesised to identify broader themes across the studies. The current review included three stages: 1) a systematic literature search of qualitative studies reporting on mothers’ experiences of recovery from PND and PP, 2) a critical appraisal of studies identified, and 3) the metasynthesis of these studies (Malpass et al. 2009).

**Systematic search**

For this review a broad definition of ‘recovery’ was used in terms of support, coping, psychosocial adjustment, rehabilitation, etc. These terms and related constructs were incorporated into the search strategy. The full list of terms related to recovery is summarised in the table below. Published articles exploring the experiences of recovery from PND and PP in mothers using qualitative methodologies were identified through searches of the following databases: Cumulative Index to Nursing and Allied Health Literature (CINAHL), MEDLINE, PsychInfo and Web of Science (WOS). This search strategy was informed by the SPIDER [Sample, Phenomenon of Interest, Design, Evaluation and Research Type] (Cook et al. 2012) search tool, designed specifically for

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\(^2\) See Paper 3, page 84 for additional discussion on rationale of combined review of PP and PND studies.
identifying qualitative and mixed research designs. The search strategy was inclusive, using broader terms that were sensitive enough to capture studies specific to the aim of the review. Hence, there was no need to search on narrow terms relating to methodology. Search strategies were tailored to each database using a combination of terms used in the database indexes; keyword terms were entered manually by the first author. Three strings of search terms were entered into each database and combined using the Boolean operators OR and AND. The terms used to build up each search string are presented in the table below.

**Table 1** Search Terms

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<thead>
<tr>
<th>Sample</th>
<th>Phenomenon</th>
<th>Recovery</th>
</tr>
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<tbody>
<tr>
<td>Woman</td>
<td>Puerperal psychosis</td>
<td>Recovery</td>
</tr>
<tr>
<td>Women</td>
<td>Psychosis</td>
<td>Rehabilitation</td>
</tr>
<tr>
<td>Wom*</td>
<td>Psychotic symptoms</td>
<td>Psychosocial rehabilitation</td>
</tr>
<tr>
<td>Female</td>
<td>Psychotic illness</td>
<td>Psychosocial readjustment</td>
</tr>
<tr>
<td>Female*</td>
<td>Postnatal psychosis</td>
<td>Coping Behaviour</td>
</tr>
<tr>
<td>Postnatal period</td>
<td>Postpartum psychosis</td>
<td>Adjustment</td>
</tr>
<tr>
<td>Mother*</td>
<td>Postpartum psycho*</td>
<td>Coping</td>
</tr>
<tr>
<td>Mothering</td>
<td>Bipolar Disorder</td>
<td></td>
</tr>
<tr>
<td>Postpartum period</td>
<td>Schizophrenia</td>
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<tr>
<td></td>
<td>Anxiety</td>
<td></td>
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<tr>
<td></td>
<td>Postnatal depression</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Postpartum depression</td>
<td></td>
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<tr>
<td></td>
<td>Postnatal mental illness</td>
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</tbody>
</table>

**Inclusion and exclusion criteria**

Studies were included in the review if they satisfied the following criteria: 1) were published in English, 2) were published in peer reviewed journals, 3) reported on primary data collected via focus groups, face-to-face interviews, ethnographic data collection or expert panel that involved mothers who experienced PND or PP, 4) used a predominantly qualitative approach to analysis, 5) reported data relating to mothers’ experiences of
recovery from PND or PP, 6) reported on the experience of mothers over the age of 18 years old, with one or more children, 7) included mothers as the primary informants. As it is good practice to be as inclusive as possible in a metasynthesis (Walsh and Downe 2005), studies describing mothers’ experiences of recovery in the broader context of social support or coping behaviour linked to becoming well or keeping well and/or describing the experience of psycho-social adjustment or rehabilitation following PND or PP were included, even if this was the only construct of relevance.

The exclusion criteria were: studies that were not published in a peer review journal, studies with no participants who experienced PND or PP and studies that used quantitative methodology.

**Screening**

The combined search strategy yielded 1513 studies, whose titles and/or abstracts were scrutinised against the selection criteria. The process of searching and screening was based on the PRISMA guidelines (Liberati et al. 2009). Initial abstract/title screening identified 43 duplicates and 1446 studies did not explore mothers’ experiences of recovery in the context of PP or PND (see Figure 1). The remaining 24 full texts were screened against the inclusion criteria. A second reviewer (SP) independently screened the 24 identified studies. Discrepancies in the criteria were discussed by referring back to the inclusion criteria, until agreement was achieved regarding studies to be included in the synthesis. Agreement between studies to be included and excluded was high at 75%. Twelve studies were excluded: four did not contain qualitative data, two did not report primary data, two were not peer reviewed and two studies did not report mothers’ experiences of recovery. Two additional studies were identified through manual searching of other sources (e.g., reference lists). Hence, 14 studies were included in the synthesis.

**Critical appraisal**

The quality of studies was appraised in accordance with the Critical Appraisal Skills Programme Criteria (CASP 2002) and guidelines developed by Walsh and Downe (2006) in order to assess different aspects of methodological quality and increase interpretive rigour (Appendix 2). Studies were rated in the following areas: appropriate participants, clear statement of aims, appropriate research design, sampling methodology, data collection, evidence of reflexivity, ethical issues, thorough description of the analysis and
clear statement of findings. Each element was then totalled out of a maximum of 20 to give each study an overall score in the following categories: Category A (high) for studies with a score of 17 or above; Category B (medium) for studies with a score between 11 and 16; Category C (low) for studies with a score of less than 11. An independent rater (NS) used this checklist to rate 40% of the included studies to ensure reliability. Minor discrepancies in ratings were discussed according to each appraisal criterion; however, this did not lead to revision in the studies’ category assignment. Overall inter-rater agreement was high at 80%.
Figure 1: Flow diagram of search process

Identification

1513 records identified through database searching

43 duplicates removed

Screening

1470 records screened using titles and abstracts against inclusion/exclusion criteria

1446 excluded as not relevant to research question

2 additional records identified through manual searching of other resources (e.g. reference lists)

Eligibility

24 full texts assessed for eligibility

12 excluded:
4 – not qualitative studies
2 — did not report primary data
2 – not peer reviewed
2 – not about recovery

Included

12 eligible articles hand searched for additional references

14 articles included in the review
**Metasynthesis procedure**

The main stages outlined by Noblit and Hare (1988) were followed: 1) deciding on a phenomenon (i.e., mothers’ experiences of recovery from PND and PP), 2) developing rigorous inclusion and exclusion criteria to select qualitative studies relevant to the area being researched, 3) familiarity with data; reading selected studies several times and carrying out detailed data extraction in terms of demographic, methodological and thematic data, 4) reciprocal translation; comparing data between studies, 5) refutational translation; contrasting data between studies, and 6) synthesis translation; creating overarching themes to explain the phenomena in studies, while preserving the integrity of the original data.

**Results**

**Study characteristics**

Of the fourteen included studies, ten were on mothers’ experience of recovery from PND and four described recovery from PP. The fourteen papers included in the review reported the views of 395 women’s experiences of recovery from PMI. Eight of the studies were categorised as high quality (Category A) and six as medium (Category B). Generally these studies gained lower scores due to limited details regarding reflexivity and ethical issues. Included studies were conducted across eight countries including the United Kingdom and reported the views of mothers from at least eight different ethnic groups. Study characteristics and demographic details of studies are presented in Tables 2 and 3 overleaf.
<table>
<thead>
<tr>
<th>Author</th>
<th>Country</th>
<th>Sample Characteristics</th>
<th>N</th>
<th>Data Collection</th>
<th>Data Analysis</th>
<th>Themes</th>
<th>Quality rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Lara-Cinisomo (2014)</td>
<td>USA</td>
<td>Twenty-two prenatal and postpartum Latina mothers participated in the study. The mean age was 24.12 years ($SD = 4.46$).</td>
<td>22</td>
<td>Each focus group took approximately 90 minutes to complete. Focus group discussions were audiotaped with the participants’ consent. Spanish, English, and bilingual (Spanish and English) focus groups were conducted based on participant preference. One prenatal and two postpartum focus groups were formed.</td>
<td>Qualitative data analysis using procedures recommended by Miles and Huberman (1984).</td>
<td>Coping strategies - planful problem-focused, cognitive coping, and emotional disengagement. Treatment preferences (a hierarchy of care: the women’s coping strategy; formal social support – health visitor; formal clinical support - less preferred than health visitor; pharmacology – last resort)</td>
<td>B: Medium</td>
</tr>
<tr>
<td>2. Williams, P. (2013)</td>
<td>USA</td>
<td>Women who perceived themselves to recover from postpartum depression. The ages of the participants ranged from 29 to 54 years.</td>
<td>9</td>
<td>In-depth interviews</td>
<td>Constant Comparison Method</td>
<td>Themes identified by women as crucial to recovery were: prelude to recovery igniting recovery, recounting recovery as a victory and realising recovery has been achieved.</td>
<td>A: High</td>
</tr>
<tr>
<td>3. Haga, S., Lynne, A.; Slinning, K &amp; Kraft, P. (2012)</td>
<td>Norway</td>
<td>First-time mothers (aged 25 to 44 years) self-selected to participate in the study. Three women described themselves as depressed. One woman described crying and hopelessness that lasted several weeks. Five of the women described themselves as slightly depressed with fewer symptoms with lower intensity and shorter duration.</td>
<td>12</td>
<td>Semi-structured interviews</td>
<td>Thematic analysis</td>
<td>Themes identified: Personal approach – ‘controlled’ vs. ‘relaxed’; Social support; Managing breastfeeding and well-being</td>
<td>B: Medium</td>
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<tr>
<td>4. Montgomery, P., Mossey, S., Adams, S. &amp; Bailey, P.H. (2012)</td>
<td>Canada</td>
<td>Seven women living with PND accessing peer support. Five of the women attended all sessions and two women attended the last group session only. The women were aged 18 to 30 years.</td>
<td>7</td>
<td>Ethnography/participatory action research – written, visual and spoken stories. Invited researcher sat in on support groups over a 6 month period. The women were also equipped with disposal cameras and blank diaries to record their recovery experience in the manner of their choice.</td>
<td>Structural Narrative Analysis</td>
<td>Three groups of recovery stories were revealed. These were labelled as illness, mothering wisdom and mobilising.</td>
<td>A: High</td>
</tr>
<tr>
<td></td>
<td>Slade, P., Morrell, J.C., Rigby, A., Ricci, K, Spittlehouse, J. &amp; Brugh &amp;</td>
<td>UK</td>
<td>Thirty women who took part in the PONDER trial with a score on Edinburgh Postnatal Depression scale (EDPS) indicating the likelihood of depressive symptoms participated in this research. The women ranged ages from 18 to 45 years.</td>
<td>30</td>
<td>‘Template’ approach to data analysis</td>
<td>Semi-structured interviews</td>
<td>Three broad themes: seeking help; roles and relationship and experiences of intervention or support</td>
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<tr>
<td></td>
<td>Di Mascio, V., Kent., A, fiander, M. &amp; Lawrence, J. (2008)</td>
<td>UK</td>
<td>Two panels of women who had recovered from PND. Panel 1: 10 mothers recruited by Health Visitors who had recovered from PND. Panel 2: 158 women recovered from PND and part of national support group</td>
<td>168</td>
<td>Interviews and questionnaire</td>
<td>Delphi Technique</td>
<td>The eight recovery factors rated as ‘essential’ for recovery were: emotional support from partner; sleep; improved communication with partner; diagnosis; practical support from partner; emotional support from friends; time to bond with the new baby and prompt assessment by a health visitor.</td>
</tr>
<tr>
<td></td>
<td>McCarthy, M.</td>
<td>New</td>
<td>Fifteen women (aged 27 years to 41 years)</td>
<td>15</td>
<td>Interview questions were open-ended, with prompts to Modified Analytic</td>
<td>Five core themes: an initial concern that</td>
<td>A: High</td>
</tr>
</tbody>
</table>
and McMahon, C. (2008) Zealand treated by community mental health service for PND took part in the study. encourage women to expand on their perceptions, experiences, and needs. The interview was audiotaped and later transcribed. Induction Method something is wrong; reaching a crisis point and obtaining help; accepting the diagnosis; the gradual breaking down of the stigma through disclosure and the discovery that a wide range of women suffered the same problem; and subsequent recovery.

8. Letourneau, N., Duffet-Leger, L., Stewart, M., Hegadoran, K., Dennis, C.L., Rinaldi, C.M. and Stoppard J. (2007) Canada Fifty two women with average age of 31.2 years who had experienced postpartum depression. The participants’ education level ranged from partial high school to university or graduate degree. Data was collected using semi-structured interviews followed up by focus groups to elaborate on interview findings. Thematic content analysis One-on-one support preferred initially. Group support should be available once the mothers start to feel better and are able to comfortably interact with other mothers in a group format. B: Medium

9. Chen, C.H., Wang, s.Y., Chung, U.L., Tseng, Y.F., Chou, F. (2006) Taiwan Participants were 23 Taiwanese women screened with BDI 6 weeks after birth for postpartum depression. Women ranged in age from 19 to 38 years old. Only two out of 23 The initial interviews were arranged at 10–12 weeks after childbirth, and the BDI was carried out before each interview. The participants were considered recovered from PPD when their BDI score had dropped below the Grounded Theory Four stages of coping: shattered role identity; feeling trapped and breaking down; struggling for self-integrity and regaining vitality. B: Medium
The 23 were being treated for depression at the time.

Cut-off point of 10 at the time of interview. Follow-up interviews were conducted every month until the point of recovery. Each participant was interviewed on one to three occasions. The length of each interview was 1.5–2 hours.

<table>
<thead>
<tr>
<th>Study</th>
<th>Country</th>
<th>Sample</th>
<th>Methodology</th>
<th>Themes Identified</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. Amankwaa, L.C. (2003)</td>
<td>USA</td>
<td>Twelve African-American women interviewed after their last episode of PND</td>
<td>Interviews</td>
<td>Constant Comparative Method</td>
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<td>11. McGrath, L., Peters, S., Wieck, A., &amp; Wittkowski, A. (2013)</td>
<td>UK</td>
<td>All women were White British, living in England or Wales.</td>
<td>Semi-structured interviews</td>
<td>Grounded theory</td>
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<td>12. Heron, J., Gilbert, N., &amp;</td>
<td>UK</td>
<td>Five women who were members of Action</td>
<td>Service users trained at qualitative research workshop</td>
<td>Grounded analytic</td>
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<td>Study</td>
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<td>Dolman, C. et al. (2012)</td>
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<td>Postpartum Psychosis and who had considered themselves recovered from their episode of postpartum Psychosis. The time length since their PP episode varied from 3 years to 20 years.</td>
<td>Conducted 45 minute interviews with each other.</td>
<td>Induction approach</td>
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<td>13. Doucet, S., Letourneau, N. &amp; Blackmore, E.R. (2012)</td>
<td>Canada and USA</td>
<td>Nine mothers who experienced PPP, 8 fathers/partners of the above woman. All mothers were hospitalized and treated in general adult psychiatric units.</td>
<td>The interview took place over the telephone (n = 9) or in person (n = 8) in a mutually agreed-upon setting. The interviews ranged from 45 to 120 minutes, with most lasting approximately one hour.</td>
<td>Inductive Thematic analysis</td>
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<td>14. Robertson, E. &amp; Lyons, A. (2003)</td>
<td>UK</td>
<td>Women diagnosed and treated with PPP. Participants ranged in age from 28 to 44 years of age (M = 34 years). Duration of postpartum psychosis ranged from 1 month to 1 year and 10 months. Recovery time ranged from 1 -</td>
<td>Interviews</td>
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Table 3. Demographic Characteristics of Studies

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<th>No.</th>
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<th>Ethnicity</th>
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<th>Marital status</th>
<th>Ed³ &amp; employment</th>
<th>No. of children</th>
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<th>Time: recovery - interview</th>
<th>Birth/pregnancy complications</th>
<th>Symptom onset</th>
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<td>Less than 1 year to 24</td>
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³ Ed. = Education
⁴ NS = Not stated
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<th>No.</th>
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<th>Service/Support</th>
<th>Minimum Education/Characteristics</th>
<th>Health Visitor/Pregnancy Experience</th>
<th>Health Advice/Prescription</th>
<th>Depression History/Precedents</th>
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<td>Cohabitating with partner</td>
<td>All min. high school.</td>
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<td>21: 1st Baby</td>
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<td>27 - 41</td>
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<td>All in relationship with 6: 6 years of high school 4: polytechnic</td>
<td>7: 2nd child 1: 3rd</td>
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disorder
2: previous diagnosis of depression
Synthesis

The findings of the synthesis identify recovery as a process along a continuum ranging from severe to mild symptoms (see Figure 2). Four key processes that facilitate recovery were identified across studies. Within each stage recovery process key sub themes or elements emerged from the synthesis. The recovery experience begins with recognising the problem consists of one subtheme of crisis and relational distress. The process of seeking help is conceptualised as accepting help and help to access help. Achieving recovery includes sharing with others like me, coping strategies and noticing recovery. The process of maintaining recovery is characterised by incorporating coping strategies into daily life, acquiring a different model of motherhood and processing the experience. The role of the family is embedded within each of the four recovery processes. A diagram illustrating the relationships between themes across the four recovery processes is provided in Figure 2. Similarly to Dolman et al.’s review (2013), themes in this metasynthesis were not ranked according to importance or the number of times mentioned across the studies. Hence, each theme represents a process experienced by the mothers across time and at overlapping points throughout recovery experience. While findings of the synthesis support that recovery has a clear starting point, the overall experience is non-linear. In that it is possible for elements of each recovery process to overlap. Therefore women may move back and forth between processes. Therefore, the findings of the synthesis suggest the recovery journey is a fluid process. Table 4 summarises the themes identified across studies (Appendix 3).
Figure 2. Model illustrating the relationships between experiences of recovery and the role of the family

Recognising the problem

Seeking help

Achieving Recovery

Maintaining Recovery

Crisis and relational distress

Accepting Help

Sharing with others like me

Incorporating coping strategies into daily life

Help to access help

Coping

Acquiring a different model of motherhood

Noticing recovery

Processing the experience

The role of the family

Time

Severe

Symptoms

Mild
The role of the family

The family had a key role throughout each stage of recovery, which ranged from helping mothers to recognise that there is a problem to maintaining recovery. Family members (such as a woman’s partner and her parents) aided mothers to access and accept help from professionals. Emotional support from family was pivotal to recovery: “The support of my family helped more than anything” (Heron et al. 2012, p. 161). However, on some occasions family members could be a source of anxiety. Partners were often described as limited in the support they offered to mothers because they didn’t know how to help. “He fully supported me. I think the only reason he couldn’t have helped me more is he wasn’t sure how to” (Letourneau 2007, p. 444). Participants stated that fathers needed help to understand their partner’s experiences in order to provide emotional support as well as practical support during their wife’s recovery. “If my husband had a support group for new fathers to deal with a psychotic wife, it would have changed everything. He would have been far more compassionate had he known about my illness. He needed the tools to deal with a mentally ill wife” (Doucet, Letourneau and Blackmore 2012, p. 241). When mothers moved toward the latter stages of recovery, families understood what they had gone through and were in a position to help: “I found they were totally different. My family seemed to have understood what I had done for them. They all knew that. They talked differently, not taking everything I did for granted anymore” (Chen et al. 2006, p. 454).

Recognising of the problem

For recovery to commence mothers had to go through the process of recognising that there is a problem. For the mothers this consisted of crisis and relational distress triggered in response to the presence of severe illness.

Crisis and relational distress

Recovery commenced with recognising illness, which is necessary to help mothers move through later phases of recovery. It was during the crisis that mothers acknowledged that they recognised the presence of symptoms: “I had to walk-I’d try to get a mental grip. Okay. Go over and pick up the soap, you know, the routine. It is like we have a routine of doing things, and I couldn’t really remember what the routine was. It was like, well, wow, I must really be, you know out of it. I can’t even wash my face” (Amankawa 2003, p. 304). When in crisis many mothers accepted that they were ill with the help of immediate family
members (e.g. partners, parents or siblings of the women). Mothers were unable to recognise and actively draw on strategies that facilitate the acceptance of illness. “My friend said you have got to see C (psychiatrist) …. By this stage it was quite obvious that I needed hospitalization. I couldn’t make a decision to save myself. But that night dad said, ‘This is just getting bloody ridiculous. You need help’. And mum said, ‘Get on the phone and ring’ and I rang an 0800 number that night at the mental health unit” (McCarthy and McMahon 2014, p. 626). During this phase many mothers described their partners or parents as taking control, making decisions and accessing support.

Many mothers reported relational distress during the initial stages of recovery. “I was being really weird and telling him I wanted to kill myself. He was trying to be supportive but he just looked scared, I put a lot of pressure on him” (Robertson and Lyons 2003, p. 421). Relational distress with partners and infants was intrinsic to those immediate family members recognising that the mothers were in crisis. Many mothers talked about turning to their own mothers when they felt they could no longer care for their baby. “…I said to my mother, this is after-I was just like totally overwhelmed, and overwhelmed feeling. I said you are probably going to have to have the baby, so-I don’t think I can take care of this baby” (Amankwaa, 2003, p. 304).

**Seeking help**

Seeking help involved accepting professional help that was often mediated through the family system. Mothers needed help from partners, parents or in some cases siblings to access formal and informal help.

**Accepting help**

Formal support and contact with health professionals was a necessary component in recovery. The perception of the health visitor role and the relationship with the health visitor was influential in accessing professional support. Some mothers described their perceptions “She wasn’t as person-centred and she didn’t really have the people skills to manage” (Slade et al. 2010, p. 443) as a barrier to accessing support from the health visitor. In contrast “prompt support from a health visitor” that “validates” their experiences (Di Mascio et al. 2008, p. 256) were examples of effective professional support. Many mothers with postnatal depression feared being judged as ‘not coping’ which limited their ability to access support from professionals. Some mothers sought
support from health care professionals, in the guise of seeking care for their baby: “... so I called him [GP] out ... I called him for [my infant] but I did want to talk to him at the same time ... but I used the excuse of him coming to see [my infant]” (Slade et al. 2010, p. 443). Overall mothers responded well to strong advice from family and partners that they needed help. “It was sort of my partner saying to me ‘Right if you don’t go I’m basically making you an appointment, you are going, don’t sweep it under the carpet, you know you can’t just keep feeling like this’” (Slade et al. 2010, p. 443).

When symptoms decreased, mothers needed contact with professionals that allowed them to reflect on and understand their experiences. “Once you’ve got your [child care and household] routines down and you are on top of that game. Then you need the mental working-out, then you need the counselling” (Letourneau et al. 2007, p. 445). When the mothers moved out of crisis, this was the best time to access professional support that was psychologically informed. “When you’re beginning to feel a bit better and you’re not really seeing health professionals that much I think then, if you had-five or six sessions or something, with a counsellor and just went through how you felt about it. And you know, got a little bit of advice about how to cope with it” (Heron et al. 2012, p. 158).

Help to access help
Many mothers reported the need for more information and public awareness of symptoms and support needs of PND and PP, because often mothers’ families facilitated access to professional support during crisis. “I think people in general need to be more aware. Some people might not see it until their partner or their friend or their sister or somebody says, ‘You’re not yourself’. Other people around need to know, ‘Okay, this is a possibility and these are the things you look for and this is what you can do’” (Letourneau et al. 2007, p. 446). Therefore, information and education for all the wider family (such as partners or the mother’s parents) about PND and PP is essential to recognise symptoms and help mothers to access professional help. “I think it helped my husband first to be able to put a label on what was happening. Secondly, to realise that this is what happens in PP ... It was important to him in just seeing the process through ... to stick by me, to know that there was a treatment that could work ...” (Heron et al. 2012, p. 162). This helped the family, especially partners, to understand the mothers’ symptoms and utilise strategies that supported them to recover.
Achieving recovery

Mothers shared their experiences with others as they continued through the journey of recovery. At this point mothers developed coping strategies and insight that helped them to notice that they had moved into recovery.

Sharing with others like me

When symptoms decreased, the opportunity to talk with other mothers who have had similar experiences was an important factor in getting better. Sharing with others normalised and reduced feelings of stigma. “It is amazing once you open up ... and a few other people sort of said, ‘Oh, I had that,’ and it was amazing. I have actually since found out that quite a few other people around me that are friends and I didn’t even know that they are on medication” (McCarthy and McMahon 2008, p. 650). Mothers valued support groups and a space where they discussed their feelings without being judged as a parent.

“Groups are a safe place to say ‘This isn’t the greatest time of my life’” (Letourneau 2007, p. 445). Meeting other mothers provided reassurance and hopefulness about personal recovery: “So other people ... kind of saying ‘I’ve done it too, I know how you feel’ and also you know, just to encourage you from the years ahead of you that they are, is really, really valuable” (Heron et al. 2012, p. 159). Sharing with others increased mothers’ confidence for their future wellbeing and the wellbeing of their children. “The turning point was when I talked to some-one who had gone through the exact same thing as me. The fact that she turned out okay and went on to have a happy good life with other kids was reassurance that I could get through this” (Doucet et al. 2012, p. 238). Many mothers felt that it was an important to share their experience to help others. Empathising and supporting others was described as a marker that mothers had moved forward in recovery.

“I suppose you can sympathize, well empathize with people more because you’ve been there yourself. I think that has made me a better person, I would never have done this before I was ill but now I feel I have something to offer them, and I want to give something back” (Robertsons and Lyons, 2003, p. 424). Sharing with others helped the mothers to reflect and develop narratives of their experiences: “...I felt that I was almost making sense of the experience that had happened to me by educating others” (Heron et al. 2012, p. 158).
Coping strategies
When symptoms reduced mothers developed coping strategies. For many mothers simple goals were the first coping strategies for getting better. “I had to eat something, get out of bed, and take a shower. That was my job for the day” (Williams 2013, p. 279). Many mothers found that simple pragmatic strategies, such as “sleep”, were “essential recovery factors” (Di Mascio et al. 2008, p. 256). When mothers began to feel better, they were more involved in caring for their babies, this was also noted as an effective coping strategy. “… like when I started weaning her and stuff, just seeing that she was developing normally helped” (Heron et al. 2012, p. 163).

Noticing recovery
There were key moments when mothers recognised that they were recovering. Some mothers noted that the absence of symptoms was evidence that they had taken their first steps on the path to recovery: “No depression, no anxiety or panic attacks. Um, no snippy or snappiness to my husband or kids” (Williams 2013, p. 279). Many mothers noticed small steps on a daily basis that were markers of recovery. For example, looking forward to activities planned later that day. “I wake up and I’m pretty much thinking, what am I going to take on today” (Williams 2013, p. 279). Many mothers gradually noticed increased confidence with day-to-day routines, caring for their infants and reconnecting with friends. This helped mothers to believe in their ability to take future steps towards recovery. “I did actually think for the first time I thought, Maybe I can do this” (McGrath et al. 2013, p. 344).

Maintaining recovery
Mothers integrated coping strategies developed during earlier processes and adopted new models of motherhood to maintain their recovery journey. Accessible information such as leaflets or simple advice (formal or informal) helped mothers to process and make sense of their overall experience.

Incorporating coping strategies into daily life
As mothers started to get better, earlier coping strategies remained integral to staying recovered. Similarly, Heron et al. (2012) illustrated how these initial concrete steps evolved into long-term coping strategies to maintain progress throughout their experience of recovery: “... but it was little bits at a time, piece by piece, building yourself back together again. And I kept setting myself goals to achieve and I found that helped tremendously” (p. 162). Incorporating these early coping strategies with daily life seemed to aid recovery. One example of this is returning to work. Mothers took small steps with this area of day to day life: “I went back - it’s been almost a month and half now. I went back part-time and I am not doing what I used to do. I am doing something that is pretty easy, but yeah, I guess it is pretty easy compared to what I used to do” (Amankwaa 2003, p. 308). Mothers returned to activities that they enjoyed on a daily basis; this was described as a hallmark of recovery: “... and started to do things that I enjoyed doing. That’s when I felt I was gaining more control of myself ... more control over myself and also I feel, like um, like I think I was a little bit happier” (Williams 2013, p. 279).

Acquiring a different model of motherhood

New models of motherhood helped women to care for themselves and acknowledge their limitations: “I know I don’t have as much strength or energy right now” (Letourneau 2007, p. 528). Chen et al. (2006) described a move away from high standards held by many mothers as they strived to juggle the multiple demands of motherhood: “It’s much better. I am not as busy as I used to be. I was too busy in the beginning to finish all those things that I wanted to do, for I had to take care of my baby and do all the housework. One thing is different though. In the past, I tended to do the household chores like cleaning up without being interrupted. Suppose I was in the middle of the work and my child started crying, I would feel upset. But now it’s different. I think of it this way, ‘Well, let it be. Anyway, I can do the rest tomorrow’” (p. 454).

Staying recovered involved acknowledging a change in identity and that pre-motherhood goals might not be pertinent to the mother who has recovered from PMI: “... So I am back ... I don’t feel like my old self, but at this point I am – I am wondering if that’s even realistic, because I am not the same ... I am mommy now” (Amankwaa 2003, p. 308). Mothers altered their orientation towards personal and societal expectations as a means of coping and staying recovered: “I ... possessions and things...I used to be really career orientated. I wanted to do well, I wanted to be [top of profession]. Now I don’t
have...you know, maybe I will when he’s older. I don’t have any inclination to do that now” (McGrath et al. 2013, p. 346).

Processing the experience
As mothers became less symptomatic, they valued appropriate and credible information that facilitated their understanding of their experience. “Even though it was the thing you’d not heard of, it was a relief to know ... it does exist, other people have had it before me and there are things that can be done” (McGrath et al. 2013, p. 347). Appropriate information from a credible source inspired mothers to stay recovered: “…I read it and just cried my eyes out. It was somebody suffering what I was suffering. And that was the best thing in the world because I thought, gosh somebody else had had this—it’s exactly the same as what I’m having ... so then I thought, well actually, they do know what it is and they’re sorting me out ...” (Heron et al. 2012, p. 161).

Information and time provided mothers with the reflective space to process their experiences; this processing period was pertinent to maintaining recovery. According to Williams (2013), many mothers explained that: “Time is a wonderful thing if you have it. Because I think it helps you to evolve and then you can look back and get perspective from the view of the future, so to speak” (p. 280). Similarly, mothers described a process of looking back and looking forward with hopefulness for the future and their ability to stay recovered and cope with future adversity. “I can stand back and look at myself in the past when I was ill and that isn’t me. I went from being a confident woman to ... now I’ve regained my confidence and I feel better than I did before because I’ve been through this and come out stronger. Nothing as bad can ever happen to me again” (Robertson and Lyons 2003, p. 424).

Discussion
This is the first metasynthesis to explore mothers’ experiences of recovery from the most common and severe postnatal illnesses namely PND and PP: 14 studies were systematically reviewed and their methodological quality was assessed. Four core recovery processes emerged from the synthesis. Each process consisted of key elements describing mothers’ recovery experiences.

A key finding of this review is the integral role of the family (in particular a woman’s partner or her parents) across all stages of recovery. The family were involved in
helping the mothers to recognise illness, access help, achieve and maintain recovery. This parallels the psychosis literature that states that recovery is achieved through relationships with family and friends (McCarthy et al. 2012). Recovery begins with recognising the problem through the experiences of crisis and relational distress. Beck’s (2002) metasynthesis of mothers’ experiences of coping with PND states that mothers had to accept that they needed help before they could commence recovery. For the mothers in the current review, crisis involved relational distress with partners, friends and with their babies. This mobilised the mothers’ support network to facilitate access to and acceptance of professional help which helped the mothers move through the recovery processes. Similarly, previous research suggests that when mothers accept illness by experiencing crisis, they can then acknowledge that they the need help from family members (Patel et al. 2013). Other reviews of psychosis independent of childbirth have found identifying and responding to illness as instrumental elements within recovery (Soundy et al. 2015; McCarthy et al. 2012).

Previous research indicates that mothers rely on professional support for the alleviation of symptoms (Robertson et al. 2013). Our findings showed that mothers valued prompt support from professionals as it validated their experiences. However, their fear of failing to cope in the eyes of professionals emerged as barriers to accessing professional help. This is similar to an earlier metasynthesis, which reported that the stigma of mental health difficulties prevented mothers from accessing help (Dolman et al. 2013). However, Dolman and colleagues looked at the motherhood experiences of women who had pre-existing mental health problems, whereas our review considers the recovery experiences specific to mothers with PMI. An interesting finding of our review was that in some instances mothers accessed support indirectly via guidance on childcare. For mothers who had insight into their symptoms, this approach was a more legitimate means of accepting help. Research into the experiences of mental health problems (including depression) the postpartum period has reported that often women found it difficult to ask for help due to their fear of being judged as a ‘bad mother’ (Robertson et al. 2013, Mollard, 2014). Similarly, a metasynthesis of the qualitative literature found that women who have experienced bipolar disorder or psychosis often use strategies to conceal illness (McGrath et al. 2014). When symptoms decreased, mothers moved into the recovery process of seeking help at this point there was a desire for psychologically informed professional support. As mothers’ symptoms reduced, their insight increased, which allowed them to
reflect on their experiences. This reflection helped the mother develop narratives about illness, coping strategies and overall recovery.

Many mothers expressed concern for partners and felt that professional support for partners would have facilitated their recovery. In particular fathers needed help to know how to provide practical and emotional support to their partners. Earlier studies of PND and PP have found that mothers often rely on support from families, but this support does not meet their needs (Berggren-Clive 1998; Robertson et al. 2013). Other reviews within the general psychosis literature highlight the need for supportive relationships with friends and family to facilitate recovery (Soundy et al. 2015, Wittkowski et al. 2014; McCarthy et al. 2012). A novel finding of the current review was the centrality of family members throughout recovery, with a theme of supporting families emerging from the synthesis. Hence, it seems essential to educate and support families, especially fathers to help them to support the mothers in recovery.

The opportunity to share with mothers who have had similar experiences was important for recovery. Similarly to earlier research into PND and PP, talking about experiences and sharing with others has been identified as an important coping mechanism (Berggren-Clive 1998; Robertson et al. 2013), comparable with the wider psychosis literature (Soundy et al. 2015; McCarthy et al. 2012). Social support systems that provide an outlet to share the experience of mental health difficulties has also been highlighted as an important element within recovery from depression (Corcoran et al. 2013). Many mothers talked about changing their attitude towards routines, setting small practical goals, acknowledging their limitations and using practical strategies such as regular sleep as important steps in recovery. Achieving recovery comprised of noticing recovery; this was identified as an important factor across studies (Williams 2013; McGrath et al. 2013; Montgomery et al. 2012). A parallel process has been noted in qualitative studies exploring recovery in men and women who have experienced depression (Ridge & Ziebland, 2006). When mothers noticed that they had recovered, they were hopeful about the future and were motivated to continue with their progress.

Maintaining recovery involved a move away from high standards and unrealistic expectations that mothers imposed on themselves. This was conceptualised as a subtheme of developing a new model of motherhood and is unique to recovery from postnatal mental health problems. Interestingly, the changing of expectations around motherhood has been reported elsewhere (Berggren-Clive 1998; Beck 2002) and it is comparable to research
around adaptations to motherhood (Lam, Wittkowski and Fox 2012). Thus, the latter processes in recovery are characterised by naturally occurring reactions to motherhood following childbirth. Similarly, research exploring recovery from depression in women has highlighted the importance of self care practices that lead to different ways of relating to themselves as an alternative to ‘heteronormative ideals’ of womanhood (Fullagar & O’Brien, 2014).

**Strength and limitations**

As the metasynthesis approach inherently involves a degree of subjectivity, all studies in the review were screened independently by a co-author (SP). To enhance the rigour of synthesis the methodological quality of each included study was also independently rated (by NS), a high rate of agreement was reached. Steps were taken to maximise transparency in the search strategy, screening studies, appraising studies and the synthesis of themes. Detailed tables of the included studies and relevant themes are supplied (see Tables 2-4). The search strategy was informed by the SPIDER search tool, designed specifically for identifying qualitative and mixed research designs (Cook et al. 2012). This search strategy drew on the sample, phenomenon of interest and evaluation elements of this tool to preserve sensitivity and specificity. The search strategy was inclusive, using broader terms that were sensitive enough to capture studies specific to the aim of the review. Hence, there was no need to search on narrow terms relating to methodology.

As is common with qualitative research, this review included studies of heterogenous samples, methodologies and context. All included studies were of high or medium methodological quality, notably there were no studies assigned to category C. Whilst all synthesised studies where of good methodological quality, it was not possible to verify the exact diagnoses of mothers recruited to the reviewed studies. Included papers consisted of samples of women who were assessed for PND by numerous methods such as, self report, screening instruments or clinical interviews. It was unclear how much the women varied in terms of severity of PND or if women were hospitalised. Some of the studies assigned to category B comprised of women who self identified themselves having experienced PND (Amankwaa 2003; Haga et al. 2012). Similarly, studies varied according

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5 See Paper 3, page 85 for discussion of search techniques and critical appraisal tool
to the demographic details provided across studies, which limit the extent to which findings of the metasynthesis can be extrapolated across different ethnic or social groups. However, the primary aim of a metasynthesis is to summarise and understand all experiential phenomena to develop new insights from the data (Walsh and Downe 2005). Therefore, the iterative approach of a metasynthesis does not necessitate the need for highly specific concepts such as diagnosis (Dixon-Woods et al. 2006). Within the sub sample of papers assigned to Category A, the majority studies consisted of women with a high level of education and who were in stable longterm relationships (Doucet et al. 2012; Williams 2013; Montgomery et al. 2012; McCarthy & McMahon, 2008). The findings of this subsample of papers may not be reflective of the experiences of single women with lower levels of education. Lastly, papers rated in category B often did not provide enough detail in relation to researcher reflexivity. For the purpose of transparency in qualitative research, it is important to acknowledge the researcher characteristics that may interact with the interpretation of the data (Krefting, 1991; Richards & Emslie, 2000).

This review sought to identify common themes in the experience of recovery from postnatal mental health problems. The data from studies included in this metasynthesis evidenced commonalities in the experience of recovery between PND and PP. The similarity in recovery experiences between the two groups may be understood in terms of the perinatal presentation. Clinically, these two groups are often conceptualised along a continuum of severity with PP considered the most severe (MGH Centre for Women’s Mental Health). While it would be interesting to compare and contrast recovery experiences between the two groups, this was not possible with the synthesised data in this current review. However, a finding of the review was that some women accessed help via advice on childcare. It is plausible that women who experience PND have more insight and hold beliefs about how others will perceive them as a mother. Future volumes of work in the areas of postnatal mental health problems may make it possible to compare and contrast different experiences between PND and PP, particularly as the latter strand of literature is slowly growing.

**Evidence gaps**

This review identified several gaps in the research literature. The family and particularly partners have been recognised as important to a mother’s recovery. There is a small body
of research exploring the experience of postnatal mental health difficulties from the perspectives of families and professionals (Enquivist and Nilsson 2011, Enqvivist and Nilsson 2013; Muchena 2007). However, to date there have been no reviews synthesising the experience of family members and their support needs. Future research may explore the partner’s or other family member’s experiences from the onset of postnatal mental health difficulties to recovery because the family has a significant influence throughout recovery. Future research synthesising the support needs of families would be helpful in formulating systemic interventions that draw on family members to aid the mothers’ recovery. Our findings highlight that relational distress (for example, not being able to care for the baby) is key to helping mothers recognise that there is a problem. To date, there have been no studies exploring the role of the baby in recovery.

**Implications**
The findings of this review have implications for services that come into contact with this group of mothers. The results suggest that recovery begins by reaching a crisis point when mothers acknowledge that something is wrong. However, often mothers had to rely on others to make this acknowledgement; this is particularly true in PP because mothers lack insight and awareness of the onset of symptoms (Sit 2006). Other people in a mother’s support network mediate access to professional help, which highlights an educative role for professionals involved in antenatal care to provide information to mothers, fathers and the wider family. This approach facilitates early recognition of symptoms, which may also promote quicker access to professional support. Therefore, direct contact with health professionals skilled at helping mothers and their families recognise the symptoms of illness in the perinatal period is recommended. Professionals need to validate the experiences of the mothers and their families and provide help that meets the needs of the mothers and their support network. Professionals’ support should include partners and families to help them with supporting the mothers. Accessible information delivered by professionals to partners and the wider family can also normalise the challenges experienced in supporting women recovering from PMI. Thus, professional support should take a systemic approach and consider the needs of the wider family system throughout recovery processes.

Accessible information should be provided at the individual and population level to reduce stigma associated with mental health difficulties in perinatal period. This will
enable sufferers and their families to recognise symptoms and approach services for help. Of equal importance is the value of informal peer support when mothers are able to begin reflecting on their experience. However, the timing of this level of support is essential: when mothers’ symptoms decrease, they are more able to reflect on their experience with peers or during psychologically informed support from professionals (Heron et al. 2012; Letourneau 2007). Lastly, peer support can be a powerful intervention that normalises the mothers’ experiences of illness and recovery.

**Conclusions**

The synthesis of mothers’ descriptions of their recovery experiences could be attributed to *Recognising the problem; Seeking help; Achieving recovery and Maintaining recovery*. Mothers valued support from the family that was integral to their progression throughout the overall process. These findings have implications for services and professionals who are often the first point of contact with this group of mothers and their families.

**Acknowledgements**

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https://www.researchgate.net/publication/221875376_Mens_experiences_of_their_partners_postpartum_psychiatric_disorders_narratives_from_the_Internet


Paper 2

A qualitative investigation of the role of the baby in recovery from psychosis after childbirth

Paper 2 has been prepared for submission to Clinical Psychology and Psychotherapy in accordance with the guidelines for contributors (Appendix 4).

Word Count (excluding tables, figures and references): 7,071
Abstract
Psychosis after childbirth is a rare but severe type of mental health difficulty experienced by perinatal women. Research has explored mothers’ experiences of onset and recovery from psychosis after childbirth. This current study explored the role of the baby in mothers’ experiences of recovery. A thematic analysis of the data identified three core themes that described the role of the baby in the mothers’ recovery experiences. Findings revealed that the baby was central to recovery, experienced by mothers as both helpful and unhelpful. The baby interacted with the mother, increasing self efficacy and reducing emotional distress. Findings also showed that the baby could act as a barrier to recovery by increasing the women’s emotional distress and hindering access to help and self care. The findings of the study add to the existing evidence base on recovery from psychosis after childbirth. The research and clinical implications of these findings are discussed with reference to the existing literature.

Keywords: Psychosis, Mothers, Childbirth, Recovery, Baby

Practitioner Messages
- The baby has a central role in recovery from psychosis after childbirth.
- The baby has a varied role, perceived by mothers to both hinder and help their recovery.
- Interacting with the baby can be helpful for the mothers’ recovery by improving their self efficacy and reducing emotional distress.
- Specialist interventions offered by a mother and baby unit can provide practical support that facilitates mother-baby interactions, which helps to move women forward in the recovery process.
Introduction

A woman is most at risk of severe mental health difficulties during the post-partum period compared to any other point in her life (Robertson, Dennis, Grace & Wallington, 2003). The National Institute for Clinical Excellence [NICE] (2014) recommends that first contact with services in both the antenatal and the postnatal periods should routinely assess current and previous maternal mental health. Psychosis after childbirth (also referred to as puerperal psychosis or postpartum psychosis) is the most rare and severe type of postnatal mental health difficulty. Onset is rapid, with symptoms presenting as early as two to three days after childbirth, and it can lead to emergency inpatient admittance, at a time when separation may have implications for the attachment relationship between the mother and her baby (Joint Commissioning Panel for Mental Health [JCP-MH] 2012; Sit, 2006). NICE (2015) recommends that women who need inpatient care for a mental health difficulty within 12 months of childbirth are admitted to a mother and baby unit (MBU) to prevent problems with bonding. The early days in the postpartum period are critical for mother-infant relationships, as babies begin to develop an ‘attachment style’ from birth. Attachment can be described as a range of protective behaviours that ensures the best parenting to promote the survival of children (Crittenden & Dallos, 2014). However, maternal mental health difficulties can affect the quality of the attachment relationship which is associated with child development (Alhusen, Hayat & Gross, 2013). Therefore women with mental health difficulties following childbirth should receive specialist care that allows them to maintain close contact with their baby.

Historically PP research has focussed on biomedical management, however there is a growing body of psychological literature which has explored this type of mental health difficulty from an experiential perspective (Doucet, Jones, Letourneau, Dennis & Blackmore, 2011). Early qualitative research in this area indicates that mothers experienced PP as a particular type of mental health difficulty that is distinct to and precipitated by the experience of childbirth (Robertson et al., 2003). During the course of PP, mothers often experience negative thoughts about the baby, (Glover, Jomeen, Urquhart & Martin, 2014) alongside feelings of shame and guilt over not being able to care or respond appropriately to her infant (Engqvist, Ferszt, Ahlin & Nilsson, 2011; Engqvist &

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6 The terms puerperal psychosis and postpartum psychosis are often used interchangeably in the literature to refer to psychosis symptoms unique to the period following childbirth. In this paper we use the term Postpartum psychosis (PP).
Mothers often reported that family members cannot cope or understand the illness, and that this was detrimental to their recovery (Glover et al. 2014). Studies exploring the experience of recovery highlighted the importance of supportive relationships during recovery (McGrath et al., 2013; Doucet, Letourneau & Blackmore, 2012). Lack of knowledge about the illness within a woman’s support system has been found to delay the recovery (Doucet et al., 2012). Promoting public awareness of PP that educates family members about symptoms will help mothers to recognise that they need to access professional help (Doucet et al., 2012; Plunkett, Peters & Wittkowski, 2015). The family and particularly partners have been recognised as integral to a woman’s recovery (Engqvist & Nilsson, 2011; Plunkett et al., 2015). Thus, health professionals need to implement interventions that facilitate family functioning. This involves educating family members that recovery will take time (Heron, Gilbert, Dolman, Shah, Beare, Dearden, Muckelroy; Jones & Ives, 2012). Recovery is viewed as progressive and non-linear with turns and milestones (Heron et al., 2012; McGrath et al., 2013). In MBU settings, practical interventions that promote mothering and play are argued to be necessary for recovery (Heron et al., 2012).

Notably, no research to date has examined the role of the baby in recovery. Given the centrality of the baby in the onset of symptoms, it is likely that this relationship impacts on the recovery process. This relationship may facilitate help-seeking behaviour and may be formulated as a protective factor within recovery interventions. This may have implications for the treatment of mothers by health professionals and for the advice given to partners and family members. Lastly, findings from this research in this area may be pertinent to the organisation of services available for these mothers. For example, clinical guidance recommends that all mothers vulnerable to mental health problems during pregnancy and or postnatal period should have equitable access to specialist MBU treatment (NICE, 2015; Maternal Mental Health Alliance, 2015). For this reason, the aim of this study was to explore the role of the baby in recovery from psychosis after childbirth.

**Method**

Ethical approval was granted by the University Research Ethics Committee (ref: 14367), the local NHS Research Ethics Committee (ref: 14/NW/0278) and the relevant NHS Trust Research and Development Department (Appendix 5). Recruitment took place between
August 2014 and March 2015. Participants were recruited from an MBU in England and by advertisement on website forums for mothers who have experienced PP (Appendix 6). Recruiting participants from within and outside clinical services increased the likelihood of accessing mothers with a wide range of experiences and at different stages of recovery. Potential participants were provided with a Participant Information Sheet detailing the aims and procedures involved (Appendix 7). Once written informed consent (Appendix 8) was obtained, mothers were interviewed by the first author.

**Participants**

Women who believed they experienced any form of PP were included in the study. Inclusion criteria were 1) over 18 years of age, 2) fluent in verbal and written English and 3) women who perceived themselves to have received a diagnosis of any disorder in the schizophrenia category, a manic episode or bipolar affective disorder according to the International Classification for Diseases version 10 (World Health Organisation, 1992) specific to the period following childbirth. The inclusion criteria were broadly defined to gather diverse viewpoints on the process of recovery. Therefore, participants were recruited from different locations with different experiences of professional support at different stages of recovery. Where possible diagnosis was verified by staff identifying mothers through the MBU. However, no formal psychiatric assessment was made of mothers identified via website forums. To verify diagnosis, information about symptoms and diagnoses were collected using a demographic questionnaire (Appendix 10). The demographic characteristics of participants are summarised in Table 1.

Mothers under 18 years of age, not fluent in English, who previously experienced psychosis not related to childbirth or who had received a diagnosis of schizophrenia during pregnancy were excluded from the study.
<table>
<thead>
<tr>
<th>Participant number</th>
<th>Maternal age</th>
<th>Child’s age</th>
<th>Education level</th>
<th>Marital status</th>
<th>Diagnosis</th>
<th>Recruitment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>31 years</td>
<td>5 months</td>
<td>A-level equivalent</td>
<td>Married</td>
<td>Postpartum depression with psychosis</td>
<td>MBU</td>
</tr>
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<td>23 years</td>
<td>6 months</td>
<td>College level</td>
<td>Engaged</td>
<td>Postpartum psychosis</td>
<td>MBU</td>
</tr>
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<td>6 weeks</td>
<td>Masters degree</td>
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<td>MBU</td>
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<td>3.5 years</td>
<td>Degree</td>
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<td>Postpartum psychosis</td>
<td>Advert</td>
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<td>Postpartum psychosis symptoms</td>
<td>Advert</td>
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<td>8 years</td>
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<tr>
<td>12</td>
<td>54 years</td>
<td>26 years</td>
<td>A-level</td>
<td>Married</td>
<td>Puerperal psychosis</td>
<td>Advert</td>
</tr>
</tbody>
</table>
**Interviews**

A semi-structured interview schedule containing open ended questions to guide areas of discussion relating to the mothers’ experiences was developed (Appendix 9). The schedule was adapted according to mothers’ comments and the areas of discussion raised during the interview. Interviews were digitally audio-recorded for the purpose of data analysis. They lasted from 22 to 52 minutes (mean = 33). Five mothers were interviewed face-to-face and seven interviews were conducted over the telephone due to geographical distance and at participants’ convenience (Opdenakker, 2006; McGrath et al., 2013).

**Data analysis**

Thematic analysis is a qualitative analytic method that can be used to report on participants’ experiences and how they apply meaning to their reality (Braun & Clark, 2006). This approach may be applied inductively, when there is limited theory and pre-existing research, or deductively with specific research questions that map on to a theory (Braun & Clark, 2006). This is the first study to consider the role of the baby in the recovery process from psychosis after child birth. Therefore an inductive thematic analysis was used with the purpose of identifying common themes across the data.

The analysis comprised the following: 1) transcribing, reading and re-reading interviews to generate initial ideas; 2) systematic coding of each data set; 3) organising codes into potential themes; 4) reviewing themes and coded extracts to create a thematic map; 5) refining the specifics of themes and naming themes to create a coherent story and lastly 6) writing a report of analysis with selected extracts linking back to the research aim (Braun & Clark, 2006). The first author transcribed 58% of the interviews, while the remaining 42% were transcribed by an experienced transcriber and administrator, independent to the research team (TH). All interviews were checked for accuracy alongside the audio-recordings. The first author undertook the initial analysis, which was finalised through discussions within the research team to ensure the trustworthiness of the findings (Krefting, 1991). This was a subjective process, for transparency, information about the backgrounds of the researchers and their interest in this subject is described below.
The first author (a trainee clinical psychologist) was a white British woman who did not have children. She had a strong professional interest in this area, but very little prior experience in the context of PP. The second and third authors were a clinical psychologist and health psychologist respectively, with clinical expertise working with women who have experienced PP and academic experience of qualitative research. The second and third authors are also working mothers. None of the research team had personally experienced PP.

Results

Participant characteristics

Twelve participants agreed to take part in the study. Three of the women were recruited via the local MBU and nine were recruited from adverts placed on online forums. During the recruitment period there were three women admitted to the MBU who received a diagnosis of PP. All three women who were approached to take part in the study agreed to participate. Similarly, all women who enquired about the study in response to forum adverts went on to participate in the study. Interestingly, there were no women who chose to opt out of the research at any point in the process.

Ten of the mothers described themselves as White British. One woman described herself as British mixed race and another as Latin American. Participants’ ages ranged from 23 to 56 years (mean age 39.5). Consistent with previous research exploring recovery from PP (McGrath et al., 2013; Heron et al., 2012), mothers reported experiences of PP with their onset having occurred, between two months and 26 years prior to the interview. Five of the mothers experienced PP following the birth of their first child. Two mothers had subsequent pregnancies, neither of which resulted in a recurrence of psychosis. Four of the mothers in the sample also had older children when they experienced psychosis following the birth of their baby. However, these four women did not experience psychosis following these earlier pregnancies. None of the mothers had experienced any form of severe mental health difficulties prior to the episode of PP, but one woman had a history of postnatal depression following the birth of an older child. There was variability in the care that mothers received following the episode of PP: four

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7 See Paper 3, page 82 for a discussion of reflexivity.
mothers were admitted to a general psychiatric ward, four to an MBU and three received care in the community. One mother received care in a private hospital. The majority of mothers in this sample where in long term stable relationships with the fathers of their children. However, there were two mothers who ended the relationships with their partners in the years following the episode of psychosis. Both women had then gone on to form long-term stable relationships with different partners. One woman in the sample was also a single parent. Nine of the mothers in the sample where highly educated and were of higher socio-economic status. The demographic characteristics of this sample are not unique to this study. Reviews of qualitative and quantitative studies exploring motherhood in large scale samples of postnatal women have reported the views of highly educated participants who are white, middle class and in long term secure relationships (Brunton, Wiggins & Oakley, 2011; Nelson, 2003). However, for the purpose of transparency it is important to acknowledge that the findings presented from this thematic analysis may not fully reflect the views of a more demographically diverse group of women.

**Themes**

The three core themes identified in the analysis are: the centrality of the baby throughout recovery, which is presented first in the analysis. The remaining themes reflect the roles that the baby has throughout recovery. The baby is a barrier to recovery, this includes two subthemes: the baby increases emotional distress and the baby hinders getting help and self care. The third role identified in the analysis is the baby facilitates recovery, which includes three subthemes: the baby reduces emotional distress, the baby interacts with the mother and the baby increases self efficacy. A thematic map illustrates the roles of the baby centred throughout mothers’ experiences of their recovery from PP (Figure 1).
Figure 1. Thematic map illustrating the roles of the baby in recovery from PP

- The baby has a central role in recovery
- The baby reduces emotional distress
- The baby facilitates recovery
- The baby interacts with the mother
- The baby increases self efficacy
- The baby has a varied role in recovery
- The baby is a barrier to recovery
- The baby increases emotional distress
- The baby hinders getting help and self care
The baby is central throughout recovery

Mothers’ experiences of recovery from PP highlighted the centrality of the baby. Mothers who perceived themselves as recovered from PP stated that the baby was intrinsic to their recovery. “He’ll never know how much that the little things that he did helped me to survive, I suppose” (P8). Interactions with the baby motivated the mothers to get better and take more steps towards recovery and caring for their baby. “… yeah he was definitely, you know he was the key reason, he was the reason I wanted to get better, and he was the reason that I wanted to be able to do all of these things again” (P6). The baby promoted recovery from PP; mothers who had been separated from their babies reflected that if they had stayed with their baby throughout they might have recovered quicker. “Er, I think if I could have fed him first, from the start of feeling this and gone onto the baby unit ... things could have turned out different...” (P11). The baby motivated mothers towards life goals that maintained their recovery. “Yes for me like ... it made me like continue my life ... obviously I went back to uni and everything. It definitely made me a better person having [name] as well. I think if I didn’t have a purpose ... I would have probably had depression longer” (P4).

However, the baby was not always viewed as helpful: “I thought if she goes, I’ll get better. But I didn’t realise actually, she needs to stay and I need to be her mum to get better, it was actually the opposite thing that ended up making it better, which comes a bit later down the line but actually being her mum and growing to love her and feeling competent and all those things that were absolutely central to me getting better” (P10). The baby had a complexed role that was experienced by mothers both positively and negatively during their recovery.

The baby is a barrier to recovery

The responsibility of a caring for a new baby and meeting his/her needs created emotional distress that acted as a barrier to recovery. Societal expectations around mothering delayed some mothers from getting help. The physical demands of caring for the baby impacted on the mother’s capacity for self-care.

The baby increases emotional distress

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8 P = participant
When mothers started to recover from PP, meeting the baby’s needs was perceived to increase emotional distress. Many mothers feared being alone with their child. “I didn’t want to be on my own with [baby’s name] you know all the time, I said mum you’ve got to be with me ... all the time” (P10). Mothers who feared that they could not provide a good enough experience for their baby; distanced themselves within the relationship. “…I wouldn’t be on my own with him, when I was discharged from the hospital, I think that was my way of protecting him as a mother” (P11). Women reported that they struggled to physically manage to care for their baby. This created maternal distress that impacted negatively on their recovery. “Er, it was more that I wasn’t capable of doing it, and is it, in your, I thought I was, it meant that I wouldn’t be able to so and the breastfeeding and not being able to do that made it feel double worse” (P9). Mothers reported that the demands of getting better following an episode of PP depleted their responsiveness to their infant’s cues. This had a negative impact on their emotional wellbeing: “Initially I think that, erm, added to the guilt of me not being able to do things, like the breastfeeding or not know what that cry meant” (P9).

The baby hinders getting help and self-care

The demands of motherhood and the pressure to appear to be coping caused anxiety in mothers. This made it difficult for mothers to access professional help. “That would be the number one reason for me not telling anyone. Cos I was utterly convinced if I told the doctor I am thinking of throwing my baby out of the window ... they are going to think ‘Oh my god that poor baby’. And you know you hear that from the paper that they were taken away and that’s it. I didn’t tell a soul” (P7).

In the early stages of recovery there was conflict between getting well after an episode of PP and being a mother to the baby. For some mothers the baby hindered self-care. “… You’re trying to get better of a really awful illness and also your life has change so much. And I think it like takes a long time, I think if you didn’t have a baby ... say you just got really poorly and you didn’t have a baby you could spend some time in bed...” (P4). Mothers reported caring for the baby involved sacrifice of their physical and emotional wellbeing. For some mothers it was impossible to look after themselves and the baby because the presence of the baby appeared to block strategies for getting better such as sleep. “Erm, because I wanted to go to sleep so I would turn over, and I’d be like, I don’t want to be with him now, and, erm, but that was just, I suppose it was a bit like the idea of putting your own gas mask on first” (P9).
The baby facilitates recovery

Babies facilitated their mothers’ recovery in several ways; physical contact with the baby reduced maternal distress. When the baby interacted with the mother, she recognised that she had bonded with her baby and this increased her self-efficacy.

The baby reduces emotional distress

Knowledge that the baby was safe and that they could see him or her whenever they wanted improved mothers’ well-being. “Ummm well he was safe and here with me ... And if I ever feel like a bit upset or anything I just go and see him and feel better.” (P2). Contact with the baby alleviated mothers’ emotional distress. “If I felt anxious or felt upset then the first thing I would do is get back to the babies cos I found that the most calm thing and I would just want to be with them” (P5). Many mothers believed that not seeing their baby would have increased their distress. “I think ..., if I hadn’t have been with him, I would, I would have probably, erm, wanted to hurt myself, ... I wanted to be there even if I couldn’t do all the physical tasks, I would still want to be there” (P9). Furthermore, many mothers reported that separation from the baby would have been detrimental to recovery. “And I think if I’d if I had my babies taken away at that stage then I would not have recovered. Well that would have too much to bare cos if I had an isolated psychotic incident without the children ... do you see what I mean, having the babies helped” (P5).

Mothers valued practical help with looking after the baby when they were very ill “... so they would do the night feeds for me just so that I would get my sleep which helped...” (P2). This type of help simultaneously reduced anxiety about the baby’s wellbeing and allowed the mothers to rest. This type of practical intervention promoted recovery because the mothers were able to simultaneously look after themselves and remain in close contact with the baby.

The baby interacts with the mother

Practical care in the evenings enabled mothers to rest at night and feel renewed during the day, which allowed them to focus on their child in the daytime; which helped to develop their relationship. When mothers experienced positive feedback from their baby, they felt stronger and more motivated towards recovery. “It’s been massively helpful to have the care during the night. Because it gives me the chance to get enough sleep because I found the sleep massively helpful about getting back to ... not only because of the physical problems but massively mentally and I found that I feel more positive and more able to
cope with caring for him really well during the day. Which then built a more positive relationship with him because of the feedback.” (P3).

As the baby interacted more with the mother, the bonding process was enhanced. For many mothers realising that they had bonded with their baby was crucial to their recovery. Through the joy of simple interactions with their baby, mothers recognised that they were in recovery. “Yeah I think I started to do more and obviously when they get like ... babies get a bit older they get more interactive and I started to enjoy it more and I got better” (P4). Knowing that there was a strong relationship with the baby was described as a key factor in recovery. One mother reported that cues from her baby that signified that she knew his needs better than anyone else was a powerful factor in her recovery: “…I still knew my child better than the people that had had him three months, and which is, was such a relief, I mean even down to simple little things like, they’d tried feeding him warm milk, and I knew from the start he never liked warm milk ...” (P11).

Physical contact and feeling emotional connected with the baby helped mothers to recognise that they were in recovery. “…the day I actually picked him up and I remember I picked him up and it just felt so right, ‘cos it, I felt so wrong, but when I picked him up it felt so right, that’s when I knew, it was coming back” (P11). The baby was central in helping mothers to adjust to motherhood. Mothers who were in recovery felt that separation from the baby actually prevented them from getting better in the long term. “I think separation’s never a good thing, you know I was glad, I thought great it will relieve the pressure you need the pressure off you know I can’t do this and have a baby and I just can’t handle her but actually most probably it made me worse in retrospect being separated” (P10). Close contact with the baby provided mothers with the opportunity for interactions that facilitated bonding. “… I think that being in the Mother and Baby Unit was a key factor because they kept us together and they encourage you, they help you with things like baby massage, they encourage you to do as much as you can for them when you’re well enough, erm, yeah, I don’t really know how we would have been affected if we hadn’t been together ...” (P6). Overall when the baby interacted with the mothers this reassured women of the security of their relationship. This in turn increased self efficacy within the mothering role.

The baby increased self efficacy

Confidence and feelings of enhanced self efficacy was a marker of recovery. Handling and interacting with the baby gave mothers feelings of self efficacy that they could cope as a
parent. This made mothers want to spend more time with the baby which facilitated their recovery. As the baby promoted a woman’s confidence in who she was as a mother and as an individual. Mothers started to take responsibility for their baby: “but at first it was very much just doing his physical needs if I’m honest” (P9). These early steps caring for the baby increased the mother’s self efficacy in meeting her baby’s needs and appeared to strengthen the mothering bond. “I think in my recovery and it’s very subtle, you just gradually, it’s not like you don’t love the baby one day and you do the next, you just gradually start enjoying things more and more and noticing things more and more and feeling more confident in your ability to, erm, to look after the baby” (P10).

Maternal self efficacy referred to both practical care and an emotional connection with the baby. Mothers reported that professionals, especially MBU staff as influential in promoting efficacy within the mother-baby relationship. “I think it’s important to have the nursery nurses around you because any doubts or if you don’t know how to do something it’s good for them to give you guidance. That’s really helpful … expert … helps build your confidence back up” (P2). Mothers marked self efficacy and not being scared to be alone with the baby as major milestones in their recovery: “… and that to me was my first memory of quite enjoying his company and not feeling petrified. I think I remember that because it was a cataclysmic shift …” (P7). Physical contact with the baby enhanced self efficacy and shifted mothers towards positive thoughts about recovery. The realisation that they had progressed to a point where they could enjoy their baby filled mothers with hope. “And I do remember having her in my arms but dancing with her and started to sort of you know … you start to sort of … there’s a bit of light at the end of the tunnel” (P8).

Discussion
This is the first study to explore the role of the baby in recovery from PP. The findings indicate that the baby has a central role in women’s recovery. However, the nature of the baby’s involvement in maternal recovery is complex and can be experienced both negatively and positively.

Based on the accounts of these 12 mothers, the baby can be experienced as a barrier that increased emotional distress including feelings of guilt and anxiety permeating the recovery process. Guilt and fear of not being able to look after the baby has been identified in previous studies exploring the experiences of illness and recovery from PP (Heron et al., 2012; Doucet et al., 2012, Enquivist et al., 2011). Mothers’ distress around caring for their child led them to avoid the baby. This impacted negatively on the mother’s
wellbeing and hindered their recovery. It is possible that negative feelings about the baby could be ‘normalised’ for mothers and this in turn can be used to facilitate recovery. Social pressures to appear as a mother who is coping well delayed getting professional help. This finding has also been cited in earlier studies exploring recovery (McGrath et al., 2013), which implies that professionals working with perinatal women need to be aware of the difficulty of accepting illness and asking for help. A novel finding of this study is that caring for the baby was experienced by participants as having to sacrifice their own self-care. This observation highlights the importance of practical support for mothers, which allows them to simultaneously care for the baby and themselves. While the baby can be experienced as a barrier, this does not mean that the baby is not important to recovery; indeed the baby can simultaneously be experienced positively. As stated above, mothers may need lots of help to maintain close proximity to the baby so that they also experience the positive aspects of the relationship that facilitates recovery.

Our findings suggest that the baby has a helpful role, with several elements that facilitated recovery. Mothers’ confidence increased through interactions with the baby that were mutually enjoyable. Furthermore, help with practical care for the baby increased mothers’ confidence in the security of her attachment with her child. This type of support from family or MBU staff creates social learning opportunities, such as modelling and mastery of care for the baby, which improved the mother’s self-efficacy (Bandura, 1965; Bandura 1977). This parallels attachment informed mental healthcare (Bucci, Roberts, Danquah & Berry, 2015) in that practical support allows mothers to develop secure attachments not only with staff but also with their babies. Hence, mothers were confident that they fulfilled their child’s needs and that they can function as a capable mother. This in turn facilitated a positive cycle that supports recovery. Relationship milestones with the baby, helped mothers to recognise that recovery was taking place, in this way the baby can be described as a co-therapist within the mother-infant dyad (Frailberg, Adelson & Shapiro, 1975). As the baby has a helpful role in promoting self-efficacy and overall recovery, separation from the baby (through inpatient psychiatric admission) was found to be detrimental. Although the baby could be experienced as unhelpful and helpful, it remained essential throughout recovery for the mothers to have contact with the baby.

A novel finding of this study is that the baby was found to be helpful in reducing mothers’ emotional distress. Parent-child-interaction interventions have been reported to be beneficial for mothers with postnatal depression (Puckering, McIntosh, Hickey & Longford 2010). It is possible that the baby’s presence interrupted self-focussed attention
in the mother in a manner comparable with the principles of attention training and detached mindfulness (Wells, 2009). Contact with the baby alleviated distress, which allowed the mothers to develop an emotional connection that facilitated and sustained recovery. According to compassion focussed models of recovery after psychosis, the baby may have activated the soothing system, signifying safety for mother and baby (Gumley, Braehler, Laithwaite, MacBeth & Gilbert, 2010).

The onset of mental health difficulties can be a highly stressful life event for any individual across the lifespan. Adjusting to motherhood has been described in the existing literature as being extraordinary and overwhelming at the same time (Brunton 2011). Similarly, the transition to motherhood has been described as time of conflict and growth (Nelson, 2003). A striking feature of mental health difficulties occurring in the perinatal period is that women are required to adjust to two life events that are intrinsically enmeshed around the physical and psychological process of childbirth. Furthermore, international guidance in the UK has acknowledged the specialist needs of women who experience mental health problems following childbirth (NICE 2014; Scottish Intercollegiate Guidelines, 2012). Furthermore, women experience PP at time when social norms consider a period of joy. However, the experience of PP often leads to admission to an MBU or inpatient unit and psychiatric medication which is comparable to trauma. This negative experience may be further exacerbated by physical health problems and or neonatal difficulties due complications with childbirth. To date there are no studies exploring illness beliefs or perceptions in women who have experienced psychosis following childbirth. However, research exploring beliefs around postnatal depression has highlighted that these type of mental health difficulties were viewed by women to be distinct to the perinatal period (Baines, Wittkowksi & Wieck, 2013). The experience of postnatal depression was characterised by grief in a manner that did not map on to other models of illness beliefs (Patel, Wittkowski, Fox & Wieck, 2013).

A key finding of this study is that the baby can be experienced as both helpful and unhelpful to recovery. It is possible that the baby is experienced in these two different ways at different points in recovery. Alternatively, as our findings suggest the two overarching roles may not be mutually exclusive and may be experienced simultaneously this illustrates that while the baby’s role is important to recovery; it is a complex role. These findings suggest that there are more empirical questions to further our understanding of the baby’s role in recovery from psychosis after childbirth. Future research may also consider the role of attachment in recovery from psychosis after childbirth. Research in
the area of postnatal depression has found insecure attachments styles to be a risk factor for this type of mental health difficulty (Warfa, Harper, Nicolais & Bhui, 2014). Currently, there is no existing research exploring the relationship between attachment style and the onset of psychosis after childbirth. However, existing research has suggested that in individuals with psychosis an insecure attachment is associative with a less integrative recovery style (Berry, Barrowclough & Wearden, 2007). It possible that future quantitative studies may identify styles of attachment and recovery in women who have experienced psychosis after child birth which may have implications for mother-infant relationships.

**Strengths and limitations**

Although mothers were recruited from across England, the majority of this sample was white British; one mother was of mixed British background and another was Latin American. Therefore, the findings may not be generalizable to other ethnic groups. For example studies of childbirth and postpartum mothers of Chinese ethnicity highlight additional conflicts experienced by this group of women regarding traditional beliefs about mental health problems and gender roles (Lam, Wittkowski & Fox, 2012; Chan & Ley, 2003). The majority of the sample consisted of women who were well educated. Women with a lower level of educational attainment may have offered different accounts of the baby’s role in recovery. For example, this group of women may experience different challenges to recovery in relation to systemic resources such as financial pressures, support with childcare, etc. Alternatively, this group of women may have held beliefs about professionals and hierarchy which may have led to them to be fearful of sharing negative aspects of the baby and recovery. In general research volunteers tend to be individuals from higher socio-economic status groups (Weber-Cannon, Higgibotham & Leung, 1988). However, women from different, ethnic, cultural and socio-economic backgrounds are admitted to the MBU. Therefore, recruitment via the MBU meant that participation in the study was open to a diverse range of women. It is possible that the findings of the study may only be transferable to women who are highly educated and from higher socio-economic status backgrounds. Consistent with previous research (McGrath et al., 2013), a heterogeneous group of mothers was recruited in terms of age and the time lapse that had occurred since the episode of PP. For some women many years had passed since their episode of PP, therefore it is possible that their retrospective accounts may have been
affected by poor recall. However, recall around childbirth and traumatic experiences of illness such as psychosis is generally reported to be excellent (Doucet et al. 2012). Furthermore, previous studies in this area have recruited women who have experienced PP more than 10 years ago (Heron et al. 2012, McGrath et al. 2013). These women may have had different experiences of care which may have influenced their experience of recovery. It is also possible that this group of women may have had time to process and detach from the experience. They may feel secure enough – at this moment in time to disclose the more negative aspects of the baby’s role in recovery. It was necessary to include these women as all experiences were considered important to understand the role of the baby in recovery. Overall, irrespective of the retrospective nature of many women’s account of recovery, the same themes consistently emerged across the data. This study was designed to be inclusive of this diversity in order to capture the views of mothers at various stages in recovery. The diversity in recovery experiences is a strength of this study and increases generalisability of the findings.9

It is not unusual in qualitative research to include participants who select themselves because they believe that they meet the criteria for a particular mental health problem. Due to the rarity of PP it may not have been feasible to only include women who had received a formal diagnosis. A limitation of the study was that it was not possible to verify the diagnosis for mothers with PP who were recruited via web forums. Similar to existing research in this area recruitment consisted of women who identified themselves as experiencing psychosis after childbirth (Glover et al. 2014; McGrath et al. 2013, Heron et al. 2012). However, consistent with a previous research in this area (McGrath et al. 2013) a symptom checklist was developed to try to verify diagnosis as much as possible within the parameters of the study. The symptom checklist was informed by the psychotic screening module of the Structured Clinical Interview for DSM disorders (First et al. 2002) to ensure that all mothers reported symptoms consistent with a diagnosis of PP.

Consistent with earlier research in this area, this study successfully utilised various approaches to interview (face-to-face and telephone) to capture hard-to-reach mothers, specifically those with young children (McGrath et al. 2013; Opdenakker, 2006). As PP is rare, participants were geographically dispersed, therefore our interview approach had to be flexible and offer mothers the choice of face-to-face or telephone interview. By asking mothers about their relationship with the baby it is possible to introduce a social

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9 See Paper 3, page 83 for discussion of sampling and data saturation
desirability bias into the participants’ responses, hence this approach was also designed to minimise bias by offering the opportunity for telephone interviews (Novik, 2008). Telephone interviews were found to be comparable in quality to face-to-face interviews (Carr & Worth, 2001). It is possible there is an element of social desirability within the data derived from the sample. For example it is plausible that women in this sample felt the need to minimise negative feelings and maximise positive feelings regarding the baby. However, this data set presents women’s accounts of the baby being experienced as a barrier to recovery. Therefore, the rich data gathered from the interviews in this study provides evidence of limited social desirability bias.

**Clinical implications**

As motherhood and childbirth is central to the onset of PP, the baby is also central to recovery from PP. Hence, the baby can be experienced as both unhelpful and helpful to recovery. Tailored information for families can help (Heron et al., 2012) to normalise viewing the baby as unhelpful to recovery, especially after the onset of symptoms. Care in an MBU provides the ideal setting to provide holistic support that activates the baby’s helping role in recovery. Mothers are reassured that the baby is safe; they access mother-baby interventions delivered by trained nursery nurses and have psychological support from clinical psychologists and other mental health staff. Although inpatient admission can be perceived as distressing by mothers; immediately after the onset of symptoms is the optimal time to access specialist treatment in an MBU. In this setting mental health staff can provide powerful interventions alongside practical support that allows mothers to rest while maintaining energy to engage and interact with her baby. Elsewhere support from the family has been found to be central to recovery from postnatal mental health problems (Plunkett et al., 2015). Specialist interventions such as mother baby interactive play can help mothers recognise positive feedback from their babies and move them forward in recovery. These findings highlight the necessity of equitable access to MBUs for all mothers regardless of geographical location (Maternal Mental Health Alliance, 2015) and they argue in favour of health providers commissioning more specialist mental health services for women in the perinatal period.

**Future research**

In this study the importance of the baby in the recovery process has been highlighted and the bivariate nature of the role discussed. To better understand the bivariate role of the
baby future research may gather prospective data. Subsequent studies may focus exclusively on the helpful or unhelpful aspects of the baby’s roles in recovery at different time points. Longitudinal designs that capture prospective data at various time points in the women’s journey may provide a rich overview of the role of the baby in recovery. These findings emphasise fruitful areas of exploration for future research, which may explore the role of the baby and other family member’s experiences of supporting mothers recovering from PP. This study may also be replicated to include a wider range of mothers from different socio-economic and ethnic groups. Findings suggest that the relationship with the baby may have therapeutic benefits that facilitate recovery from PP, which supports the argument for specialist MBU treatment promoting the parent-child-relationship. To date, little is known about how other family members or how MBU staff perceive the role of the baby in recovery from PP. Therefore, future qualitative research may address these gaps in the literature on recovery from PP.

**Conclusions**

Overall, the findings of this study contribute to existing research, specifically highlighting the centrality of the baby in recovery from PP. While the baby has a bivariate role in recovery (can be experienced as helpful and unhelpful), they emphasise the importance of women remaining close to their babies throughout this process. The findings support specialist treatment in MBU for all mothers. The MBU setting provides holistic support enhancing aspects of the baby that promote mothers’ recovery from PP as early as possible.
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A critical review of the qualitative process of exploring the role of the baby in recovery from psychosis after childbirth

Word count (excluding references): 4,246
Critical Reflection and Discussion

Introduction
In this chapter a critique of Paper one and Paper two is presented including the rationale for the research design in both the meta-synthesis and the empirical paper. The strengths and limitations of each are discussed alongside the clinical and research implications. Researcher reflexivity and personal reflections are also discussed.

Choice of research area
The early days and weeks of the bond between parent and child is crucial for healthy infant development both physically and psychologically (Leadsom, Field, Bursto, & Lucas, 2013). The challenges of caregiving and adjustment to parenthood, requires a degree of resilience in parents to manage the demands of caring and meeting the needs of a newborn baby. The fragility of the parent’s psychological wellbeing during this period, especially in the context of mental illness can have implications for the attachment relationship (Rees, 2007). As earlier research links childbirth and mothering to the onset of Postpartum Psychosis (PP) (Sit, Rothschild, & Wisner, 2006); this leads to questions about the role of the baby in the women’s experience of recovery from PP. Within the growing body of psychological literature in this area; there is a move to understand the women’s experience of recovery, with family relationships highlighted as an important factor (Heron, Gilbert, Dolman et al., 2012; McGrath, Peters, Wieck & Wittkowski, 2013). However, strikingly there is no research exploring the role of the baby and recovery.

Rationale for qualitative approach
Scoping of the literature revealed that much of the research in PP has been conducted within a biomedical paradigm (Glover, Jomeen, Urquhart & Martin, 2014). There was a small body of qualitative research exploring women’s broader experiences of illness and recovery, many of which were included in my review (see Paper 1). This evidence base sought to explore and understand the participant’s perspective within a limited psychological evidence base and these studies adopted qualitative methodologies. Qualitative approaches are important in the exploration and understanding of under-researched phenomenon and generating new ideas (Peters, 2010). A qualitative methodology was chosen for this study because there is no pre-existing research exploring the role of the baby in recovery from PP. Furthermore, qualitative research captures rich data on people’s lived experience (Noblit & Hare, 1988). With quantitative research (for
example, questionnaires) there would be a risk of missing key data pertinent to the role of the baby in women’s experience of recovery from PP.

There are a broad range of qualitative methodologies that can be adopted to understand new experiences of phenomena. Grounded theory is a technique often employed inductively to understand and develop a conceptual framework around the lived experience of participants (Charmaz, 1990). Alternatively, thematic analysis is a qualitative analytic method, which can be applied flexibly across a range of theoretical paradigms to describe participants’ experiences. Interpretative Phenomenological Analysis is another technique often used with small samples to capture rich data on the lived experience (Pringle, Drummond, McLafferty & Hendry, 2011). However this approach privileges the individual and seeks to develop themes anchored in specific quotes (Pringle et al., 2011). However, in the present study the aim was to explore women’s common experiences of the role of their baby in recovery from PP after childbirth. Thematic analysis can be used to summarise and describe common patterns across the data or used to interpret the data (Braun & Clark, 2006). There is a small evidence base around recovery from PP. Furthermore, McGrath et al. (2013) previously used grounded theory to understand women’s recovery experiences of PP after childbirth. Therefore, in this study it seemed appropriate to use thematic analysis inductively to understand more about the role of the baby as opposed to developing a conceptual framework of recovery. An advantage of thematic analysis is that it has been commonly used in healthcare research with small or large sample sizes (Peters, 2010). PP is a rare form of perinatal mental illness; one to two women in 1000 live births will develop postpartum psychosis (Brockington, 1996). It was anticipated that this study would have a smaller sample size and thematic analysis seemed the most appropriate qualitative methodology to identify aspects important for healthcare planning and provision.

Interview procedure
Developing an interview schedule (Appendix 9) was a pivotal task early on in the research. Prior to interview a lot of time was invested reflecting and preparing for asking potentially difficult questions around women’s feelings about their baby. Research supervision was used to reflect on approach to questioning and to develop these techniques further in subsequent interviews. The interview schedule was developed based on similar exploratory studies of PP (McGrath et al., 2013), discussions with the research team and feedback from service user groups such as Action Postpartum Psychosis and the Clinical
Liaison Group at the University of Manchester. To capture more details, open-ended questions were used with follow-up probe questions as advised in guidelines for qualitative interviews (Charmaz, 2006). Initially, the interview schedule was quite lengthy with some questions leading to data irrelevant to the research question. However, due to the sensitive nature of the subject area, it was necessary to have certain questions at the beginning of the interview to engage and to develop a rapport with participants, especially during telephone interviews. Throughout data collection and during research supervision certain questions emerged as irrelevant to the research question. For example questions around women’s stay in hospital or contact with health professionals seemed irrelevant to the research aims after the second interview. After Interview four questions around the women’s feelings about the baby in relation to the onset of illness also seemed irrelevant to the research aims. During interviews women were asked if there was anything that we needed to ask or consider to understand their experiences. The interview schedule was revised on two occasions based on this feedback. Consistent with guidance on qualitative research the data was generated in an iterative manner (Elliott, Fischer & Rennie, 1999).

The costs and benefits to participants taking part in the research were carefully considered. The nature of the topic meant that the interviews could be emotive. Prior to commencing with interviews the distress protocol (Appendix 11) was discussed with women. There was the potential for risk issues arising with this group of women. Any deterioration in mental wellbeing may have had implications for the safety of the mothers and or their children. In circumstances where potential risk was anticipated, contact (if needed during the interview) with the research supervisor (an experienced Clinical Psychologist who has worked with many women with PP) was planned in advance. The women were briefed on the process of managing risk and if necessary that they could to stop the interview at any point. The benefits of taking part in a study should outweigh the risks (British Psychological Society, [BPS] 2010; Birbaum, 2004). Previous research reported that participants who took part in qualitative interviews that discussed difficult experiences, found them to be therapeutic (Woglemuth, Erdil-Moody, Opsal, Cross, Kaanta, Dickmann & Colomers, 2014; Richards & Emslie, 2000). Furthermore, women who have experienced distress related to childbirth have found the process of helping other women through research as beneficial (Beck, 2005). Overall the evidence suggested that benefits taking part in the study outweighed the risks,
**Ethical approval**

The NHS Research Ethic Committee (NREC) expressed concerns regarding online recruitment and restricted recruitment to the local Mother and Baby Unit (MBU). Mainly that the study would involve discussing sensitive issues with potentially vulnerable participants who were not engaged with NHS services, making it difficult for the research team to manage any distress caused to participants during the interviews. However, web based recruitment is a low cost way to reach specialists sample (Birnbaum, 2004). The committee’s concerns led to detailed consideration of the procedures for gaining informed consent from this group of participants (BPS, 2010). This meant that prior to giving consent women had to be aware that participating in the research involved talking about a sensitive topic that may cause distress and that they could withdraw consent at any point in the research process. Women who came forward in response to web forum advertisements were given the Participant Information Sheet (Appendix 9) inviting them to contact the researcher for more information. Women who contacted the researcher for a second time where then asked to complete and return a consent form before proceeding with research interviews. Similar studies interviewing women successfully recruited women through web forums without any risk or distress to participants (McGrath et al., 2013, Beck, 2005).

The concerns of the committee led to an appeal for an amendment that would allow us to recruit via web forums with reassurance that a similar study had been completed without any difficulties. The appeal process delayed the wider recruitment by at least six months. Given that a similar study (McGrath et al., 2013) received NREC approval to recruit through the MBU and web forums this decision could not have been anticipated. The research team decided to explore recruitment through the University Research Ethics Committee (UREC), because it was uncertain if women who used these specific forum regarding PP were still NHS patients or had been discharged from mental health services, as McGrath et al. (2013) discovered in the study exploring the experience of PP. Ethical approval from UREC allowed for face-to-face or telephone interviews. The unexpected delay with ethical approval had a negative impact on the timeframe for the study and the shortened the period allocated for recruitment.

**Recruitment**

As PP is rare, the researcher endeavoured to recruit widely through a local MBU and online support forum to capture an appropriate sample size. Recruiting women from an MBU meant that the researcher had to fit around the activities of the ward and participant’s
routines with her baby. It was essential for the researcher to be flexible regarding the timing of interviews; as the women with younger babies where in the earlier stages of recovery and had to feel well and relaxed to be able to engage in the interview process.

*Recruitment through web forums*

Utilising the internet is growing more common in qualitative research (Beck, 2005). Recruitment via the web is low cost and helps to reach hidden populations especially when discussing sensitive issues (Duffy 2002; Binik, Mah, & Kiesler, 1999). In this study recruitment through web forums enriched the data captured during interviews because this subgroup of mothers brought different reflections to the interviews. For example, mothers who experienced PP many years ago reflected that initially they saw the baby as a barrier to recovery. They could not perceive the baby as having a helping role until much later. These reflections may be due to different experiences of healthcare. Indeed women who experienced PP several decades ago were not admitted to an MBU and hence did not receive support by specialist MBU staff. In contrast women who were within months of recovery may have experienced care from MBU staff, whose intervention helped them to see the baby in a helpful role. Alternatively, women in the latter stages of recovery had less emotional conflict and could securely express the reflection the baby was initially perceived as hindering recovery. The variance in reflections was pertinent to understanding the multifaceted role of the baby and answering the research question as discussed in Paper 2. The dual approach to recruitment yielded a sample of 12 participants.

**Analysis**

Interviews were transcribed and analysed simultaneously with data collection. Methodological rigour was ensured by following guidelines outlined by Braun and Clark (2006). Analysis commenced with familiarising with the data through reading and then re-reading transcripts on several occasions. As the majority of interviews were transcribed by the researcher this increased familiarity with the data. The next phase of analysis involved coding the data line by line; this is a time consuming and laborious process that often generates codes unrelated to the research aims. In real world research this phase in the analysis is questionable especially within a narrow time frame. However, this was a necessary process for identifying patterns across the data that informed ideas about themes developed at later stages. The methodology of thematic analysis has been described as “anything goes” (Antaki, Billig, Edwards & Potter, 2002), this can be disconcerting for
novice researchers who prefer more concise and structured approaches. However, the flexibility within the approach means that data can be coded at the descriptive level or at an interpretive. In our study coding the data in accordance with the research aims provided a rich description (Alhojailan, 2012) of the role of the baby in recovery from PP. This approach captured rich data that would have been lost in quantitative methods such as questionnaires. The thematic map helped to understand the relationships between themes. The maps was used reflectively in supervision to develop and revise themes accordingly, hence ensuring reliability and validity of the findings (Alhojailan, 2012). In this way thematic analysis can described as iterative and reflexive process that acknowledged the subjectivity of the researcher.

**Reflexivity**

Evidence suggests that the professional background of the researcher can influence participants’ responses during research interviews (Richards & Emslie, 2000). All of the participants were aware that this research formed a key part of the researcher’s training as a trainee clinical psychologist. Comparable with clinical experience a ‘non expert’ role was adopted during interviews which greatly enhanced rapport and helped women to speak freely about their experiences. Researcher characteristics such as gender can be exaggerated in certain interview contexts (Morgan, 1986). The researcher was a women of childbearing age; these could be salient characteristics during interviews that explored experiences linked to childbirth. In woman to woman interview pairs, shared gender has been reported to create a sense of “cultural homogeneity” that reduces power imbalance (Oakley, 1981). On a few occasions some of the women asked if the researcher had children and commented that she sounded ‘young’ during the telephone interviews. One woman commented that she hoped that hearing about experiences of psychosis following childbirth in the interviews did not put the researcher off motherhood. Existing research reports that various forms of power relationships occur due to social, cultural and personal differences between women during interviews (Tang, 2002). It is plausible that the women were trying to ‘protect’ the researcher by providing a happy ending to their experiences. As a young professional women who does not have children, the researcher may have represented aspects of the participants’ identity that existed before motherhood.
**Strengths and limitations of empirical paper**

**Sampling**

Consistent with previous research in PP (McGrath et al., 2013; Heron et al., 2012), this study included mothers with young babies who had recently experienced PP and mothers who recovered over a decade ago. The sampling technique maintained the principle of maximum variance to discover core themes that are shared across a relatively diverse sample (Patton, 2001). Furthermore, in qualitative methodologies sample consistency is considered in terms of trackable variability (Guba, 1981). In qualitative research variability stems from the fact that the objective is to capture the range of experience, as opposed to the average experience (Krefting, 1991). Therefore, it is important to include varied insights into the findings.

This sample of mothers could be considered relatively homogenous which may limit the generalizability of the findings. Sandelowski (1986) argues that the purpose of qualitative research is not to generalize but to describe an experience or phenomenon. However, Guba (1981) proposed that if the data is described sufficiently to allow comparison with other contexts, then the issue of generalizability has been addressed. Adhering to the above criterion the demographic characteristics of the sample have been sufficiently described to enable comparison with other groups of mothers.

**Data saturation**

In qualitative research data collection continues until ‘data saturation’ has achieved; no new ideas emerge from the data (Glaser & Strauss, 1967). As this concept may be impractical for applied research, ‘data sufficiency’ may be more fitting; that is that new ideas do not add anything to the overall story (Dey, 1999; Strauss & Corbin, 1998). All volunteers where interviewed with the aim of achieving data sufficiency. Half way through data collection, it became apparent that women who were in the latter stages of recovery added slightly different reflections. Various authors advise that for qualitative research six participants are sufficient to develop meaningful themes and interpretations (Guest, Bunce & Johnson 2006; Isman, Ekéus, & Berggren, 2013; Isman, Mahmoud Warsame, Johansson, Fried, & Berggren, 2013). Our sample of consisted of 12 women and the information provided by them met the principle of data sufficiency. On completion of data collection from the 12 interviews there was evidence of a rich data set no evidence of new themes emerging. This is in keeping with guidelines for thematic analysis which
argue that six to ten participants are sufficient to identify patterns in the data gathered from interviews (Braun & Clark, 2013).

Implications
Through undertaking this research and immersion in data collection and analysis, the researcher was struck by how little is known about the experience of PP in relation to the role of the baby in terms of the experience of illness and recovery. For women in the early stages of recovery from perinatal mental illness, practical intervention that helps activate the helpful role of the baby is a priority. There are opportunities for more qualitative research in understanding the role of significant others in the women’s recovery from PP, which may include partners, siblings, other children, peers and health professionals.

The literature review
Rationale for metasynthesis
Scoping the literature on the experiences of perinatal illness, revealed two disparate strands of qualitative literature related to recovery: Postnatal Depression (PND) and PP. Each illness may present with different difficulties in the postnatal period but, depending on severity, both can lead to an emergency inpatient admittance, at a time when separation may have implications for the attachment relationship between the mother and her baby (JCP-MH 2012). Earlier reviews have explored the experiences of women across the spectrum of perinatal mental illness (including depression, anxiety or psychosis) in the weeks and months following childbirth (Robertson, Curtis, Lasher, Jacques & Tom, 2013). Similarly, a meta-analysis on motherhood included women with mental illness (including PND and PP) in the perinatal period, (Dolman, Jones & Howard, 2013). However, these reviews did not consider mothers’ recovery experiences from mental illness specifically occurring in the period following childbirth. Therefore, mother’s experience of recovery from mental illness in the perinatal period seemed a suitable area for review.

As mentioned earlier the small body of literature on recovery in the perinatal period were qualitative studies concentrated in the areas of PND and PP. To fully understand the experience of recovery in the perinatal period the current review was inclusive and retrieved studies relating to recovery from all mental illness experienced in the perinatal period rather than just a sample of studies (Barosso et al., 2003). However, scoping the literature did not identify papers relating to recovery from other perinatal mental illnesses, such as anxiety. Therefore, it was agreed with the research team that reviewing qualitative
studies in the area of PND and PP seemed appropriate and consistent with similar studies in this area (Robertson et al., 2013; Dolman et al., 2013). However, in contrast to the above reviews, our metasynthesis explored recovery from postnatal mental illness. The review involved summarising and synthesising the qualitative literature related to experiential phenomena in the area of recovery from PND and PP. Metasynthesis is considered the most appropriate approach to minimise bias and preserve the interpretative properties of the literature (Teagarden, 1989; Walsh & Downe, 2005).

Searching and identifying papers for the review
Steps were taken to maximise transparency in the search strategy, screening studies, appraising studies and the synthesis of themes. This search strategy was informed by the SPIDER (Sample, Phenomenon of Interest, Design, Evaluation and Research Type) search tool, designed specifically for identifying qualitative and mixed research designs (Cook, Smith & Booth, 2012). The design and research type elements of this tool have been criticised as reducing sensitivity (Methley, Campbell, Chew-Graham, McNally & Cheraghi-Sohi, 2014). This search strategy drew on the sample, phenomenon of interest and evaluation elements of this tool to preserve sensitivity and specificity. As is common with qualitative research this review included studies of heterogenous samples, methodologies and context. The search strategy was implemented across multiple databases including CINAH, which is considered the gold standard for qualitative research (Evan 2002).

Critical appraisal of papers included in the review
Dolman et al. (2013) had 20% of their included studies independently rated; however, in the current review an independent rater appraised 40% of the included studies The rate of agreement was high at 80%; a minimum of 67% is deemed acceptable by existing research (Marques & McCall, 2005; Armstrong, Gosliing, Weinman & Mateau, 1997). This fact increased the researcher’s confidence in the rigour of the critical appraisal tool, considering that one of the strengths of the metasynthesis was that no study was considered low quality.

Strengths and limitations of the literature review
The metasynthesis only included studies that were published in peer-reviewed journals. Sometimes information presented in the unpublished, non peer reviewed literature is
incomplete and therefore not ameanable to critical appraisal or the metasynthesis approach (Hopewell, Clarke, & Askie, 2006). The advantage of studies that were published in peer-reviewed journals is that there is sufficiently detailed information that facilitates critical appraisal and metasynthesis. A potential limitation of this metasynthesis is the heterogeneous sample of included papers regarding methodology and diagnostic context. Noblit and Hare (1988) argue that only similar studies should be synthesised. However, in this review we included papers that focussed on the experience of ‘recovery’ from PP and PND as opposed to the broader experience of illness. Furthermore, other researchers argue in favour of ‘inclusivity’, therefore experiential phenomenon can be understood by multiple in perspectives (Sherwood, 1997). This metasynthesis has adopted a paradigm of inclusivity by including a variety of methodologically approaches (Walsh & Downe, 2005). This reflects that it is an emerging literature. In future the volume of work will allow for more homogenous syntheses to be conducted. Included papers consisted of samples of women considered to have experienced PND by numerous methods such, screening instruments or clinical interviews. It was unclear how much the women varied in terms of severity of PND or if women were hospitalised. Similarly, studies varied according to the demographic details provided across studies, which limit the extent to which findings of the metasynthesis can be extrapolated across different ethnic or social groups. However, the design and quality of studies was acknowledged during the quality appraisal of studies in the synthesis (Sandelowski, Docherty & Emden, 1997). Three of the included studies (McGrath et al., 2013; Doucet, Letourneau & Blackmore, 2012; Robertson & Lyons, 2003) were also included in a metasynthesis by Dolman et al. (2013), but their review did not explore the qualitative data in relation to the women’s experience of recovery from illness. Therefore, this meta-synthesis considered these studies from a different perspective to develop new insights within the data.

Implications of the review findings
With time then women can engage in more psychological intervention that allows them to reflect on their experience and develop long term coping strategies for recovery. The role of the family is central, advocating the need for holistic interventions to support bonds and attachments within the family system. Furthermore, in the latter stages of recovery the role of informal peer support should never be underestimated as a powerful intervention that is the vehicle for sustaining recovery. The small body of studies included in the meta-
synthesis indicates a shift in paradigm towards more psychological understanding of recovery from PND and PP.

**Personal reflections**

Immersion in the qualitative methodology helped the researcher to understand the role of the baby in recovery from PP. Parallels were noted between the skills of a qualitative researcher and a clinical psychologists. There are parallels in technical skills, such as the use of open-ended questions, transparency, reflexivity and using diagrams to illustrate conceptual understandings of psychological processes. Secondly, there are overlapping interpersonal skills. Both qualitative work and clinical psychology requires a great deal of self-awareness within the context of relating to another person and gaining a shared understanding of experience. Both qualitative research and clinical psychology demands a tolerance for distress and uncertainty. Therefore, the clinical psychologist has skills that are highly transferable to the skills of the qualitative researcher. However, the clinician must be mindful of the boundaries of the qualitative interview. A clinical psychologist must avoid being drawn into a therapeutic dialogues or processes similar to psychological formulation or intervention during the research interview. Qualitative research provides insights (Al-Busaidi, 2008) that demystify the experiences of hard to reach groups (Neale, Allen & Coombes, 2005). The rigorous preparation of qualitative research is highly labour-intensive (Pope, Ziebland & Mays, 2000) but highly worthwhile in understanding the lived experience of people in the real world.

**Conclusions**

The findings of both Paper 1 and Paper 2 highlight the importance of interventions to help the women engage with their babies. Moreover, they underline that the timing and type of intervention are crucial. In the first stages of recovery from PP and PND simple practical help that allows women to rest in the evening then focus on the baby during the days is enough. Of equal importance are systemic interventions that meet the needs of the whole family. Paper 1 highlighted that often the support needs of the family are overlooked. In order to fully support women’s recovery from severe PND and PP, the family need help with helping the women.
References

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3087733/


DOI: 10.1146/annurev.psych.55.090902.141601


https://www.researchgate.net/publication/20072050_The_problem_of_rigor_in_qualitative_research

https://www.researchgate.net/publication/13963089_Focus_on_qualitative_methods_Qualitative_metasynthesis_issues_and_techniques


Appendix 1

Contributor guidelines for the journal *Archives of Women’s mental Health*
Instructions for Authors

TYPES OF PAPERS

Original Contributions / Research Articles

Original Contributions / Research Articles should be arranged under the following headings:

Abstract:
Not to exceed 150–200 words

Keywords:
Not more than five

Introduction:
To include the background literature as well as the objectiv (s) of the study

Materials and Methods:
Describe the basic study design. State the setting (e.g., primary care, referral center). Explain selection of study subjects and state the system of diagnostic criteria used. Describe any interventions and include their duration and method of administration. Indicate the main outcome measure(s). Specify the dates in which data were collected (month/year to month/year).

Results:
Include the key findings. Give specific data and their statistical significance, if possible (include p value if findings were significant). Subset Ns should accompany percentages if the total N is <100 Discussion and Conclusion. Sections conforming to standard scientific reporting style.

Discussion and Conclusion
Sections conform to standard scientific reporting style
Reviews
Reviews are intended to draw together important information from recent publications on subjects of broad interest. They are meant to provide a venue for critical examination and considered opinion of such information.

Reviews are not meant to be encyclopedic and should not exceed 20 pages when typed. Reviews may contain figures and tables. References should be cited in the same way as in full-length articles.

It is recommended that authors contact the Editor-in-Chief beforehand to determine if a proposed review is likely to be suitable for publication. Reviews should be comprehensive, fully referenced expositions of subjects of general interest, including background information and detailed critical analyses of current work in the field and its significance. They should be designed to serve as source materials.

Short Communications

Short Communications should be prepared as described above except for the following:

The average length of Short Communications should not exceed 1500 words and may include a maximum of two figures or tables and up to 12 references. The summary should not exceed 80 words. Short Communications can only be accepted or rejected.

Letters to the Editor

Letters to the Editor should be a maximum of 750 words and may include one table or figure and up to five references.

MANUSCRIPT SUBMISSION

Manuscript Submission

Submission of a manuscript implies: that the work described has not been published before; that it is not under consideration for publication anywhere else; that its publication has been approved by all co-authors, if any, as well as by the responsible authorities – tacitly or explicitly – at the institute where the work has been carried out. The publisher will not be held legally responsible should there be any claims for compensation.

Permissions

Authors wishing to include figures, tables, or text passages that have already been published elsewhere are required to obtain permission from the copyright owner(s) for both the print and online format and to include evidence that such permission has been granted when submitting their papers. Any material received without such evidence will be assumed to originate from the authors.

Online Submission

Authors should submit their manuscripts online. Electronic submission substantially reduces the editorial processing and reviewing times and shortens overall publication times. Please follow the hyperlink “Submit online” on the right and upload all of your manuscript files following the instructions given on the screen.

Reviewer suggestions

Authors will be kindly asked to suggest up to 5 potential reviewers for their papers. These recommendations will be of help to ensure the journal’s high scientific level and will support a quick review process and thus shorten the time from manuscript submission to publication.
Please note that only reviewer suggestions from institutions of international reputation other than the institution of the corresponding author will be taken into consideration, otherwise your paper can not be considered for further handling.

TITLE PAGE

Title Page

The title page should include:

- The name(s) of the author(s)
- A concise and informative title
- The affiliation(s) and address(es) of the author(s)
- The e-mail address, telephone and fax numbers of the corresponding author

Abstract

Please provide a structured abstract of 150 to 250 words which should be divided into the following sections:

- Purpose (stating the main purposes and research question)
- Methods
- Results
- Conclusions

Keywords

Please provide 4 to 6 keywords which can be used for indexing purposes.

Important note:

Please ensure your authorship is correct, check spelling of authors’ names, line up, etc.

No changes can be made once copyright has been transferred to us.

TEXT

Text Formatting

Manuscripts should be submitted in Word.

- Use a normal, plain font (e.g., 10-point Times Roman) for text.
- Use italics for emphasis.
- Use the automatic page numbering function to number the pages.
- Do not use field functions.
- Use tab stops or other commands for indents, not the space bar.
- Use the table function, not spreadsheets, to make tables.
- Use the equation editor or MathType for equations.
- Save your file in docx format (Word 2007 or higher) or doc format (older Word versions).

Manuscripts with mathematical content can also be submitted in LaTeX.

LaTeX macro package (zip, 182 kB)
Headings

Please use no more than three levels of displayed headings.

Abbreviations

Abbreviations should be defined at first mention and used consistently thereafter.

Footnotes

Footnotes can be used to give additional information, which may include the citation of a reference included in the reference list. They should not consist solely of a reference citation, and they should never include the bibliographic details of a reference. They should also not contain any figures or tables.

Footnotes to the text are numbered consecutively; those to tables should be indicated by superscript lower-case letters (or asterisks for significance values and other statistical data). Footnotes to the title or the authors of the article are not given reference symbols.

Always use footnotes instead of endnotes.

Acknowledgments

Acknowledgments of people, grants, funds, etc. should be placed in a separate section before the reference list. The names of funding organizations should be written in full.

REFERENCES

Citation

Cite references in the text by name and year in parentheses. Some examples:

- Negotiation research spans many disciplines (Thompson 1990).
- This result was later contradicted by Becker and Seligman (1996).
- This effect has been widely studied (Abbott 1991; Barakat et al. 1995; Kelso and Smith 1998; Medvec et al. 1999).

Reference list

The list of references should only include works that are cited in the text and that have been published or accepted for publication. Personal communications and unpublished works should only be mentioned in the text. Do not use footnotes or endnotes as a substitute for a reference list.

Reference list entries should be alphabetized by the last names of the first author of each work.

- Journal article

  Ideally, the names of all authors should be provided, but the usage of “et al” in long author lists will also be accepted:

- Article by DOI

  doi: 10.1007/s00421-0080955-8

Book

Book chapter

Online document

Dissertation
Trent JW (1975) Experimental acute renal failure. Dissertation, University of California

Always use the standard abbreviation of a journal's name according to the ISSN List of Title Word Abbreviations, see

ISSN.org LTWA

If you are unsure, please use the full journal title.
Appendix 2

Quality assessment checklist used to critically appraise review studies
Quality Assessment Criteria
(Informed by Critical Appraisal Skills Programme, 2002; Walsh & Downe, 2006; Wittkowski, McGrath & Peters, 2014)

<table>
<thead>
<tr>
<th>Essential Criteria</th>
<th>Scoring: Clearly Described (2), Partially Described (1) Not Described (0)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Women who had experienced postnatal mental illness were the primary informants</td>
<td></td>
</tr>
<tr>
<td>2. At least 50% of the sample were women who had experienced postnatal psychosis or postnatal depression For example:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Sample made up of women and professionals where at least half of participants are women</td>
</tr>
<tr>
<td></td>
<td>• Or sample made up of women and their partners where at least half of sample are women</td>
</tr>
<tr>
<td>3. The aims of the study were clearly stated. For example:</td>
<td></td>
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<tr>
<td></td>
<td>• What was the goal of the research?</td>
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<tr>
<td></td>
<td>• Why it was thought important?</td>
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<tr>
<td>4. Research design was appropriate to the study question. For example:</td>
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<tr>
<td></td>
<td>• If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants?</td>
</tr>
<tr>
<td></td>
<td>• Researchers explained the rationale for specific</td>
</tr>
</tbody>
</table>
5. **The sampling/recruitment method was clearly described.**
   For example:
   - Discussion of why recruitment was employed and discrepancy between planned and actual recruitment?

6. **The data collection methods were clearly described and justified.**
   For example:
   - Data were likely to capture the complexity/diversity of experience and illuminate context in sufficient detail.
   - Discussion of form of data and saturation of themes.

7. **Discussion of reflexivity.**
   For example:
   - How the relationship between the researcher and participants may bias the research process?
   - Evidence of self-awareness/insight?

8. **Discussion of ethical issues.**
   For example:
   - Details of informed consent and confidentiality.
   - Approval from relevant ethics committees sought.

9. **Thorough description of analysis.**
   For example:
   - Discussion how categories/themes were derived.
   - Discussion of reliability/validity/rigour of analysis.
   - Evidence that findings are grounded in the data through the use of e.g. quotations.

10. **Clear statement of findings.**
For example:
- Discussion in relation to research questions, contributions to existing knowledge, implications and recommendations for further work.
- Discussion of limitations of the work.
- Discussion of transferability of findings.

Each study can be allocated a total score out of 20 and assigned to a corresponding classification.

Category A: High quality – 17 to 20.

Category B: Medium quality – 11 to 16.

Category C: Low quality – less than 11 out of 20.
Appendix 3

Table 5: Summary of themes identified across studies in the metasynthesis
## Table 5 Themes identified across studies

<table>
<thead>
<tr>
<th>Themes</th>
<th>Study Number</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Role of the family</td>
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<tr>
<td>Stage 1: Recognition of the problem</td>
<td></td>
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<tr>
<td>Crisis and relational distress</td>
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<tr>
<td>Stage 2: Seeking help</td>
<td></td>
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<tr>
<td>Accepting help</td>
<td>yes</td>
</tr>
<tr>
<td>Help to access help</td>
<td>yes</td>
</tr>
<tr>
<td>Stage 3: Recovery</td>
<td></td>
</tr>
<tr>
<td>Sharing with others like me</td>
<td></td>
</tr>
<tr>
<td>Coping strategies</td>
<td>-</td>
</tr>
<tr>
<td>Noticing recovery</td>
<td>-</td>
</tr>
</tbody>
</table>
### Stage 4: Maintaining recovery

| Incorporating coping strategies into daily life | - | yes | - | yes | - | - | yes | - | - | yes | - | - |
| Acquiring a different model of motherhood | - | - | - | - | - | - | yes | yes | yes | yes | - | - | yes |
| Processing the experience | - | yes | - | - | yes | - | yes | - | yes | yes | yes | yes | yes | yes | yes |
Appendix 4

Author guidelines for *Journal of Clinical Psychology and Psychotherapy*
For additional tools visit Author Resources - an enhanced suite of online tools for Wiley Online Library journal authors, featuring Article Tracking, E-mail Publication Alerts and Customized Research Tools.

Author Guidelines

MANUSCRIPT SUBMISSION

Clinical Psychology & Psychotherapy operates an online submission and peer review system that allows authors to submit articles online and track their progress via a web interface. Please read the remainder of these instructions to authors and then visit http://mc.manuscriptcentral.com/cpp and navigate to the Clinical Psychology & Psychotherapy online submission site.

IMPORTANT: Please check whether you already have an account in the system before trying to create a new one. If you have reviewed or authored for the journal in the past year it is likely that you will have had an account created.

Pre-submission English-language editing

Authors for whom English is a second language may choose to have their manuscript professionally edited before submission to improve the English. A list of independent suppliers of editing services can be found at http://wileyeditingservices.com/en/. All services are paid for and arranged by the author, and use of one of these services does not guarantee acceptance or preference for publication.

All papers must be submitted via the online system.

File types. Preferred formats for the text and tables of your manuscript are .doc, .docx, .rtf, .ppt, .xls. LaTeX files may be submitted provided that an .eps or .pdf file is provided in addition to the source files. Figures may be provided in .tiff or .eps format.

NEW MANUSCRIPT

Non-LaTeX users. Upload your manuscript files. At this stage, further source files do not need to be uploaded. LaTeX users. For reviewing purposes you should upload a single
.pdf that you have generated from your source files. You must use the File Designation "Main Document" from the dropdown box.

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If your paper is accepted, the author identified as the formal corresponding author for the paper will receive an email prompting them to login into Author Services; where via the Wiley Author Licensing Service (WALS) they will be able to complete the license agreement on behalf of all authors on the paper.

Title and Abstract Optimisation Information.

As more research is read online, the electronic version of articles becomes ever more important. In a move to improve search engine rankings for individual articles and increase readership and future citations to Clinical Psychology & Psychotherapy at the same time please visit Optimizing Your Abstract for Search Engines for guidelines on the preparation of keywords and descriptive titles.

MANUSCRIPT STYLE

The language of the journal is English. 12-point type in one of the standard fonts: Times, Helvetica, or Courier is preferred. It is not necessary to double-line space your manuscript. Tables must be on separate pages after the reference list, and not be incorporated into the main text. Figures should be uploaded as separate figure files.

- During the submission process you must enter the full title, short title of up to 70 characters and names and affiliations of all authors. Give the full address, including email, telephone and fax, of the author who is to check the proofs.

- Include the name(s) of any sponsor(s) of the research contained in the paper, along with grant number(s).

- Enter an abstract of up to 250 words for all articles [except book reviews]. An abstract is a concise summary of the whole paper, not just the conclusions, and is understandable without reference to the rest of the paper. It should contain no citation to other published work.

- All articles should include a Key Practitioner Message — 3-5 bullet points summarizing the relevance of the article to practice.

- Include up to six keywords that describe your paper for indexing purposes.
Research Articles: Substantial articles making a significant theoretical or empirical contribution.

Reviews: Articles providing comprehensive reviews or meta-analyses with an emphasis on clinically relevant studies.

Assessments: Articles reporting useful information and data about new or existing measures.

Practitioner Reports: Shorter articles that typically contain interesting clinical material.

Book Reviews: Published on invitation only. Critical summaries of recent books that are of general interest to readers of the journal.

Reference style. The APA system of citing sources indicates the author's last name and the date, in parentheses, within the text of the paper.

A. A typical citation of an entire work consists of the author's name and the year of publication.

Example: Charlotte and Emily Bronte were polar opposites, not only in their personalities but in their sources of inspiration for writing (Taylor, 1990). Use the last name only in both first and subsequent citations, except when there is more than one author with the same last name. In that case, use the last name and the first initial.

B. If the author is named in the text, only the year is cited.

Example: According to Irene Taylor (1990), the personalities of Charlotte... 

C. If both the name of the author and the date are used in the text, parenthetical reference is not necessary.

Example: In a 1989 article, Gould explains Darwin's most successful...

D. Specific citations of pages or chapters follow the year.

Example: Emily Bronte "expressed increasing hostility for the world of human relationships, whether sexual or social" (Taylor, 1988, p. 11).

E. When the reference is to a work by two authors, cite both names each time the reference appears.
Example: Sexual-selection theory often has been used to explore patterns of various insect matings (Alcock & Thornhill, 1983) . . . Alcock and Thornhill (1983) also demonstrate.

F. When the reference is to a work by three to five authors, cite all the authors the first time the reference appears. In a subsequent reference, use the first author's last name followed by et al. (meaning "and others").

Example: Patterns of byzantine intrigue have long plagued the internal politics of community college administration in Texas (Douglas et al., 1997) When the reference is to a work by six or more authors, use only the first author's name followed by et al. in the first and all subsequent references. The only exceptions to this rule are when some confusion might result because of similar names or the same author being cited. In that case, cite enough authors so that the distinction is clear.

G. When the reference is to a work by a corporate author, use the name of the organization as the author.

Example: Retired officers retain access to all of the university's educational and recreational facilities (Columbia University, 1987, p. 54).

H. Personal letters, telephone calls, and other material that cannot be retrieved are not listed in References but are cited in the text.

Example: Jesse Moore (telephone conversation, April 17, 1989) confirmed that the ideas.

I. Parenthetical references may mention more than one work, particularly when ideas have been summarized after drawing from several sources. Multiple citations should be arranged as follows.

Examples:

- List two or more works by the same author in order of the date of publication: (Gould, 1987, 1989)
- Differentiate works by the same author and with the same publication date by adding an identifying letter to each date: (Bloom, 1987a, 1987b)
- List works by different authors in alphabetical order by last name, and use semicolons to separate the references: (Gould, 1989; Smith, 1983; Tutwiler, 1989).
All references must be complete and accurate. Where possible the DOI for the reference should be included at the end of the reference. Online citations should include date of access. If necessary, cite unpublished or personal work in the text but do not include it in the reference list. References should be listed in the following style:

**Journal Article**


**Book**


**Book with More than One Author**


The abbreviation *et al.* is not used in the reference list, regardless of the number of authors, although it can be used in the text citation of material with three to five authors (after the initial citation, when all are listed) and in all parenthetical citations of material with six or more authors.

**Web Document on University Program or Department Web Site**


**Stand-alone Web Document (no date)**


**Journal Article from Database**

Abstract from Secondary Database


Article or Chapter in an Edited Book


*The Digital Object Identifier (DOI) is an identification system for intellectual property in the digital environment. Developed by the International DOI Foundation on behalf of the publishing industry, its goals are to provide a framework for managing intellectual content, link customers with publishers, facilitate electronic commerce, and enable automated copyright management.*
Appendix 5

NREC and UREC approval letters
Miss Charlene Plunkett  
Trainee Clinical Psychologist  
Manchester Mental Health and Social Care NHS Trust  
School of Psychological Sciences  
2nd Floor Zochonis Building  
University of Manchester  
M13 9PL

Dear Miss Plunkett

Study title: The Role of Baby in Recovery From Psychosis After Childbirth  
REC reference: 14/NW/0278  
IRAS project ID: 142703

Thank you for your letter of 08 June 2014, responding to the Committee’s request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact the REC Manager, Mrs Kath Osborne, nrescommittee.northwest-gmccentral@nhs.net.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised subject to the conditions specified below.
Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at [http://www.rdforum.nhs.uk](http://www.rdforum.nhs.uk).

Where a NHS organisation’s role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:
<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copies of advertisement materials for research participants</td>
<td>1</td>
<td>08 January 2014</td>
</tr>
<tr>
<td>Evidence of Sponsor insurance or indemnity (non NHS Sponsors only)</td>
<td></td>
<td>22 January 2014</td>
</tr>
<tr>
<td>GP/consultant information sheets or letters</td>
<td>1</td>
<td>07 January 2014</td>
</tr>
<tr>
<td>Interview schedules or topic guides for participants</td>
<td>1</td>
<td>07 January 2014</td>
</tr>
<tr>
<td>Letter from sponsor</td>
<td></td>
<td>22 January 2014</td>
</tr>
<tr>
<td>Other [Distress Risk Flow Chart]</td>
<td>1</td>
<td>27 May 2014</td>
</tr>
<tr>
<td>Other [Distress Protocol]</td>
<td>1</td>
<td>07 January 2014</td>
</tr>
<tr>
<td>Other [Demographic Questionnaire]</td>
<td>2</td>
<td>08 June 2014</td>
</tr>
<tr>
<td>Other [Distress Leaflet]</td>
<td>1</td>
<td>07 January 2014</td>
</tr>
<tr>
<td>Participant consent form</td>
<td>2</td>
<td>20 May 2014</td>
</tr>
<tr>
<td>REC Application Form</td>
<td>142703/595785/1/127</td>
<td>07 April 2014</td>
</tr>
<tr>
<td>Research protocol or project proposal</td>
<td>1</td>
<td>08 January 2014</td>
</tr>
<tr>
<td>Response to Request for Further Information</td>
<td></td>
<td>08 June 2014</td>
</tr>
<tr>
<td>Summary CV for Chief Investigator (CI)</td>
<td>Sarah Peters (Academic Supervisor)</td>
<td>23 December 2013</td>
</tr>
<tr>
<td>Summary CV for Chief Investigator (CI)</td>
<td>Dr Anja Wittkowski (Academic Supervisor)</td>
<td>17 December 2013</td>
</tr>
<tr>
<td>Summary CV for Chief Investigator (CI)</td>
<td>Miss Charlene Plunkett (CI)</td>
<td>30 March 2014</td>
</tr>
<tr>
<td>Summary CV for Chief Investigator (CI)</td>
<td>Angelika Wieck</td>
<td>23 December 2013</td>
</tr>
<tr>
<td>Validated questionnaire [Demographic Questionnaire]</td>
<td>1</td>
<td>08 January 2014</td>
</tr>
</tbody>
</table>

**Statement of compliance**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

**After ethical review**

**Reporting requirements**

The attached document “After ethical review – guidance for researchers” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

**Feedback**
You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:
http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

We are pleased to welcome researchers and R & D staff at our NRES committee members’ training days – see details at http://www.hra.nhs.uk/hra-training/

| 14/NW/0278 | Please quote this number on all correspondence |

With the Committee’s best wishes for the success of this project.

Yours sincerely

Signed on behalf of Professor S Mitchell Chair

Email:nrescommittee.northwest-gmcentral@nhs.net

Enclosures: “After ethical review – guidance for researchers”

Copy to: Ms L Macrae, University of Manchester

Ms L Dowell, Manchester Mental Health & Social Care NHS Trust
Research Ethics Committee 2

[Plunkett/Wittkowski: The Role of the Baby in Recovery from Psychosis After Childbirth (ref 14367)]

I write to thank you and Miss Plunkett for coming to meet the Committee on 17th November 2014 and to confirm that it gave the above research project, after the submission of amendments / clarifications, a favourable ethical opinion.

This approval is effective for a period of five years and if the project continues beyond that period it must be submitted for review. It is the Committee’s practice to warn investigators that they should not depart from the agreed protocol without seeking the approval of the Committee, as any significant deviation could invalidate the insurance arrangements and constitute research misconduct. We also ask that any information sheet should carry a University logo or other indication of where it came from, and that, in accordance with University policy, any data carrying personal identifiers must be encrypted when not held on a university computer or kept as a hard copy in a location which is accessible only to those involved with the research.

Finally, I would be grateful if you could complete and return the attached form at the end of the project or by the end of December 2015.

We hope the research goes well.

Yours sincerely,

Ms. Genevieve Pridham
Secretary to University Research Ethics Committee 2
Appendix 6

Advertisement posted on web forums
Did you have unusual experiences following childbirth? These experiences are sometimes described as psychosis or puerperal psychosis.

I would like to invite you to take part in my research which is being hosted by the University of Manchester.

Taking part will simply involve talking about your experiences for approximately one hour at a time and place which convenient for you.

It is hoped that this work will help advance knowledge about this experience and inform people who work with women who have similar experiences in the future.

For more information please contact, Charlene Plunkett (Trainee Clinical Psychologist) at charlene.plunkett@postgrad.manchester.ac.uk
Appendix 7

Participant information sheet
Participant Information Sheet

Thank you for reading this participant information sheet about my study. This research study is undertaken by a Trainee Clinical Psychologist as part of the Clinical Psychology Doctorate Programme at the University of Manchester.

This sheet is designed to provide you with information about the research I am doing which is part of my Doctorate in Clinical Psychology from the University of Manchester. Before you decide if you would like to take part, it is important that you understand why the study is being done and what it will involve.

1. Title of the research project
The role of the baby in recovery from psychosis after childbirth.

2. What is the research about?
It is quite common for women to experience some changes in their mood after childbirth but some women have more unusual experiences such as seeing or hearing things that other people can’t perceive or they develop unusual ideas that seem strange to others. These experiences are sometimes called psychotic symptoms and the experience of these symptoms following childbirth is sometimes called puerperal psychosis. Understandably, this can be a difficult time for the new mother and her family. In this study we will explore the role of the baby in a woman’s recovery from psychosis after childbirth. The findings of our study may promote understanding of the role of the baby in the recovery process among professionals who will have contact with women prior to the onset of symptoms and at the various stages of recovery. Sharing information about the relationship with the baby may be valuable in interventions that promote supportive relationships to help with recovery.

3. Invitation
We are aiming to explore the role of the baby in recovery from psychosis after childbirth and would like to invite you to take part in the study.

4. Why have I been invited?
I am inviting women who have had unusual experiences or psychotic symptoms following childbirth and do not have any current mental health problems at this point in time. I would like to explore the role of the baby in relation to a woman’s recovery from psychosis after childbirth.

5. Do I have to take part?
No. Taking part is voluntary. If you decide that you do not want to take part, you do not have to give a reason and if you are currently receiving a service, this will not affect the care you receive.

6. What happens if I initially agree to take part in the study but then change my mind?
If you decide that you would like to take part but then change your mind, you can withdraw from the study at any time without giving a reason and again, if you are currently receiving a service, this will not affect the care you receive. I will give you a consent form for you to sign when we meet and you can keep a copy of that form.
7. What do I have to do?
If you choose to meet with me, the meeting will be one to two hours. I can meet with you at a suitable time at your home or another place that is convenient to you, such as in a room at the University of Manchester. Alternatively I can arrange to interview you over the telephone at a time that is convenient for you. First I will go through a brief demographic questionnaire to get some more information about you such as who you live with and how many children you have. Then I would ask you about your experiences following childbirth and what role you think your baby may or may not have had in your experience overall. The interview will be audio recorded to help me remember your answers. The interviews will last one to two hours.
You may be contacted to take part in validation checks of the data. This means that you will be provided with summaries of the data analysis and asked for your feedback on the researcher’s analysis and interpretation of the data. This is optional and you do not have to agree to the take part in the validation checks to participate in the study.

8. Are there possible disadvantages and risks of taking part?
Usually there are no risks associated with studies of this kind. If you are currently receiving a service, the care you receive will not be affected whether you agree to meet with me or not. The interview may include talking about experiences you found distressing. If you became upset during the interview you would be offered the following: to continue, to take a break, to postpone or to stop the interview altogether. You may also be offered help in contacting appropriate services or professionals, such as your GP, for advice or to discuss any concerns raised by being involved in the study. What you say in the interview will be confidential. However, I would need to tell someone else if I was worried about any risk of harm to yourself or someone else but I would talk to you about this first.

9. Are there any benefits to taking part in the research?
There are no direct benefits of taking part in this research however; you may find speaking to someone about your feelings and experiences helpful. Ultimately the study may influence the work of professionals who work with women who have had unusual experiences or experienced psychotic symptoms following childbirth.

10. Expenses and payments.
If you decide to take part in the study you will be reimbursed with a £5 voucher redeemable on high streets stores such as Boots.

11. What will happen to the information I give you at our meeting?
After I meet with you I will listen to the audio recording and write down what was said word for word. On occasion someone else may transcribe the audio recording but they will be bound by the same rules of confidentiality. Once this is done, the audio recording will be destroyed. Any information you provide will be stored in a locked cabinet. Any forms that you fill in will be anonymised and the forms will have a number on them instead of your name.

12. What happens when the research study stops?
All personal information (with the exception of completed consent forms) that I have gained from the study will be destroyed as soon as they are no longer required, which is
likely to be when the study is finished. The research that I write up will be published but your name and any identifiable information will be changed. I will be able to give you a summary of the findings if you wish. Study data will be retained for \textbf{5 years after the last publication} in accordance with the University of Manchester guidelines.

13. \textbf{What if there is a problem?}

\textbf{Complaints:} If you have a concern about any aspect of this study, you should ask to speak to the researcher or the researcher’s supervisors who will do the best to answer your questions. The researcher’s supervisor can be contacted using the address shown at the bottom of the page or on 0161 306 0400. If they are unable to resolve your concern or you wish to make a complaint regarding the study, please contact a University Research Practice and Governance Co-ordinator on 0161 2757583 or 0161 2758093 or by email on \texttt{research.complaints@manchester.ac.uk}. Harm In the unlikely event that something does go wrong and you are harmed during the research and this is due to someone’s negligence then you may have grounds for a legal action for compensation against the University of Manchester, but you may have to pay for your legal costs.

14. \textbf{Who is involved with the organising and funding the research?}

The research has been organised and funded by the University of Manchester. This research is being conducted by Anja Wittkowski in collaboration with Angelika Wieck. The data is being collected by a trainee clinical psychologist. If you would like any more information about the study, please do not hesitate to contact me on 0161 306 0401 or call or text 0779 267 3497. If I am not available you can leave a message and I will get back to you. I can also be contacted on \texttt{Charlene.plunkett@postgrad.manchester.ac.uk}.

15. \textbf{Who has reviewed the study?}

This study has been reviewed by the University of Manchester Research Ethics Committee (UREC) and was given a favourable opinion on (insert date). The UREC reference number is (insert number). This research has also been reviewed by the research subcommittee at the University of Manchester and was approved on the 18th November 2013.

Thank you for considering taking part in the research, if you would like to get more information about this research please get in touch with any of the researchers listed below.

Dr Anja Wittkowski
Senior Lecturer in Clinical Psychology
and Clinical Psychologist
University of Manchester
School of Psychological Sciences
2nd Floor Zochonis Building
Brunswick Street
Manchester M13 9PL
Tel. 0161 306 0400 or 291 6971
Email: \texttt{Anja.wittkowski@manchester.ac.uk}.

Dr Angelika Wieck
Consultant Psychiatrist
Department of Psychiatry,
Laureate House
Southmoor Road
Wythenshawe Hospital
Manchester M23 9TL
Tel: 0161 291 6930

Charlene Plunkett
Trainee Clinical Psychologist
Same University Address
Email: \texttt{Charlene.plunkett@postgrad.manchester.ac.uk}.
Appendix 8

Consent form
Project Title: The role of the baby in recovery from psychosis after childbirth
Researcher: Charlene Plunkett (Trainee Clinical Psychologist)

CONSENT FORM

If you are happy to participate please complete and sign the consent form below.

1. I confirm that I have read the attached information sheet on the above project and have had the opportunity to consider the information and ask questions and had these answered satisfactorily.

2. I understand that my participation in the study is voluntary and that I am free to withdraw at any time without giving a reason and without detriment to any treatment/service.

3. I agree to participate in one to one interviews either in person or by telephone interview.

4. I understand that the interviews will be audio-recorded and transcribed by members of the research team.

5. I agree to the use of anonymous quotes in published reports and or in conference presentations.

6. I understand that data collected during the study, may be looked at by individuals from the University of Manchester, from regulatory authorities or form the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data.

7. I agree to be contacted to take part in respondent validation checks (optional).

I agree to take part in the above project

<table>
<thead>
<tr>
<th>Name of participant</th>
<th>Date</th>
<th>Signature</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Name of person taking consent</th>
<th>Date</th>
<th>Signature</th>
</tr>
</thead>
</table>
Appendix 9

Demographic information sheet used with participants to describe symptoms
## Demographic Questionnaire

**Title of Project:** The Role of the Baby in Recovery from Psychosis after Childbirth.  
*To be filled in by the researcher:*

<table>
<thead>
<tr>
<th>Participant Number</th>
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<tbody>
<tr>
<td>Date of assessment</td>
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</table>

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth of Child</td>
<td></td>
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<tr>
<td>Gender of Child</td>
<td></td>
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<tr>
<td>Mode of Delivery</td>
<td></td>
</tr>
<tr>
<td>How many children do you have?</td>
<td></td>
</tr>
<tr>
<td>How old are your children?</td>
<td></td>
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</table>

### Ethnicity: with which ethnic group do you identify? [Please tick one]

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<table>
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<tr>
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<tbody>
<tr>
<td><strong>White</strong></td>
<td>White – British</td>
</tr>
<tr>
<td></td>
<td>White – Irish</td>
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<tr>
<td></td>
<td>White – Any other white background</td>
</tr>
<tr>
<td><strong>Mixed</strong></td>
<td>Mixed – White and Black Caribbean</td>
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<tr>
<td></td>
<td>Mixed – White and Black African</td>
</tr>
<tr>
<td></td>
<td>Mixed – White and Asian</td>
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<td></td>
<td>Mixed – Any other mixed background</td>
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<tr>
<td><strong>Asian or Asian British</strong></td>
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<td>Asian or Asian British – Indian</td>
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<td>Asian or Asian British – Pakistani</td>
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<td></td>
<td>Asian or Asian British – Bangladeshi</td>
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<td></td>
<td>Asian or Asian British – Any other Asian Background</td>
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<td><strong>Black or Black British</strong></td>
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<td></td>
<td>Black or Black British – Caribbean</td>
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<tr>
<td></td>
<td>Black or Black British – African</td>
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<tr>
<td><strong>Other ethnic groups</strong></td>
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<td></td>
<td>Other ethnic groups – Chinese</td>
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<tr>
<td></td>
<td>Other ethnic groups – Any other ethnic group</td>
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</table>

### Marital status [please tick one]

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<tr>
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<td>Married</td>
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<td>Divorced</td>
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<td>Separated</td>
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<td>Other</td>
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### Who do you live with? [please tick as many as you like]

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<tr>
<th></th>
<th>Partner</th>
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<td>Parents</td>
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<td>Alone</td>
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<td><strong>Employment [please tick one]</strong></td>
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<td>Student</td>
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<td><strong>Highest level of educational attainment [please tick one]</strong></td>
<td>GCSE (or equivalent)</td>
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Appendix 10

Interview schedule
Topic Guide

Study title: The role of the baby in recovery from psychosis after childbirth

**Tell me about your pregnancy and your baby?**
- thoughts/feelings about pregnancy and motherhood
- expectations and comparisons with previous births
- follow up on any complications with pregnancy

**Tell me about the birth?**
- thoughts/feelings about the birth
- complications during birth

**How would you describe the time after you had given birth to your baby?**
- thoughts/feelings about the baby/motherhood
- thoughts/feelings about ability to care for baby after birth

**How did you manage difficulties that occurred following birth?**
- Prompt for any support you received (health professionals and others)
- what was helpful/unhelpful in terms of treatment?
- what was helpful/unhelpful in terms of factors other than formal treatment?
- what if any thoughts or feelings did you have about your baby in relation difficultes that occurred after the birth?
- where there pleasant/unpleasant thoughts/feelings about your baby?
- if you already had older children where these thoughts/feelings about your new baby different to thoughts/feelings you had about your other children?

**How has this experience changed you if at all?**
- Discouraged from having another child?

**Was your relationship with your baby important in your recovery?**
- why was this relationship important?
- what was helpful or unhelpful about this relationship?
- what if any thoughts or feelings did you have about your baby in relation to recovery?
- where these thoughts or feelings helpful/unhelpful?
- any strategies used to stay well?
- any strategies used to increase understanding?
- any strategies used to aid recovery?
- how did you make decision around subsequent pregnancies?

**What, if any is the impact of this experience on your relationship with your child now?**
- how has this experience changed your relationship with your baby?

**Ending the interview**
Is there anything else you would like to talk about that you think would help us to understand your experience better?

**Thank you for taking part in this interview.**
Appendix 11

Distress protocol
Project Title: The role of the baby in recovery from psychosis after childbirth

Distress Protocol

During the course of the interview, it is possible that participants may become distressed as a result of discussing their treatment decisions. Should this happen, the following action will be taken:

1. If the interview is ongoing, the participant’s distress will be acknowledged and they will be asked if they would like to take a break or end the session. The participant’s decision will be respected and their levels of distress will be monitored throughout the interview.

2. The researcher who is training as a Clinical Psychologist and is therefore experienced in dealing with emotional distress will spend time with the participant and will explore with them what caused the distress.

3. The participant will be encouraged to contact their G.P., care co-ordinator or psychiatrist and will be assisted with this if desired.

4. If the interview is taking place out of hours, the participant will be directed to the emergency G.P. telephone number and will be assisted with this if necessary.

5. Participants will be given contact telephone numbers for various support services, e.g. their local Accident and Emergency department, their GP, organisations such as Mind, Saneline etc.

6. Participants will also be provided with the researcher’s telephone number to use should they become distressed after the interview has finished.

The research does not include any intervention component and thus the researcher would not provide any direct input for a participant who becomes distressed as a result of the research. However, as the researcher is a Trainee Clinical Psychologist who receives ongoing clinical supervision, it will be possible for the participant’s acute and chronic emotional distress to be assessed and for the researcher to use her clinical judgement as appropriate to ascertain potential further steps that may need to be considered in ensuring that the participant received appropriate support.

Participants who expressed feelings of distress during the research would be encouraged to contact their G.P or care co-ordinator (as detailed above) and would be assisted with this process if required but the ultimate decision regarding whether or not they access help would remain theirs. However, should a participant show a level of distress which rendered them a potential risk to themselves or others then the researcher would make appropriate contact with the participant’s G.P., care co-ordinator, social services or community mental health team. Furthermore, the researcher would seek guidance on the appropriate course of action to take from her project supervisors, two of whom are experienced Clinical Psychologists and are trained to deal with risk situations.

Participants who revealed distress at the time of the interview, or who revealed distress following the interview by contacting the researcher and disclosing this would be telephoned 24 hours after revealing their distress by the researcher who would check on whether their distress levels were subsiding or not. Should distress levels remain or have
worsened, the participant would be encouraged to seek support from their mental health team or from the support services detailed in their support services sheet. Should issues pertaining to risk be revealed, the appropriate agencies would be contacted (see previous paragraph).

Participants will be asked to consent to their GP being informed of their participation in the research before proceeding with research interviews.