Postpartum Psychosis and Beyond:
Exploring Mothers' Experiences of Postpartum Psychosis and Recovery

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CANDIDATE DECLARATION

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Declaration and signature of candidate

I confirm that the thesis submitted is the outcome of work that I have undertaken during my programme of study, and except where explicitly stated, it is all my own work.

I confirm that the decision to submit this thesis is my own.

I confirm that except where explicitly stated, the work has not been submitted for another academic award.

I confirm that the work has been conducted ethically and that I have maintained the anonymity of research participants at all times within the thesis.

Signed: S. Chotai Date: 08/08/2016

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Last but not least, I dedicate this piece of work to my wonderful mother who taught me the power of love and the strength of kindness.

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Thesis Abstract

The aim of this thesis is to provide an understanding of motherhood and the mother-infant relationship within the context of postnatal distress. To facilitate this, it is necessary to understand universal experiences of motherhood as well as mental health difficulties following childbirth. Part of this understanding includes mothers' experiences and management of distressing, repetitive thoughts of infant harm. Therefore, paper one consists of a literature review in which 10 empirical studies regarding thoughts of intentional infant harm (TIIHs) were critically appraised and synthesised. These thoughts were experienced in clinical and non-clinical samples. Common themes were found in terms of cognitive, emotional and behavioural responses to TIIHs and understood within the context of the parenting role. This review differentiated TIIHs between psychotic and non-psychotic difficulties and identified the need to understand such thoughts within mothers' experiences of postpartum psychosis (PP).

Paper two is a qualitative study exploring mothers' experiences of PP and recovery. Purposive sampling was used to interview eight women across the United Kingdom. Transcripts were analysed using Interpretative Phenomenological Analysis (Smith, Flowers, & Larkin, 2009) and four super-ordinate themes were identified: 'becoming unrecognisable', 'mourning losses', 'recovery as an ongoing process' and 'post-traumatic growth'. These themes demonstrated the need for physical and psychological space to facilitate recovery following childbirth.

Paper three provides a personal reflective account of completing this thesis. The dynamic process of transitioning to a qualified psychologist is likened to the transformative process of motherhood. Ethical issues and the recent surge in perinatal mental health awareness are presented.

Word Count: 250

Paper One: Literature Review

Maternal Thoughts of Intentional Infant Harm across Clinical and Non-Clinical Samples

Target Journal: Journal of Infant Mental Health (Appendix A)

Word Count: 8,604

Abstract

Purpose: This review presents literature on the maternal experience of coping with thoughts associated with intentional infant harm within the postnatal period. Thoughts of intentional infant harm (TIIHs) can affect the mother-infant relationship and evoke maternal distress, however, this is the first known review which synthesises such thoughts across clinical and non-clinical samples.

Method: A literature search was conducted using EBSCO Host, NHS databases and Web of Science. This search revealed 10 studies which met the inclusion criteria. The findings of the studies were critically appraised and synthesised to provide a comprehensive literature review.

Results: Thematic analysis identified four common themes across the population of childbearing women including: 1) ‘the spectrum of TIIHs’; 2) ‘responses and coping with TIIHs’ (cognitive, emotional and behavioural); 3) ‘socio-cultural context’ and 4) ‘mother-infant relationships’.

Conclusions: There are numerous methodological limitations across the studies, however, most authors demonstrate that TIIHs occur in both clinical and non-clinical populations. The intensity of TIIHs is likely to be higher in clinical populations. The studies suggest that TIIHs within a diagnosis of psychosis are different to such thoughts in other presentations. Little research has been conducted on how mothers make sense of TIIHs and behaviour during recovery from postpartum psychosis, therefore research in this area is important.

Keywords: infant harm; harm thoughts; postnatal

Word Count: 208

Introduction

Perinatal mental health services are concerned with the prevention, detection and management of psychological issues that complicate pregnancy and the postnatal period (Joint Commissioning Panel for Mental Health, 2012). Becoming a mother for most is a loving and happy experience, however, 20% of women are at risk of developing affective problems during pregnancy and within the first postpartum year (Mental Health Taskforce Strategy, 2016). Promoting emotional and physical wellbeing in mothers and the development of the infant should be central to service provision within perinatal mental health services (The National Institute for Health and Care Excellence [NICE], 2014). In particular, the postnatal period is a time of increased risk of developing emotional difficulties (Kendell, McGuire, Connor, & Cox, 1981) due to a sudden increase in responsibility for a dependent infant (Coates, Ayers, & de Visser, 2014). Certain symptoms such as intrusive thoughts and obsessions are more focused on the infant during the postnatal period (Chaudron & Nirodi, 2010; McGuiness, Blissett, & Jones, 2011). Therefore, to facilitate the understanding of emotional distress and intrusive thoughts following childbirth, this review focuses on the postnatal period rather than experiences during pregnancy.

Common postnatal mental health problems include postnatal depression (PND), anxiety disorders (i.e. obsessive compulsive disorder, post-traumatic stress) and postpartum psychosis (PP) (NICE, 2014). The three key mental health problems are PND, obsessive compulsive disorder (OCD) and PP (Brockington, 2004). PND is conceptualised as a non-psychotic depressive episode with severe low mood commencing within 12 weeks postpartum and consists of negative, ruminative thoughts (O’Hara & Swan, 1996). PND affects approximately 10% of women in the United Kingdom (UK) (Cox, Murray, & Chapman, 2011). Women can also experience obsessive compulsive disorder (OCD) which is rooted in pervasive anxiety whereby recurrent distressing, unwelcome thoughts and images are experienced. These can include obsessions concerning contamination, symmetry/exactness and infant harm which may be intentional (i.e. ‘would the baby be brain damaged if I threw her out of the window') or accidental (i.e. 'the dog might attack the baby'). The distress only abates when certain acts, compulsions or behaviours are carried out (McGuinness et al., 2011). Finally, PP is described as the most severe postnatal mental health condition in that it often requires emergency inpatient admission (Doucet, Jones, Letourneau, Dennis, & Blackmore, 2011; NICE, 2014). PP is characterised by mood lability, hallucinations, mania and delusional thoughts which can involve the baby. It usually has an acute onset and typically occurs within two to four weeks of childbirth (Sit, Rothschild, & Wisner, 2006). PP is known to affect between one to two women per 1,000 births in the UK (Kendell, Chalmers, & Platz, 1987).

Financial Implications

The UK economic cost of perinatal (antenatal and postnatal) mental health problems per year is £8.1 billion. It is a topic which requires prioritisation given the long-term impact of mothers' psychological health, the mother-infant relationship and the emotional development of the child (Bauer, Parsonage, Knapp, Lemmi, & Adelaja, 2014). Despite this, 60% of Clinical Commissioning Groups (CCGs) have no plans to implement a perinatal strategy in the future even though service provision is inconsistent across the country (National Children's Trust, NCT, 2015).

Encouragingly, a £290 million investment has been pledged to provide specialist maternal mental health by 2020 (Department of Health, DoH, 2016). The intention is to improve access to community psychological therapies and timely access to local mother and baby units (MBUs), which are all objectives advocated by the NICE guidelines (2014; NICE, 2016). However, no method of ring-fencing the funding at CCG level has been published as of yet.

Accessing Mental Health Support

Professionals' risk assessments in the postnatal period should include exploration of mothers' self-harm, self-neglect and risk to the baby (NICE 2014; NICE 2016). However, there are many barriers that prevent women disclosing this information to professionals due to concerns of the child being removed and a fear of being perceived as unable to cope (Edwards & Timmons, 2005; NCT, 2015). The shame of disclosing difficulties is compounded by fears of being misunderstood or judged as a neglectful parent, particularly if negative thoughts related to the infant are present (Challacombe & Wroe, 2013).

Postnatal Infant-Harming Thoughts

Following a recent review of antenatal and postnatal care in the UK, the authors highlighted that mothers experience thoughts that are “frightening, horrifying and debilitating” during postnatal distress (Megnin-Viggars, Symington, Howard, & Pilling, 2015, p. 754). Intrusive thoughts of harming the infant are experienced across mental health diagnoses and even in non-clinical samples (Fairbrother & Woody, 2008; McGuinness et al., 2011). The nature of thoughts and appraisals vary across clinical populations. Understanding the appraisals of intrusive thoughts is important as they drive individual responses and can cause the thoughts to feel threatening, therefore intensifying their personal significance (Wells, 1997). Postnatal OCD involves both obsessional (i.e. intrusive, repetitive, unacceptable) and ruminative (i.e. passively focusing on distress) thoughts which are harder to dismiss (Fairbrother & Woody, 2008). Obsessional thoughts are not considered to be significant in the maintenance of depression. Instead, ruminative thoughts play a major role in maintaining low mood due to the personal, negative content which reduces self-esteem and perpetuates learned helplessness (Wahl et al., 2011). These thoughts can violate mothers’ morals and values (i.e. to be a loving, devoted mother) causing significant distress. These are therefore known as ego-dystonic thoughts. The focus within the PP literature in relation to infant harming thoughts concentrates on infanticide (the killing of one’s own child within one year of birth), with 4% of women with PP found to commit this act (Spinelli, 2009; Stanton, Simpson, & Wouldes, 2000). In the acute phase of PP, mothers may rationalise infanticide if convinced by the delusions (i.e. the child needing to be sacrificed to save others) and these are therefore known as ego-syntonic thoughts (Link & Stueve, 1994; Spinelli, 2009). Other features such as impaired impulse control, affective dysregulation, lack of cognitive flexibility and unbalanced judgement contribute to maternal justification of infanticide during psychosis (Stanton et al., 2000).

Infant harming thoughts are not processed or responded to in the same way across motherhood which suggests different etiologies across the clinical populations. Consequently, the impact on the mother and the mother-infant relationship will be different which has implications on the type of intervention offered. For example, exposure based cognitive behavioural therapy (CBT) and interpersonal therapy have shown to be effective for OCD, whereas behavioural activation and verbal cognitive techniques are more successful in depression (Abramowitz, Meltzer-Brody, Leserman, & Mahaffey, 2010). A comprehensive understanding of infant harming thoughts would inform healthcare professionals working with mothers. Over half of psychiatrists (53%) do not specifically ask mothers with PP about infant harming thoughts. This may reflect a limited awareness of the prevalence of such thoughts as 57% of psychiatrists underestimated the number of depressed mothers who have infant harming thoughts (Friedman, Sorrentine, Stankowski, Holden, & Resnick, 2008). This indicates the need for further training, awareness and knowledge regarding the typology of such thoughts, how they are understood by mothers and the associated risks. This would improve the safety of mothers and infants and prompt identification of appropriate interventions.

Psychological Theories of Infant Harming Thoughts

According to CBT, if significance is given to an intrusive thought (i.e. infant harming) this may be accompanied by certain behaviours (compulsions) in an attempt to dismiss the thought and to ameliorate the associated distress (Wells, 1997). These compulsions include checking the safety of the baby, thought suppression, situational avoidance (avoiding triggers i.e. knives) or avoidance of caring responsibilities (Abramowitz, Schwartz, Moore, & Luenzmann, 2003; Fairbrother & Abramowitz, 2007). Other strategies to manage intrusive thoughts include distraction and stringent monitoring of cognitions (Wells, 1997). However, these control strategies have been found to increase the significance, frequency and mother's preoccupation with the thoughts as well as enhancing the mother's distress (Larsen et al., 2006). Consequently, mothers fear interaction with the child when thoughts specific to intentional infant harm occur, meaning care responsibilities are often transferred to family members (Barr & Beck, 2008).

Thoughts of intentional infant harm (TIIHs) can prevent mothers providing emotional attunement, maternal sensitivity and consistent care to their infant which can jeopardise the development of secure attachments (Bowlby, 1969; Maimon, 2012). Secure attachments make the infant feel safe (Holmes, 1993) and are important for optimum cognitive, emotional and social development (Crittenden & Ainsworth, 1989). Mothers may become preoccupied with the obsessional, ruminative or delusional thoughts and developing strategies to stifle these thoughts takes priority (Larsen et al., 2006). Mothers with OCD are more likely to avoid triggers for TIIHs (Abramowitz et al., 2010). There is also heightened sensitivity to the infant's cues, meaning mothers may over-apply positive parenting principles (i.e. maintaining eye-contact) and risk becoming over-intrusive in their parenting style, potentially leading to inconsistent care (Doron & Kyrios, 2005; Leckman et al., 1999). In PND, mothers' interaction style with the infant can be either intrusive and over-stimulating or withdrawn and passive (Field, 2010). Therefore, it is hypothesised that the presence of TIIHs has an influence on parenting style and maternal availability.

Rationale for Review

Studies thus far have focused on postnatal TIIHs in a specific diagnostic category on their own or accompanied with a control group, and are yet to be collated. Assimilating studies which span across clinical and non-clinical samples would improve awareness for healthcare professionals to determine the likelihood of harm occurring. It is important that healthcare professionals develop confidence in undertaking risk assessments to establish the safety of mothers and infants, as well as acknowledging women's courage when disclosing such thoughts (Challacombe & Wroe, 2013; McGuinness et al., 2011). Psychological interventions targeted at increasing maternal sensitivity towards the infant would also support the development of secure attachments (Ainsworth, Blehar, Waters, & Wall, 1978). Improving health professionals' awareness of the diversity of TIIHs across a range of mental health problems and the effects on the mother and infant would increase the likelihood that these women receive appropriate interventions (Barr & Beck, 2008). Some mothers may find relief and reassurance through normalisation and depathologisation of such experiences (Fairbrother & Woody, 2008; Hall & Wittkowski, 2006). However, this is ineffective for some mothers as it may minimise the debilitating distress caused by such thoughts. It is argued to be more productive to engage with such thoughts and foster an understanding of the self in relation to the child (Murray & Finn, 2011). Alternatively, some mothers may require safeguarding measures to be implemented to ensure the safety of both themselves and their infant (Christl, Reilly, Yin, & Austin, 2015).

Aim

This literature review aims to provide a current and comprehensive synthesis of mothers' experiences of having TIIHs and identify the implications of having such thoughts (inclusive of images and ideas). The focus will be on the postnatal period within one year following childbirth as defined by NICE (2014) and NICE (2016).

Methodology

Search Strategy

A systematic approach was taken to conduct this literature review which was completed as part of the researcher’s role as a Trainee Clinical Psychologist in a local NHS Trust. An initial search of the Cochrane Library was undertaken to assess the pre-existence of published systematic reviews on maternal experiences of TIIHs. An electronic literature search was conducted using the following databases facilitated through EBSCOhost:

- Academic Search Complete
- AgeLine
- AMED (The Allied and Complimentary Medicine Database)
- BNI (British Nursing Index)
- CINAHL (Cumulative Index to Nursing and Allied Health)
- EMBASE (Exerpta Medica Database)
- MEDLINE (Medical Literature Analysis and Retrieval System Online)
- PsycARTICLES
- PsycInfo.

Grey literature was also searched for using ProQuest. A supplementary hand search was undertaken to maximise the breadth of literature considered.

The search terms were developed following an initial scoping search on Google Scholar and utilising the thesaurus function on EBSCOhost to search for similar relevant words. The search terms used were:

(“postnatal” OR “post-natal” OR “postpartum” OR “post-partum" OR "maternal" OR "puerper*" OR “PND” OR “postnatal depression” OR “postpartum psychosis” OR “OCDpp”)

AND

(“unwanted thoughts” OR “intrusive thoughts” OR “aggressi*” OR “child* harm*” OR “infant* harm*” “infantid*” OR “filicid*” OR “neofanticid*”)

Search Criteria

The following criteria were set to establish studies for inclusion in the review:

Table 1

Inclusion and Exclusion Criteria

Inclusion criteria:	Human studies published in English. Aim or outcome focused on maternal TIIHs (physical/sexual) which did not result in infant mortality. Related to mother's own child. Within the postnatal period (one year of childbirth). Empirical studies.
Exclusion criteria:	TIIHs only in pregnancy. Paternal experiences of TIIHs. Mothers who have committed infanticide (due to the forensic focus and complicated grieving process that would be too broad for the scope of this review).

Screening Process

The Cochrane Library search did not yield any relevant systematic reviews within this area. To the researcher's knowledge, this is the first review paper to focus on this topic across clinical and non-clinical populations therefore there were no filters based upon publication date to ensure relevant studies were captured.

The literature search was conducted on 19th October 2015 and produced 305 studies (following the removal of 86 duplicates and the screening of titles). These 305 studies were reduced to 34 following abstract screening then reduced again to nine following screening of the full-text. The addition of one unpublished thesis was added to create a total of 10 papers (Figure 1).

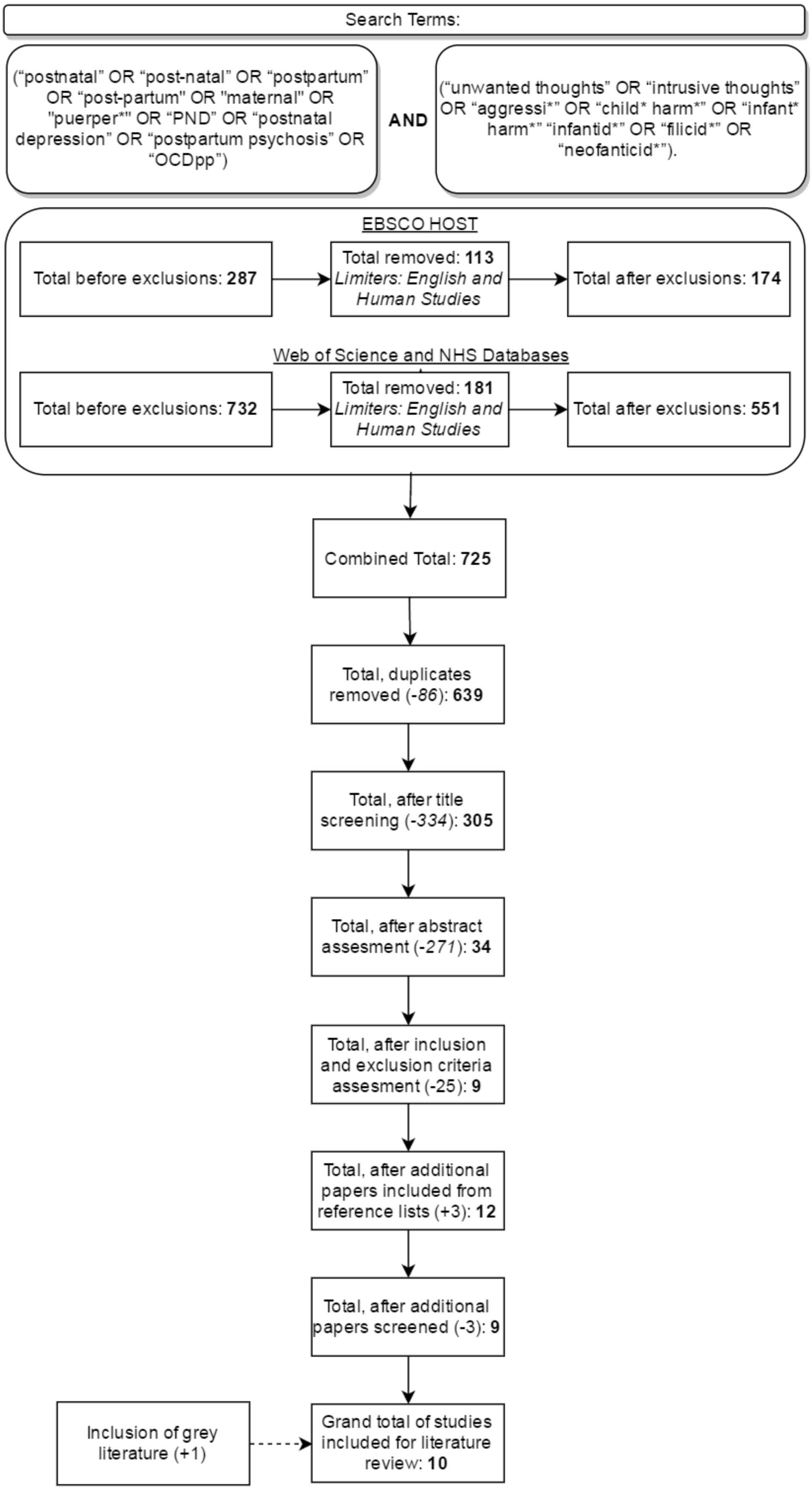

Figure 1. Flowchart demonstrating the literature screening process

Search Results

In total, there were three qualitative and seven quantitative papers shortlisted. There is a dominance of quantitative studies which considers the frequency of intrusive thoughts within OCD during the postnatal period. These studies showed that 12% to 46% of mothers experienced TIIHs in non-clinical samples (Abramowitz et al., 2003; Abramowitz, Khadker, Nelson, Deacon, & Rygwall, 2006; Abramowitz, Nelson, Rygwall, & Khandker, 2007; Leckman et al., 1999) and in a sample of women with postnatal “mood complaints” (Abramowitz et al., 2010, p. 523). Other studies also briefly mentioned TIIHs are prevalent in 4% of a non-clinical sample of mothers (Hall & Wittowski, 2006). However, as TIIHs were a small focus in these studies and explorations of such thoughts were not offered, these papers have not been included in the review.

Critical Appraisal Process

A descriptive overview of the studies including sampling details, data collection, analysis and key findings are offered in the data extraction and prevalence tables (Appendix B). The review is split into qualitative and quantitative sections as the criteria for appraising quality differed across the two subtypes of studies. The methodological critique will be presented for individual papers to orient the reader to the material selected and the quality of the material. Following this, a synthesis of common findings and themes across the literature will be shared.

Quality Assessment of Qualitative Papers

Criteria from the Critical Appraisal Skills Programme (CASP) (Public Health Resource Unit, 2006) were used to critically appraise the shortlisted qualitative papers. The CASP was chosen to develop a consistent, structured approach to the evaluation of studies (Aveyard, 2010). The 10 checklist items from the CASP appraisal tool were entered into a spreadsheet (Appendix C) to enable the researcher to evaluate whether each study satisfied the items on the checklist. This was rated on colour-coded scale from ‘yes’, ‘partially met’ to ‘no’. Two other categories were included to recognise when details were not reported (NR) or not applicable to the study (N/A). Four broad issues were also considered when appraising qualitative methods; relevance (usefulness of the findings), rigour (appropriateness of approach), transparency and credibility (presentation of results and meaningfulness) and importance (impact of the results) (Yardley, 2000).

Quality Assessment of Quantitative Papers

The Crowe Critical Appraisal Tool (CCAT: Crowe, 2013; Appendix D) was chosen due to its good construct validity and inter-rater reliability with a Cronbach's alpha of 0.74 (Crowe & Sheppard, 2011). Domain scores and combined total percentages are presented in Appendix E; a higher score implies higher credibility of the study. The CASP for cohort and case-controlled studies were rejected as they have been criticised for an inability to measure intrinsic methodological quality and have poor sensitivity to validity (Hannes, Lockwood & Pearson, 2010). The Methodological Quality Checklist by Downs and Black (1998) was also discarded due to the intervention focus of the tool which was not relevant to the shortlisted studies.

Categorical methods were used to assess whether the qualitative and quantitative studies met the checklist criterion (Appendix C; Appendix E) as there is a higher risk of inconsistent ratings in numerical ranking scores (Greenland & O'Rourke, 2001).

Summary of Qualitative Studies

Barr and Beck (2008) conducted interviews in a community setting with 15 mothers with a PND diagnosis. The aim was to explore the characteristics of maternal TIIHs. The data were analysed using thematic analysis and six themes were identified; 1) 'imagined acts of infanticide', where women envisaged carrying out infant harming behaviour; 2) 'the experience of horror', which related to shock of having infant harming thoughts; 3) 'distorted sense of responsibility', women experiencing hopelessness and suicidal ideation coinciding with infant harming thoughts; 4) 'consuming negativity', negative feelings towards the infant such as anger and rage; 5) 'keeping secrets', feelings of shame and inability to disclose thoughts to others and 6) 'managing the crisis’, in regards to adopting strategies to placate negative thoughts.

The consideration of ethical issues and the emotional impact of the questions regarding TIIHs was a key strength to this study. A qualitative, interview method was appropriate for the aim of the study, however, there is no information regarding the development of questions for the interview which reduces the trustworthiness of the study (Yardley, 2000). Limited data was offered in regards to participants’ demographic information (i.e. marital status, number of live babies, episode of depression). Providing further demographic information i.e. socio-economic status and ethnicity would help the reader to judge transferability of the findings. Additionally, whilst the influence of researcher’s role was acknowledged in the analysis of the interview data, information regarding reflexivity and epistemology was absent. Despite the researcher holding “previous assumptions (prejudices)” (p. 1717.e2), information about how this influenced the interpretation of the data would have been welcomed. Participant extracts were presented, however, some themes were accompanied by extracts from three participants and for others (i.e. ‘imagined acts of infanticide’) the authors omitted extracts entirely, thus reducing the commitment and rigour of the study (Yardley, 2000).

Maimon (2012) aimed to understand the ego-dystonic, TIIHs in a non-clinical sample. Interviews were conducted with five women and analysed using Interpretative Phenomenological Analysis (IPA: Smith, Flowers, & Larkin, 2009). The author identified three super-ordinate themes: 1) ‘experiencing intrusive thoughts of harm’; 2) ‘psychological states’ and 3) ‘pregnancy to postpartum life’. This study highlighted ego-dystonic TIIHs as a barrier to maternal attunement. Cognitive (self-dialogue), behavioural (checking, avoidance) and emotional responses (fear, shame) to these thoughts were also shared.

Strengths to this study include the acknowledgement of the socio-cultural setting of the study and ethical considerations. Other strengths include the author’s description of the bracketing of bias process including personal reflexivity and the detailed description of the analysis process. A variety of quotations from all participants were presented to provide evidence for the themes and to ensure fair representation of participants. It would have been helpful to provide separate extracts of participants' transcripts rather than interspersing quotations throughout the author's interpretations. This would have enabled the reader to become absorbed by the richness of the participants' experiences as described by them. Additionally, the inclusion of a table detailing the cases in which the super-ordinate themes and sub-ordinate themes were present would make for a clearer findings section.

Santos Jr, Sandelowski and Gualda (2014) aimed to understand the experience of TIIHs in 15 Brazilian women with PND. These thoughts were conceptualised as ego-dystonic as participants battled against a strong urge to harm the baby (e.g. throwing the child out of the window). TIIHs occurred intensely when mothers were caring for their child resulting in the complete transfer of care or shared responsibility of care with family. Interviews were analysed using thematic analysis (Braun & Clarke, 2006). The detail of data collection procedures is a particular strength and increases transparency and trustworthiness (Yardley, 2000). Attempts were made to improve interpretative validity by using professional translating services suggesting a commitment to the data (Yardley, 2000). Unfortunately the paper did not acknowledge the researcher's role when analysing the data and it is also unclear how the themes were derived from the data.

Synthesis of Qualitative Studies

The qualitative papers attempted to provide a novel and valuable account of the emotional consequences of living with TIIHs from the mothers' perspectives. Nevertheless, there are methodological limitations with the papers which reduce the overall rigour. This includes insufficient detail and consideration regarding data analysis, lack of researcher reflexivity and validation of themes.

Despite inclusion of different populations; women with PND (Barr & Beck, 2008, Santos Jr et al., 2014) and a non-clinical sample (Maimon, 2012), the three qualitative studies found that mothers' experiences of infant harming thoughts evoked negative emotions such as shame, disgust and horror. These thoughts were understood as ego-dystonic and therefore mothers adopted common strategies of coping to reduce distress and preoccupation with the thoughts. These included distraction in an attempt to reduce preoccupation with the thought, transferring care to a child minder (Barr & Beck, 2008; Santos Jr et al., 2014), entering into self-dialogue to prevent the acting out of the thought, distancing from the child and checking behaviours to ensure safety of the child (Maimon, 2012). An inability to disclose distressing thoughts of infant harm to others due to fear of judgement was also identified in all studies.

Two authors used data saturation to determine the end of recruitment (Barr & Beck, 2008; Maimon, 2012), whereas there is limited detail regarding the theme development in Santos Jr et al.'s (2014) study. Based on the brevity of Barr and Beck's (2008) paper, an in-depth analysis of the 15 participants' experiences is absent. Despite having the same sample size, Santos Jr et al. (2014) offer more depth of data but are still unclear about how the themes presented across the entire sample i.e. was theme one identified in all cases. In contrast, Maimon (2012) provides a thorough understanding of the experiences of five mothers. This difference may be explained by the sample sizes as depth of participant experience is difficult to achieve with a large sample size (Smith et al., 2009).

Summary of Quantitative Studies

Gutiérrez-Zotes, Farnós, Vilella and Labad (2013) hypothesised that neuroticism and psychoticism were predictors of the development of infant harming thoughts. These thoughts were measured by a semi-structured interview developed by the authors. Depression was also measured using the Edinburgh Postnatal Depression Scale (Garcia-Esteve, Ascaso, & Navarro, 2003). A non-clinical sample of 137 women were asked if they had TIIHs which was then ranked on a scale from one (the absence of intrusive thoughts) to five (the mother has inflicted a harmful act on the newborn). Neuroticism and psychoticism variables were measured by a Spanish version of the Eysenck Personality Questionnaire (Eysenck & Eysenck, 2011). A logistic regression identified psychoticism as the only significant risk factor for TIIHs, (OR: 1.68, 95% CI: 1.19-2.34, p = 0.003). Mothers experienced fear of the thought occurring, being alone with the infant and a reduced perception of mothering capabilities.

As the authors assessed participants at two time points (two to three days following childbirth and eight weeks post delivery) information regarding attrition rates would have been useful. Attrition can introduce bias if the characteristics of the participants lost to the second time point differ from the participants who completed the study (Dumvill, Torgerson, & Hewitt, 2006). It is unclear whether the completed cases are representative of the original identified sample. The postnatal period was defined as the first eight weeks after childbirth however there is no stated reference to support this. Returning to complete the second assessment after eight weeks may not be a sufficient amount of time to capture the phenomenon. This study would have been strengthened if a further follow up assessment was conducted to assess change in TIIHs, self-rated psychoticism and depression as the child developed. A follow up of 12 weeks would be recommended as depressive symptoms can occur three months following childbirth (Gavin, Gaynes, & Lohr, 2005).

Jennings, Ross, Popper and Elmore (1999) studied 100 mothers who scored above 18 on the Inventory to Diagnose Depression (IDD) (Zimmerman, Coryell, Corenthal, & Wilson, 1986). TIIHs were compared between mothers with PND and a control group of women who had recently given birth but had no diagnosable mental health problem (*n*=46). TIIHs were asked by a single question and participants selected which statement fitted their experience i.e. having done something potentially harming to the child to no thoughts of harming the child. Findings showed that 41% of mothers with depression reported TIIHs. Interestingly, depressed mothers with psychotic features reported more thoughts of infant harm. In comparison, 6.5% of mothers from the control group reported TIIHs.

A strength to Jennings et al.’s (1999) study was the use of a match-controlled sample of non-depressed mothers to allow for a comparison across non-clinical populations. An improvement in the study would include an equal number of participants in both groups. There was also researcher bias interfering with the data collection as some questions were omitted for the control group i.e. fears of being alone and caring for infant. Furthermore, participants were allocated into the ‘depressed’ or ‘non-depressed group’ based upon their IDD score (Zimmerman et al., 1986). If the score was 12 or less the participant was eligible for the non-depressed group, if the score was 18 or above the participant was eligible for the depressed group. However, no information is provided about the mothers whose scores fell between these cut off scores and it is unclear how many women were excluded from this study as a result. It was also surprising that the authors did not include ethical considerations as part of the paper considering this sensitive field of study.

Fairbrother and Woody’s (2008) aimed to assess the nature and predictors in TIIHs in new mothers. The sample consisted of 100 new mothers who were recruited during pregnancy (35 weeks gestation) at which point they completed the Eysenck Personality Questionnaire – Revised Short Scale (Eysenck, Eysenck, & Barrett, 1985). Further data were obtained regarding parenting stress (Parenting Stress Index; Abidin, 1995), social support and infant harm (intentional and accidental) through a semi-structured interview. These measures were conducted at two time points, four weeks and 12 weeks following childbirth. Examples of TIIHs included: ‘shaking the baby’; ‘dropping or throwing the baby out of the window/off the balcony’; ‘intentionally hitting the baby when burping them’ and 'touching baby’s genitals in an inappropriate manner’. A dependent samples t-tests identified TIIHs as significantly more upsetting and distressing than thoughts of accidental harm ($t(44) = -3.68$, $p = .001$). A logistic regression indicated that high parenting stress (including mother’s poor perception of the mother-infant relationship) and lack of social support predicted the prevalence of TIIHs ($R^2 = .37$, $X^2 = 24.54$, $p < .001$).

The study revealed that ego-dystonic TIIHs are a normative experience during the early postnatal period. The recruitment from multiple sites was a particular strength; participants were recruited from two major hospitals, midwifery offices, clinician offices and pre-natal classes. At four weeks postpartum, authors asked about the presence of harming thoughts within the previous four weeks. At the second time point the presence of such thoughts were only considered if they occurred within the previous week. An inconsistent time frame to assess the prevalence of TIIHs reduces the possibility of an accurate, comparable measurement.

Humenik and Fingerhut (2007) found that PND was significantly and positively correlated with both frequency and intensity of TIIHs. This was based on a sample of 50 mothers who had given birth four to six months prior to participation. A significant positive correlation was also found between negative self-view and intensity of TIIHs which was reported as “.24” significant at the $p<.05$ level (p. 364). However, the type of correlational analyses (Pearson’s *r* or Spearman’s *p*) was not reported therefore it is unknown whether the data met parametric assumptions.

Chandra, Venkatasubramanian and Thomas (2002) conducted a prospective study of 49 mothers in India. An independent samples t-test revealed that mothers with TIIHs had significantly more psychotic symptoms than those without TIIHs ($t(45) = 3.1$, $p = .003$). Information was gained from the mothers’ partners, nursing observations and psychiatric assessments within the first week of admission onto an inpatient psychiatric unit. Although a valuable study which explores TIIHs in mothers within an inpatient unit (often under-researched due to ethical concerns), there is no recognition that observations of behaviour and interpretations are subjective.

Wisner, Peindl, Gigliotti and Hanusa (1999) studied obsessions and compulsions for women with ‘postpartum onset major depressive disorder’ (n=37) which were compared with a control group of women with ‘major depressive disorder’ but not postnatal onset (n=28). The Yale-Brown Obsessive Compulsive Scale (YBOCS; Goodman, 1989) was used to assess ‘aggressive obsessions’ of infant harm. It was claimed that the most frequent obsession for postpartum women was intrusive TIIHs towards their child. Examples expressed by participants included: ‘putting the baby in the microwave’; ‘drowning the baby’; ‘stabbing the baby’ and/or ‘throwing the baby down the stairs’. Despite the YBOCS (Goodman, 1989) being accompanied by examples to facilitate the participant’s answers (i.e. fear of harming the baby), the tool is not specific to infant relating. The reduced face validity means the YBOCS may not be an appropriate measure for TIIHs.

Labad et al. (2011) assessed whether the hypothalamic-pituitary-adrenal (HPA) axis was associated with greater risk of experiencing TIIHs for 132 non-clinical mothers. Participants were assessed at two time points; two to three days postpartum and eight weeks postpartum. A semi-structured interview was conducted to assess whether participants experienced active (intentional) and/or passive (accidental) thoughts of infant harm. Questionnaires used to measure depression (Edinburgh Postnatal Depression Scale, Garcia-Esteve et al., 2003) and acute life events were included (St. Paul Ramsey Life Experience Scale (Roy, Pickar, Linnoila, Doran & Paul, 1986). Stress hormones cortisol and adrenocorticotrophin hormone (ACTH) were measured through blood tests. Chi-squared tests demonstrated that participants experiencing TIIHs had higher levels of ACTH and cortisol (*p* = 0.016). Logistic regression revealed that ACHT was associated with the occurrence of infant harming thoughts (OR: 5.2, 95% CI:1.2-22.6, *p* = 0.029). The authors concluded that increased ACTH could be an indicator of HPA axis dysfunction which may contribute to TIIHs. This study was the first to research the association between HPA activity and TIIHs during the postnatal period. However, the direction of the relationship is not straightforward; it could be argued that the TIIHs could be the cause of the stress hormone increase. In addition, despite a significant relationship between TIIHs and number of life events presented in a table, little attention is given to this result demonstrating outcome reporting bias.

Synthesis of Quantitative Studies

Across the studies, all authors provide a clear rationale and focus for the study presented, commenting that it is an under-researched area. However, there are a number of methodological weaknesses across the papers which reduced the reliability, validity and generalisability of the results.

Participants

All studies except for one (Humenik & Fingerhut, 2007) neglected to present a power calculation. This would ultimately provide information about the number of participants required to achieve statistical power given an estimated effect size.

Four studies assessed infant harming thoughts purely within a non-clinical sample (Fairbrother & Woody, 2008; Gutiérrez-Zotes et al., 2013; Humenik & Fingerhut, 2007; Labad et al., 2011). Two papers included a non-clinical sample for a case controlled study (Jennings et al., 1999; Wisner et al., 1999). However, only two were explicit about the way they determined the non-clinical sample by excluding women with a history of severe health issues or use of an inventory to exclude depression (Gutiérrez-Zotes, 2013; Jennings et al., 1999).

Clinical populations included severe mental health issues requiring inpatient admission i.e. PP (Chandra et al., 2002) and at least one group of mothers with depression (Jennings et al., 1999; Wisner, 1999). The two latter studies used the IDD (Zimmerman et al., 1986), however this measure was designed to diagnose 'major depressive disorder' and therefore the transferability of the measure for use in the postnatal period has not yet been validated. This raises queries as the items may be overrepresented in all new parents such as changes to sleep patterns which are common for mothers in the postnatal period (Gay, Lee, & Lee, 2004). Therefore, this measure has low face validity as it does not measure what it claims to in the context of postnatal mental health issues (Coolican, 2004).

Data Collection

Six studies obtained data using face-to-face interviews and questionnaires (Fairbrother & Woody, 2008; Gutiérrez-Zotes et al., 2013; Humenik & Fingerhut, 2007; Jennings et al., 1999; Wisner, 1999). Although time consuming, these methods provide an opportunity for the participants to gain a rapport with the researcher which is important to elicit sensitive information from a participant (Goudy & Potter, 1975). One study used various means to triangulate data including reports from partners, nursing observations and psychiatric assessments to assess TIIHs and behaviours (Chandra et al., 2002). Observations are deemed appropriate for this population and setting due to the reduced reactivity effects (Coolican, 2004) particularly as nurses are a predictable and familiar part of the ward environment. However, issues of subjectivity and use of an unvalidated structured assessment undermines the validity and reliability of the study. This is similar to other studies using a new inventory to measure TIIHs (Fairbrother & Woody, 2008; Humenik & Fingerhut, 2007). Another study used a variety of measures (questionnaires, semi-structured interviews, physiological measures) to provide a comprehensive, multi-faceted assessment of etiology and the presence of TIIHs (Labad et al., 2011). Unfortunately it was noted that two studies used the same participants and dataset (Gutiérrez-Zotes et al., 2013; Labad et al., 2011) therefore reducing the external validity of the findings. None of the quantitative studies acknowledged the potential reporting bias of mothers' self-reports which were potentially confounded by negative distortions inherent in PND (Field, 1992; Jennings et al., 1999; Wisner, 1999).

Method

Three studies completed measures at multiple time points. Fairbrother and Woody (2008) recruited women during pregnancy and completed measures at four weeks and 12 weeks postpartum. Two studies collected data between two to three days postpartum and again at eight weeks (Gutiérrez-Zotes et al., 2013; Labad et al., 2011). Offering multiple data collection points allowed the researchers to show patterns of TIIHs over time. This is particularly important in this client group as the participants' transition into motherhood involves taking on various demands across a short space of time (Salmela-Aro, Nurmi, Saisto & Halmesmäki, 2002). Cross-sectional methods can provide a cost-effective, time efficient method for collection data (Coolican, 2004). However, caution must be taken when interpreting results from one time point as TIIHs are not a stable construct as they fluctuate over time and with adjustment to the parenting role (Spinelli, 2004).

Data Analysis

Four studies used a correlational analysis as part of the paper or as the main data analysis method (Chandra et al., 2002; Humenik & Fingerhut, 2007; Jennings et al., 1999; Labad et al., 2011). Correlations are a useful method to establish a relationship between two variables (e.g. TIIHs and postpartum depressive symptoms) but the direction of the relationship and causation cannot be fully determined (Coolican, 2004).

Results

The studies were analysed using thematic analysis (Braun & Clarke, 2006). This method was deemed more appropriate over other methods (i.e. content analysis) as it permits interpretation of the findings. The approach also encourages commitment to context which was necessary when researching such a sensitive topic with published papers from various countries (Vaismoradi, Turunen, & Bondas, 2013). Reading and re-reading the studies ensured familiarity with the findings and enabled the development of initial codes i.e. 'self-criticism'. Overlapping codes were combined and refined to create four themes (Table 2).

Table 2:

Literature Review Themes

Themes	Sub-Themes
1. The Spectrum of TIIHs	
2. Responses and Coping with TIIHs	a. Cognitive Responses b. Emotional Responses c. Behavioural Responses
3. Socio-Cultural Context	
4. Mother-Infant Relationships	

Theme One: The Spectrum of TIIHs

The overlap of TIIHs between clinical and non-clinical populations has not yet been studied, and to a large extent, is therefore unknown (McGuiness et al., 2011). The findings revealed that TIIHs occur across the spectrum of postnatal mental health difficulties and also in non-clinical samples though to a lesser degree. This suggests that TIIHs occur across a continuum with mothers presenting with increased psychological distress most likely to suffer more frequent intrusions (Chandra et al., 2002; Fairbrother & Woody, 2008; Humenik & Fingerhut, 2007; Wisner, 1999).

TIIHs are either understood as ego-dystonic (not in line with the mother’s values) or ego-syntonic (thoughts are consistent with the mother’s view of herself). All studies reveal similarities between the TIIHs that occur in non-clinical samples, PND and OCD which leave mothers feeling alarmed. However, there is reduced likelihood of the mother’s carrying out harmful acts because the mother actively resists the thought to prevent it occurring. This is contrasted against the conceptualisation of PP where infant harming thoughts were viewed as a serious risk due to aggressive intrusions being consistent with delusional thinking and behaviour. Therefore there is increased risk of the infant harm occurring (Chandra et al., 2002).

Theme Two: Responses and Coping with TIIHs

Cognitive responses. There were common findings in the way TIIHs are processed (cognitive biases) and the management of these thoughts (coping strategies). Cognitive biases such as believing that merely thinking about a situation will increase the chance of it occurring and the belief that thinking about a feared situation is equivalent to the feared event occurring, are known as thought-action fusion (Abramowitz et al., 2003; Shafran, Thordarson, & Rachman, 1996). Thirdly, thoughts are only experienced as distressing if they are appraised as being meaningful and are contradictory of the one’s own values (Abramowitz et al., 2007; Rowa, Purdon, Summerfeldt, & Antony, 2005). From this perspective, if TIIHs are ego-dystonic and threatens one’s perceptions of motherhood and the mother-infant relationship, there is a subsequent increase in anxiety (Kleiman & Wenzel, 2011; McGuinness et al., 2011; Spinelli, 2004). In contrast, delusional TIIHs in PP are described as ego-syntonic, meaning that thoughts of harm may be congruous with mother’s intentions. It may also be the case that the mother themselves has been exposed to child abuse and may therefore view aggression and violence against children as the norm (Bert, Guner, & Lanzi, 2009). The acute onset of PP associated with mood lability suggests there is a higher risk of infanticide due to poor rational judgement, disorganised thinking and mood lability (Spinelli, 2004). This can be linked to delusions (i.e. believing that the baby is the devil or ill fated). The mother may experience a distorted reality and/or a compulsion to act on the thoughts accompanied with an inability to fully assess the consequences of one's actions (Chandra, Bargavaraman, Raghunandan, & Shaligram, 2006). In terms of cognitive responses to TIIHs, the most common included obsessive rumination and thought suppression (conscious attempts to stop thinking about a thought), however, this is likely to intensify the thoughts (Humenik & Fingerhut, 2007) causing significant distress to the mother.

Emotional responses. Emotional responses to TIIHs during motherhood were identified in seven studies (Barr & Beck, 2008; Fairbrother & Woody, 2008; Humenik & Fingerhut, 2007; Jennings et al., 1999; Labad et al., 2011; Maimon, 2012; Santos et al., 2014). Participants spoke of a range of emotions but most prominently guilt, shame, fear and disgust with oneself (Jennings et al., 1999). To reduce and divert these emotions mothers engaged in a range of behavioural responses (Barr & Beck, 2008) as discussed within the next theme.

Behavioural responses. In an attempt to diffuse the cognitions of infant harm and reduce the associated anxiety, common behavioural responses included repetitively checking the baby's safety, seeking reassurance, distraction and avoidance behaviours (Humenik & Fingerhut, 2007; Maimon, 2012; Santos Jr et al., 2014). One study found depressed mothers were *not* more likely to avoid being alone with the infant however experienced great anxiety when providing care for them (Jennings et al., 1999). It is unclear whether this is a spurious result due to insufficient participants to achieve statistical power. There may also be instances where the mother acts upon the TIIHs by shouting at the infant or physically harming the child across clinical and non-clinical populations (Barr & Beck, 2008; Chandra et al., 2002; Fairbrother & Woody, 2008; Humenik & Fingerhut, 2007).

Theme Three: Socio-Cultural Context

Childbirth and the transition to motherhood occurs within a social context (Maimon, 2012) and four of the 10 studies described the experience of TIIHs in the context of societal expectations of motherhood (Chandra et al., 2002; Humenik & Fingerhut, 2007; Maimon, 2012; Santos et al., 2014).

The guilt response to TIIHs was exacerbated by a conflict of experiencing negative cognitions during a romanticised period of a women's life depicted as a period of joy and fulfilment (Maimon, 2012). Numerous socio-cultural expectations were placed upon women and there was (and still is) a dominant discourse surrounding Western motherhood as the ultimate fulfilment or pinnacle of womanhood (Murray et al., 2011). More specifically, Santos Jr et al.'s (2014) study of Brazilian women highlighted that management of multiple roles and competing demands divide the mother's time. Chandra et al. (2002) considered the Indian cultural context and gender discrimination towards the newborn when findings revealed that infanticidal ideas were associated with female infants. This illustrates the impact of the socio-cultural context on motherhood and the development of TIIHs.

Theme Four: Mother-Infant Relationships

There is a relationship between TIIHs and the quality of the mother-infant relationship (Fairbrother & Woody, 2008; Humenik & Fingerhut, 2007; Santos et al., 2014). Behavioural avoidance (see theme two) is the strongest predictor of poor outcome for the mother's well-being (Blalock & Joiner, 2000) and infant emotional regulation (Grusec & Hastings, 2014) and is likely to have an impact on the relationship. Mothers who were unhappy with the quality of infant interactions or who lacked social support in the mothering role were more likely to experience TIIHs (Fairbrother & Woody, 2008; Labad et al., 2011). Conversely, the occurrence of TIIHs may influence the perception of the relationship with the infant (Santos Jr et al., 2014). Some mothers feared interaction with the infant when TIIHs were recurrent. This can have implications on the mother-infant relationship as the mother may transfer care to family members, avoid trigger situations or become overprotective (Barr & Beck, 2008; Jennings et al., 1999; Maimon, 2012; Santos Jr et al., 2014). Mothers with PND were more likely to engage in withdrawn (under-stimulating, transferring or avoidant) or intrusive (over-stimulating, smothering) behaviours when interacting with the infant (Santos Jr et al., 2014). Negative self-view was also associated with TIIHs, this could be explained by feelings of guilt which perpetuate feelings of inadequacy and lead to criticising one's own parenting competence (Humenik & Fingerhut, 2007). Finally, harsh parenting practices were found to predict the occurrence of TIIHs. This relationship may be two-way in that the presence of TIIHs may also impact the participant's perception of the mother-infant relationship (Fairbrother & Woody, 2008).

Discussion

This review critically appraised and synthesised 10 studies investigating maternal TIIHs. The relationship between TIIHs and increased psychological distress is highlighted. Cognitive behavioural theories would suggest this relationship is bi-directional (Clark & Purdon, 1995) meaning increased distress can precipitate such thoughts and TIIHs can increase distress. Separate to this continuum sits the presence of ego-syntonic thoughts (i.e. in PP) where there is a higher risk of infanticide being committed (Spinelli, 2004). However, it must be highlighted that having such thoughts does not necessarily equate to equivalent behaviour and mothers acting on these thoughts. Such thoughts are common in motherhood and do not necessary affirm immediate risk or danger (Flynn, Shaw, & Abel, 2013).

A range of strategies were employed to reduce distress including transferring care to others, situational avoidance and thought suppression (Humenik & Fingerhut, 2007; Maimon, 2012; Santos Jr et al., 2014). These thoughts and behaviours were driven to protect the child, they were rooted in a heightened sense of responsibility and a hyper-vigilance to threat (Cree, 2015). However, they had a devastating effect on the mother-infant relationship as it prevented attunement with the infant (Humenik & Fingerhut, 2007; Leckman et al., 1999).

In PP, TIIHs become more intertwined with delusions and a confused sense of reality for mothers who experience ego-syntonic thoughts and intense fear (Engqvist, Ferszt, Åhlin & Nilsson, 2011). Similar to mothers with a diagnosis of OCD, there is a heightened sense of obligation and responsibility and mothers feel compelled to act. However, TIIHs are viewed as more impulsive in PP (Spinelli, 2004).

TIIHs were experienced as distressing and evoked strong feelings of shame for mothers particularly when compared to accidental harm for non-psychotic mothers (Beck et al., 2002; Fairbrother & Woody, 2008; Murray et al., 2011; Santos et al., 2014). Factors that influence concealment of difficulties and prevent disclosure are isolation and stigma (Edwards & Timmons, 2005). Therefore, increased awareness of the range of infant harming thoughts and emphasising common, shared experiences across motherhood is likely to increase disclosure and connectedness with others.

Clinical Implications

This review has highlighted that TIIHs are relatively common (Fairbrother & Woody, 2008; Jennings et al., 1999). Therefore, understanding such thoughts should form part of a standard assessment for all mothers with and without a diagnosis of mental health problems. Routine questions regarding TIIHs should be asked when enquiring about suicidal ideation (Health Education England, 2016). If thoughts of infant harm exist, the nature (accidental or intentional), frequency, intensity and mothers' perceptions of the likelihood of the harm being carried out must be assessed (Flynn et al., 2013). Furthermore, assessment of delusional thinking, reality testing and ability to regulate anger is important to gauge the presence of PP (Jennings et al., 1999). In congruence with the review aims, this paper has highlighted a need to train staff in risk assessment and management, in addition to improving access to mental health services and appropriate interventions. The priority is to assess whether the thoughts are ego-dystonic or ego-syntonic using questions which explore the meaning ascribed to TIIHs and the motives behind such thoughts (i.e. altruistic motive to prevent ill fate of the baby). Despite the degree of impulsivity associated with PP, conversations about the delusions and hallucinations in relation to the infant are vital to judge the necessity of further monitoring or admission to a MBU if safety cannot be assured. This would prevent separation from the baby but allow the provision of staff monitoring to ensure the safety of both parties (Friedman & Sorrentine, 2012).

A supportive relationship where the mother feels able to confide in the professional is paramount to promote openness. Normalising assessment questions should be asked such as: *'some mothers have distressing thoughts or images of doing something harmful to their baby, a thought is just a thought and not an action of course, but have you found yourself* *having any thoughts like that at all?'* The immediate appraisal of the intrusions, importance and expected consequences of such thoughts should also be assessed (Friedman et al., 2008). As supported from this review, responses to TIIHs should be captured i.e. emotional consequences, behavioural strategies and thought control strategies (i.e. suppression, distraction). A psychological formulation can then be developed.

Psychological formulations (see example in Appendix F) would facilitate an understanding of mothers' appraisals and interpretations of such thoughts as well as parenting behaviours (i.e. is the mother over-engaged or too intrusive to try and compensate for experiencing thoughts of infant harm). Clinicians can then offer appropriate individual interventions to reduce the mother's distress, support families, foster mother-infant attunement and maternal sensitivity. Mothers can then be supported to re-establish positive relationships with the infant, by challenging unwanted thoughts of harm and developing strong emotional bonds (Cree, 2015).

Limitations of Literature Review

Only 10 studies met the inclusion criteria for this review potentially due to TIIHs only representing one element of intrusive thoughts (Abramowitz et al., 2003). Additionally, this review was conducted by a single researcher therefore the short-listing of papers and development of themes may have been influenced by subjectivity. The researcher has attempted to address this by presenting the review process with as much transparency as possible.

Future Research

The literature search revealed a small number of longitudinal studies that collected data over two time points (Gutiérrez-Zotes et al., 2013; Labad et al., 2011). The longest follow up period was 12 weeks (Fairbrother & Woody, 2008) from the one year postnatal period (NICE, 2014). Longitudinal examination of TIIHs is necessary to assess the nature and responses to such thoughts over a longer period of time as mothers adjust to the parenting role. There is a potential underreporting of TIIHs that occur in research studies due to the sensitive topic (Jennings et al., 1999) therefore relying on alternative measures (observations, professional reports) would be informative (Chandra et al., 2002).

TIIHs can occur in OCD (Abramowitz et al., 2003; McGuinness et al., 2011), PND (Jennings et al., 1999; Wisner et al., 1999), non-clinical mothers (Fairbrother & Woody, 2008) and severe mental health problems such as PP (Chandra et al., 2002). However, as demonstrated by this review there is limited research on TIIHs in PP specifically. All but one study (Chandra et al., 2002) explicitly excluded women with PP (or failed to mention an exclusion criteria) due to the ego-syntonic nature of thoughts within the delusional PP context. Mothers with PP experience impulses to act on their delusions and thoughts are not subjectively resisted, meaning there is an increased risk of carrying out the harm behaviour (Brandes, Soares & Cohen, 2004; Button & Reivich, 1972; Fairbrother & Abramowitz, 2007). However, there is no recognition that TIIHs may be ego-dystonic once the mother has recovered. Two studies briefly acknowledge that mothers experience shame when reflecting on previously held TIIHs during PP (Engqvist et al., 2011; Engqvist & Nilsson, 2013). This is an area that warrants further research as living with thoughts of infant harm is a considerable burden for someone who already faces the challenge of living with a diagnosis of PP (Glover, Jomeen, Urquhart, & Martin, 2014; Robertson & Lyons, 2003; Stanton et al., 2000). However, there is a gap in the literature about how this experience is understood by mothers who come to terms with TIIHs as part of recovery in relation to PP.

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Paper Two: Empirical Paper

Postpartum Psychosis and Beyond:

Exploring Mothers' Experiences of Postpartum Psychosis and Recovery

> "Recovery is like a game of snakes and ladders. Sometimes you slide down the snake or fall off the ladder but you never go back to the start"
> (Eve Canavan, Postpartum Psychosis Survivor*)

Target Journal: Archives of Women's Mental Health (Appendix F)
Word Count: 9,356

*Permission granted to share quotation and reference.

Abstract

Purpose: Postpartum psychosis (PP) affects between one to two mothers per 1000 births and is recognised as the ‘most severe’ mental health problem following childbirth. Onset is rapid and often marked by paranoid thoughts, changes in mood, unusual perceptual experiences and confusion. Although symptom remission rates are positive following PP, recovery experiences are broader than merely symptom reduction. The purpose of this study was to explore how mothers made sense of PP and their recovery experience.

Method: Semi-structured interviews were conducted with eight mothers who had experienced PP. Participants were recruited through online forums and transcripts were analysed using Interpretative Phenomenological Analysis.

Results: Four super-ordinate themes were identified including: 1) ‘becoming unrecognisable’; 2) ‘mourning losses’; 3) ‘recovery as an ongoing process’ and 4) ‘post-traumatic growth’. Participants described an experience of feeling out of control after childbirth and battled with feelings of inadequacy. Shifting towards self-compassion and developing confidence as a mother was a common experience and a marker of recovery.

Conclusions: Mourning the loss of idealised motherhood and early bonding is necessary to consider in the context of recovery. Due to the homogeneity of this sample, further research is needed to explore the cross-cultural conceptualisations of recovery following PP.

Keywords: postpartum psychosis; perinatal; recovery; interpretative phenomenological analysis

Word Count: 199

Introduction

Postpartum Psychosis

Postpartum psychosis (PP)[1] is a severe mental health issue that is typically seen within two to four weeks following childbirth (Sit et al. 2006). PP is marked by a rapid deterioration in mental health, increased paranoid thinking, hallucinations and delusions, confusion and/or unusual perceptual experiences (Thurgood et al. 2009; Brockington 1996). PP is a condition with a sudden onset and is known to affect between one to two mothers per 1000 childbirths (Kendell et al. 1987). It has a profound effect on mother-infant bonding, contributes to maternal suicide and approximately 4% of women with PP commit infanticide (killing one's own baby within one year of birth) when experiencing delusional thinking (Posmontier 2010; Glover et al. 2014; Spinelli 2005). It is viewed as a severe mental health condition which often requires urgent assessment and inpatient admission (Sit et al. 2006).

PP is not currently classified as a distinct category in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V; American Psychiatric Association 2013) or in the International Classification of Diseases (ICD-10; World Health Organisation 1990; Bergink et al. 2015). PP is therefore often classified as postnatal depression (PND), major depression with psychotic features, schizophrenia or bipolar disorder (Doucet et al. 2012). Women with a diagnosis of bipolar disorder are considered more at risk of developing PP, with psychosis occurring following 25-50% of deliveries (Heron et al. 2008). Other risk factors include severe sleep deprivation (Sharma, 2003), traumatic birthing experiences (Sharma et al. 2004) and a family history of severe perinatal mental health difficulties (The National Institute for Health and Care Excellence [NICE], 2014). A link between previous childhood trauma and PP has also been hypothesised (Kennedy and Tripodi 2014). As such, there is currently no agreed cause of PP although most working hypotheses are positioned within the biomedical model (Sit et al. 2006; Doucet et al. 2012). This means women are usually

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[1] The terms 'puerperal psychosis' and 'postnatal psychosis' are also used within previous literature, however 'postpartum psychosis' will be used as this is congruent with a well-known UK charity; 'Action on Postpartum Psychosis'

treated with pharmacological interventions to improve psychiatric symptoms of PP.

Recovery

The psychosis recovery paradigm has shifted the understanding of recovery to being more multi-faceted than merely symptom remission (Tan et al. 2014). Recovery is defined as a unique journey of personal growth and development (Ridgeway 2001). Recovery involves building a positive identity, developing meaningful connections, fulfilling a satisfying life (as constructed by the service user) and accessing the appropriate support (British Psychological Society [BPS] 2009; Brown and Kandirikirira 2007). Specifically, recovery for psychosis may mean living and coping with potentially distressing symptoms rather than eradicating them completely (Cupitt 2010).

Recovery and PP

Maternal experiences of living with PP were first analysed using a grounded theory approach (Robertson and Lyons 2003). The themes generated from the interviews included: a ‘separate form of mental illness’, ‘loss’ and 'relationships and social roles’. The participants recognised PP as a life changing experience, advocated the need for specialist perinatal support and expressed numerous losses (over self, decision making, motherhood, future children). The participants were diagnosed with PP within the last 10 years (measured by the classification of manic or psychotic episodes in the DSM-IV). The study included 10 participants to generate a theoretical account of living with PP and to develop a conceptual, explanatory framework of recovery. Participants were recruited from a pool previously used in a genetics study and all participants believed the cause of PP was biological. This recruitment bias may have restricted the multi-faceted narrative of recovery.

One service-user collaboration study explored the PP recovery process and women’s support needs by using grounded theory (Heron et al. 2012). The authors studied mothers’ support needs from which seven themes emerged: 1) ‘unmet expectations’; 2) ‘ordering and rationalising’;

3) ‘social interaction’; 4) ‘medical support’; 5) ‘family support’; 6) ‘information’ and 7) ‘small steps and time’ (Heron et al. 2012). Despite a small sample size (*n*=5), the findings reinforced that recovery from PP was not viewed as a reduction in symptoms. Instead, it was understood as a complex process of developing confidence in parenting, self-esteem and family functioning. These findings can be used to inform family-centred care by providing insights into the priorities for individual recovery, family recovery and specialist support needs.

Although service-user led research has its strengths, participants spent two days training with fellow service-user interviewers. This may have left participants concerned about revealing sensitive information about their experiences in the presence of peers. To support this claim, women who experienced PP appraised previous thoughts as “unspeakable” particularly if related to infant harm (Glover et al., 2014, p. 258). There was also a view that the self was “unacceptable” for having such thoughts which evoked feelings of shame and disgust, meaning disclosure of such thoughts would be difficult (Chandra et al. 2006; Glover et al. 2014, p. 258). A recent review highlighted the lack of research on intentional infant harming thoughts (TIIHs) in mothers with PP (Chotai et al. 2016). Thoughts are viewed to be ego-syntonic in PP (often in harmony with the delusions) and therefore there is a higher risk of harm occurring (Chandra et al. 2006). However, Glover et al. (2009) suggested that the understanding and appraisal of TIIHs differ in recovery. One might argue that these thoughts become ego-dystonic during recovery (conflicted against personal values) as mothers express intense shame when reflecting on thoughts and behaviours during the acute phase of PP.

The Recovery Process in PP

A process model was developed to explain stage specific steps in recovery following PP (McGrath et al. 2013). The process of recovery ran alongside evolving an understanding of PP and was specifically related to expectations of motherhood. Mothers’ experiences moved from a period of immobilisation, recognising recovery, accepting loss, using their experience positively and maintaining recovery. Although strategies of recovery are named (i.e. crisis management, concealment, sharing experience and seeking support) there is minimal idiosyncratic detail about the maternal *meaning* of recovery. Additionally, the model focuses on recovery and therefore the sense-making process of PP itself is not explored. Due to number of themes developed (and potentially the word limit) participant extracts lacked depth and therefore similarities and differences within themes are neglected. Nevertheless, this study provides a helpful model to formulate a mother's stage in recovery.

The themes of recovery from PP are centred around the changing view of the self following PP, the difficulties in trusting one's own instinct, ways of overcoming PP using the support of others and the intrinsic processes to promote own recovery (Watkinson in progress). However, there remains scope to build a more interpretative account of mothers' *experiences* rather than the process of recovery per se. The priority shifts toward understanding the depths and different shades of meaning of PP and life beyond, rather than theory development.

Participants across the studies described intense confusion during PP and frustration towards a lack of specialist services (Engqvist and Nilsson 2013; McGrath et al. 2013). Mothers experienced a range of intolerable emotions (guilt, anxiety, shame, sadness) when navigating the path to motherhood and stigma prevented openness of experience (Robertson and Lyons 2003). Recovery involved changes in relationships; some negative changes (Robertson and Lyons 2003; Glover et al. 2014) and some positive changes in social and family functioning (Doucet et al. 2012; Heron et al. 2012). PP is also known to reoccur in 50% of mothers, therefore the possibility of future childbearing can cause significant worry which impacts on psychological recovery (Jones and Smith 2009).

The Cost of Perinatal Mental Health

The cost of perinatal mental health problems in the United Kingdom (UK) is £8.1billion per year, and approximately £47,489 for each case of PP (Bauer et al. 2014). This is likely to be an under-estimate due to the limited data available regarding the impact of PP on children. Therefore, with 1380 women experiencing PP each year (Hogg, 2013), the total expenditure for PP is approximately £65,534,820 per year in the UK. Fortunately, there is clear evidence that perinatal mental health is being prioritised on the political agenda. The UK government has stated that £290 million will be invested to provide care and psychological therapies to mothers by 2020 (Department of Health [DoH], 2016; Mental Health Taskforce Strategy 2016). However, it is necessary to understand the recovery experiences of women who have suffered a postnatal mental health problem to ensure that investments are expended responsibly and in consideration of the evidence base.

Gaps in Research and Rationale for Study

The proposed study aimed to extend the current research on PP using a different, interpretative approach to understanding the experience of PP and recovery. This poses the research question of 'how do mothers make sense of PP and their recovery experience'? The data will be analysed using Interpretative Phenomenology Analysis (IPA) (Smith et al. 2009) to identify themes and to capture the meaning participants attribute to their personal experience which will develop previous studies using alternative methodologies. Previous grounded theory studies have pushed forward a conceptual, theoretical framework to identify how recovery unfolds as a structural process (Heron et al. 2012; McGrath et al. 2013; Robertson and Lyons 2003). However, IPA is more concerned with the detailed and nuanced analysis of individual experiences, conceptualisations and sense-making of PP and recovery. The approach is less concerned about producing a theory based on relating sociological processes (Willig 2013). The main philosophy of IPA is that the participant is making sense of their ‘lived experience’. It is based on micro-analysis and a detailed exploration of idiographic experiences (Smith et al. 2009). No known study has used IPA to analyse mothers' experiences of PP and recovery. This approach is harmonious with the research aims as it is akin to the deeply personal process of meaning-making which occurs within recovery (Krauss 2005). It is important to understand how PP is experienced and understood from personal accounts so the differences and similarities of experiencing PP can be assimilated (Smith et al. 2009).

Research Aims

The aim of the study was to gain a better understanding of the experience of PP and recovery from PP.

Methodology

Ethical Considerations

Ethical approval was gained from Staffordshire University Ethics Committee Board (Appendix H; Appendix I). Women were not excluded if they were experiencing psychotic symptoms as this should not be the sole rationale to exclude participation in research (BPS 2008). However, sufficient safeguards (i.e. willingness to conduct capacity assessments) were put into place should the participant's capacity to consent to engage in research be questioned (DoH 2005). Informed consent was obtained from all participants.

Expert by Experience (EbE) Involvement

Involving people with previous experience of mental health difficulties in the development of research makes for more meaningful, relevant studies and provides insight into the experience of mental health (National Institute of Health Research 2013). Therefore a mother with personal experience of recovery from PP was sought and identified by a member of the research team (EB). The EbE was an author who published books concerning perinatal distress and an inspirational speaker who presented her personal experience at conferences. The following materials were developed collaboratively: invitation to participate, participant information sheet, consent form, topic guide and the demographic questionnaire.

Recruitment

Promotion of research was through online forums and social networking sites linked with charities that support women with PP (i.e. Twitter, APP; Appendix J, Appendix K). The criteria for participation was set to establish a homogenous group as required for IPA (Smith et al. 2009). The inclusion criteria consisted of women over 18 years of age who identified with the diagnosis of PP and felt that they were recovered. Fluent verbal and written English was necessary due to a limited budget to fund translation services. Women unable to provide consent and currently accessing inpatient services were excluded. It was deemed unethical to engage mothers in research during acute psychosis when there may be issues with understanding, reasoning, and impact (Kovnick et al. 2003). Although a formal diagnosis was not requested due to the contentious nosological status of PP (Doucet et al. 2012; McGrath et al. 2013), information regarding symptoms was captured through the demographic questionnaire. This demonstrated the varied clinical picture of PP (Appendix Q). As recovery is understood to be an individual, personally meaningful process (McGrath et al. 2013), the length of time since the episode of PP was purposefully not set. Pre-determining time-frames for recovery would have imposed the researcher's bias onto the phenomenon.

Participants

A purposive, community sample of eight participants formed this study, as recommended for an IPA doctoral study (Smith et al. 2009). Participants were recruited between August 2015 and January 2016. This number of participants was chosen to provide sufficient cases to explore similarities and differences but not too many that the researcher is in danger of being overwhelmed by the data generated (Turpin et al. 1997). There is also an ethical obligation to responsibly collect the minimal amount of data necessary to address the research question (BPS 2009).

The participants' mean age was 38 years (range: 25-56 years), all identified as 'White British' and reported receipt of a PP diagnosis with their first child. The mean length of time since participant's PP episode was nine years (range: one year to 27 years). Further participant demographic information is presented in Table 3. Pseudonyms were allocated to participants to preserve anonymity.

Table 3

Participant Demographic Information

	1	2	3	4	5	6	7	8
Pseudonym	Phoebe	Teresa	Monica	Cara	Laura	Katie	Jessica	Angie
Age	38	43	25	30	46	30	36	56
Education Employment	College degree Full time	Diploma Part-Time	GCSE Part-Time	Uni. Degree Part-Time	A-Level Part-Time	Doctorate Part-Time	Uni. Degree Part-Time	Uni. Degree Full-Time
No. of children	1	2	1	1	2	1	1	2
Support Received	General inpatient ward Counselling	Community	MBU	MBU	General inpatient ward Community	MBU Therapy	MBU	At home, parental support
Previous Mental Health	N/A	N/A	N/A	Depression	Depression	N/A	N/A	Bipolar. Depression
Years since PP	11	11	1	1	19	2	2	27

Procedure

An invitation to participate (Appendix K) was posted online asking potential participants to contact the researcher if interested in taking part in the study. Those who expressed interest were sent a participant information sheet detailing further information regarding the study including the rationale, potential advantages and disadvantages of taking part (Appendix L). A mutually agreed date and time was then arranged for the interview to be carried out. The face-to-face, semi-structured interview was conducted either in a private room at a community venue close to the participant’s home or at the participant’s home to reduce travelling costs and inconvenience for the participant. Participants were asked to provide signed consent (Appendix M) and further demographic information via questionnaire (Appendix O) at the interview. The interviews were recorded using an audio recording device and guided by a topic schedule (Appendix N). The schedule contained mostly exploratory questions to evoke description and reflection from the participant in line with IPA (Smith et al. 2009). Participants were informed that any identifiable information would be removed from the transcripts. Participants received a debrief sheet (Appendix P) detailing nationwide support services and an opportunity for telephone support from a clinical psychologist from the research team (SH) if participation evoked distress.

Data Analysis

The interviews ranged in length from 61 to 84 minutes. All were transcribed verbatim and analysed by the first author. The guidelines for IPA analysis were followed (Smith et al. 2009). The initial stage involved active engagement and immersion in the data by reading the transcripts several times and listening to the audio-recording alongside the transcript. Initial responses to the participant and transcripts were noted as a means of recognising the researcher’s thoughts and slowing down the summarising process to ensure submersion in the data. The second stage involved line by line coding where the transcripts were divided into ‘chunks’ and summarised using descriptive (content), linguistic (language) and conceptual (interpretation) comments (Appendix R). Analysing these exploratory comments led to the development of emergent themes to produce a concise, interpretative statement which combined descriptive and interpretative understanding. These emergent themes were typed into a chronological list (Appendix S) and eventually clustered to search for connections (Appendix T; Appendix U); this was repeated across cases (Appendix V). Finally, patterns across the entire sample were identified to create higher order concepts which encapsulated the participants' experiences, therefore creating super-ordinate themes and sub-ordinate themes (Appendix W).

Epistemological Position and Reflexivity

IPA is an idiographic approach which aims to capture the subjective sense-making experience of a particular phenomenon (Smith et al. 2009). This understanding of experience is congruent with the researcher's critical realist epistemological position. Critical realism is underpinned by the principle that phenomenon are experienced and shaped by personal beliefs and expectations (Bhaskar 1989; Willig 2001). The participants' understanding of experience is shaped by socio-cultural context and is accessible through a commitment to interpret how the participant's truth has been communicated. The purpose of this study was therefore not designed to identify a singular reality where participant's conceptualisations are categorised as 'correct' or 'incorrect' but to provide a rich and detailed interpretation of mother's subjective experiences.

IPA is an inductive process, uncovering the essence of a particular phenomenon and accessing a participant's personal world as interpreted by the researcher (Smith et al. 1999). Due to this double hermeneutic process with both the participant and researcher attempting to make sense of PP and recovery it is important to be transparent about the researcher's own understanding and biases (Willig 2013). Awareness of the researcher's biases was facilitated by maintaining a research diary.

This study was completed as part of the researcher's role as a Trainee Clinical Psychologist within an NHS setting. The researcher had previously worked with pre-school aged children and in services to improve parental well-being which sparked an interest in postnatal mental health. The first author's main model of interest is Compassion Focused Therapy (Gilbert 2010) which was developed for people experiencing high levels of shame, self-criticism, which are both common during motherhood (Cree 2015). Preconceptions identified in the bracketing process included an assumption that mothers would battle with self-criticism and guilt during recovery. Credibility and validity checks were carried out throughout the research process in supervision and an IPA group. This was to ensure these preconceptions and biases were not imposed on the findings.

Results

The results revealed four super-ordinate themes and 13 sub-ordinate themes (Table 4) which were all present in over half of the sample. An integrative analysis table (Appendix X) contains additional extracts across the sample to illustrate further evidence for the themes.

Table 4

Super-ordinate Themes and Sub-ordinate Themes

Super-ordinate Themes	**Sub-ordinate Themes**	**Theme present in case(s)**
1. Becoming Unrecognisable	a. “Something is not quite right”	All
	b. Wellness as a performance	2, 4, 6, 8
	c. Losing grip of reality	2, 4, 5, 6, 7
	d. The “terrifying and surreal world” of postpartum psychosis	All
2. “It felt like a death sentence”: Mourning Losses	d. Loss of envisaged motherhood and bonding	All
	e. Loss of the liberating side of PP	2, 4, 7, 8
3. “Recovery still goes on”: Recovery as an Ongoing Process	a. Support from others	2, 3, 4, 6, 7, 8
	b. Acknowledgement, acceptance and integration of experience	1, 2, 6, 7
	c. Negotiating space for self	1, 2, 5, 6, 7, 8
	d. Managing stumbling blocks	2, 6, 7, 8
4. Post-traumatic Growth	a. Positive life changes	2, 3, 6, 7
	b. Impact on relationships	2, 4, 6, 8
	c. Using experience to facilitate change	2, 3, 4, 6, 8

1. Becoming Unrecognisable

1a. "Something is not quite right" (Cara)

All participants referred to the concept of being "not quite right" (Monica) or that "something was wrong" (Cara) to describe an experience of losing sight of themselves and acting out of character. Difficulties articulating specific information about what felt out of place reflected the unusualness of the PP experience, an experience like no other. This feeling was reinforced as PP struck when the participants gave birth to their first child and therefore the women had no frame of reference of what motherhood would entail.

> *"Something was not quite right with me… I didn't have a clue what I was doing with the baby… so I think I started to realise something was wrong but I didn't know what was wrong" (Cara)*

The sub-ordinate theme of "something is not right" reveals mothers' abilities to intrinsically recognise the life changing transition endured and that something felt amiss. Phoebe makes a connection between the lack of awareness regarding PP and draws a direct comparison with knowledge about postnatal depression. This lack of awareness led to a confused understanding of early symptoms of PP and frustration that it was not identified early on.

> *"I knew there was something wrong you know, but there's not much awareness of it, it's not like postnatal depression" (Phoebe)*

1b. Wellness as a performance

The fear of being judged as inadequate or incompetent as a mother troubled the participants. Over half of the participants attempted to hide their distress and described various functions of demonstrating wellness including avoiding separation from the child, avoidance of a diagnosis and mental health services, and being viewed as "normal" (Teresa). Participants spoke about their efforts to convince professionals, peers and themselves that they were coping well and that interventions were not necessary.

> *"I just wanted to kind of show I could be well, I could show myself more than anyone else really, a few weeks on the medication I took myself*

> *off, I came off it without speaking to the psychiatrist… I just wanted to convince them and myself that I was normal" (Teresa)*

For Katie, fear of damage to her professional career and fear of being given a mental health diagnosis prevented disclosure of her inner despair. She spoke of putting on a persuasive show like an actress. She also shared the pressure of communicating the perception of a well mother who was able to "shower" and sit "up right".

> *"I thought no, I don't want to be involved with mental health services, I don't want to be involved with psychiatry… I need to avoid that at all costs so the next day I needed to convince [community midwife] that I'm fine, so I got up, had a shower and I sat up right in the chair talking really brightly telling her I was fine" (Katie)*

Some mothers were unable to present wellness and avoided interactions with professionals and other mothers at all costs. Angie emphasised that she felt like a "freak" when compared to other mothers and she was unable to relate to others due to her experience. Both Katie's and Angie's narratives revealed concerns about others' perceptions of their mothering competence. Both used derogative words such as "psycho" and "freak" suggesting there is a judgemental and condemning perception of perinatal mental health difficulties.

> "I couldn't take [son] to the weekly clinic, I couldn't face other women I just felt like a complete and utter *freak*… I hadn't had a normal experience" (Angie)

1c. "Losing grip of reality" (Katie)

Participants often reflected on a period of heightened confusion and losing control. Despite desperate attempts to retain their sense of self, coping with reality became overwhelming and arduous. The lack of physical and psychological recovery space for mothers meant that women had little time to process their birthing experiences even if traumatic. Katie, who faced her own mortality following childbirth, described being thrown into motherhood and at a dangerous cost.

> *"…then I realised I was really unwell and I just felt like I was right on the edge of losing my grip of reality, it was almost like I was holding on with my fingernails" (Katie)*

For all participants, a state of confusion was partially attributed by severe sleep deprivation and exhaustion. Cara expressed a concern that she would be unable to return to the person she was. She spoke of herself as being irreversibly damaged with little awareness and believed that recovery impossible.

> *"...it got to a point where I thought I had gone completely mad, I thought I was never going to be ok again, I thought I had completely lost the plot, my brain had basically snapped, broken, I didn't have a clue what had happened but I knew I was really really mentally unwell" (Cara)*

Mothers found that the world around them became unrecognisable as they encountered unusual perceptual experiences. Everything that the mothers had known or understood was shattered, leading the mothers to question normality. The self and the environment started to become unfamiliar and unrecognisable, and mothers' attempts to grasp onto reality became ineffective.

> *"…there were all these strange things going on that weren't normal like things were speeded up or slowed down, just my whole (pause) brain chemistry seemed to have just (pause) gone to pot… and it was like my body had shut down and I cannot look after this baby… you feel like you're on another planet" (Laura)*

1d. The "terrifying and surreal world" of postpartum psychosis (Teresa)

Women collectively described fear and threat infiltrating their world. There were concerns about their individual safety and the safety of the child. The source of the threat varied across the participants. Some felt that professionals were untrustworthy and aimed to cause harm, while others perceived themselves as the source of danger. Both the external world and internal world became origins of threat.

> *"I had a fear of everything, I was scared that I was going to die and nothing was normal and I feared everything… it was extraordinary fear, racing fear, didn't trust anyone, didn't want to be there, didn't want to*

> *take their pills, I didn’t want to. I just had this massive irrational fear that they [staff] were going to kill me. I was very, very, very scared” (Monica)*

> *“I’m not safe, you’re not safe, nothing in the world is safe… I’m going to kill you… I’m going to kill my baby (deep breath) I could hear myself saying it and I had no idea where it came from, I just know that I didn’t feel safe in any way and I didn’t feel safe to be around other people, like I was dangerous” (Katie)*

As the mothers’ beliefs about being the source of danger evolved, some developed a sense of increased responsibility for the well-being and the ill fate of others. Phoebe felt compelled to act upon internal commands demanding she sacrifice herself or risk harm occurring to her family. This could be viewed as a way to rationalise or justify her suicidal ideation by convincing herself that others are happier without her and committing suicide was for the benefit of others, i.e. altruistic suicide (Goldney and Schoildann 2010).

> *“I was hearing my own voice but it was heightened, it was like a bell going off and once it had gone off it was in my mind that I had to do something. It was me commanding myself to do things and if I didn’t do these things then it would mean I was selfish and it would cause harm to others. So if I didn’t kill myself and jump out of the window then my family would die. I felt compelled to do them” (Phoebe)*

2. “It felt like a death sentence”: Mourning Losses (Katie)

2a. Loss of envisaged motherhood and bonding

All of the women described a perceived loss in their predicted role as a mother and the love envisaged for the baby as they moved towards recovery. They described PP as a barrier that prevented optimum parenting and frustration when reality did not meet the expectation that they would excel within this role.

> *“I felt like I was being an inadequate mother, I felt like I wasn’t… fulfilling my role properly… I felt like I wasn’t being a good Mum, like for months and months… motherhood was the thing I could be good at so… when I wasn’t as good as I wanted to be because of the illness it hit me really hard” (Cara)*

Mothers expressed feelings of guilt and self-blame as they perceived themselves to have disappointed the mother role and that the PP overshadowed the child.

> *“It’s broke my heart because I feel like I’ve missed out on the beginning of her little life because I was too concerned with what was going on with me that I didn’t really take any notice of her, my little baby” (Monica)*

Four of the women felt mixed emotions towards the child; there was the presence of deep love but this was conflicted against resentment towards the child for having to endure PP.

> *“I had some issues with the fact obviously my whole life had been turned upside down so there was a little bit of... maybe blame towards him and like I wish I hadn’t had him and it hadn’t happened” (Cara)*

Monica reflected on the difficulties of being expected to fulfil the parenting position when feeling like the child is to blame for PP occurring. As a consequence there was a need for distance between the mother and baby, Monica in particular described entire avoidance of her child as the resentment became intolerable.

> *“I remember at points, I blamed her everything that had happened, I blamed her for the psychosis, I felt that she must have been the fault and I remember at times trying to get rid of her. I said I didn’t want her anymore, I didn’t want anything to do with her” (Monica)*

2b. Loss of the liberating side of PP

As women progressed through their recovery they reflected on mourning the loss of the beneficial and freeing side of PP. Amongst distress and despair women also experienced a world without restrictions and a new found confidence. In the context of motherhood the mania had benefits as it enabled women to be able to complete tasks and feel powerful, like a “performing Supermum” (Cara). However, this view was not shared with family members as they struggled to understand the rapid mood changes.

> *“Everything was wonderful, I felt that I was doing brilliantly, I was able to do my work, my chores, physically care for [child], I had an unbelievable*

> *amount of energy and brain power (pause) until I broke down… For the first time in my life I was confident and had self-belief, life was fantastic but for people around me it was a living nightmare, to lose all that adrenaline was painful" (Jessica)*

The opportunity to feel more connected and similar to others was an adaptive and appealing prospect which reinforced the attractive side of PP. It provided a means to cope with life and adversity.

> *"I felt quite flat, fed up and struggling and life was hard and I missed the high, euphoric feeling I had in the past where I actually felt confident and that's how everybody felt, that was normal, what I was feeling most of the time wasn't normal" (Angie)*

3. "Recovery still goes on": Recovery as an Ongoing Process (Teresa)

3a. Support from others

Six participants spoke about the impact of others support including professionals, family and peers. Accessing support was important and took various forms at different stages. Specialist perinatal support was important following disappointments with generic services. Specialist services provided detailed information and promoted hope that recovery was possible.

> *"Finally I got to see the perinatal psychiatrist, such relief when she told me what postpartum psychosis was, a huge relief to know this was a thing that sort of happened to women and to know that people recover from" (Teresa)*

All participants admitted to a MBU expressed gratitude. Embracing motherhood in an environment where other mothers were also having mental health difficulties was a normalising experience. Sharing some of the overwhelming responsibility of becoming a mother and under the supervision of supportive staff was a relief. However, trust was difficult to build initially but eventually feeling safe facilitated confidence in professionals.

> *"I really think going to the MBU was a massive thing in my recovery…there was things like (pause) the opportunity to be normal, to be a normal Mum" (Cara)*

Four women were appreciative of family support as they trusted their loved ones to have their best interests at heart during decision making and family members helped participants restore their sense of self as they grew confidence in their parenting role.

> *"The biggest help I have had is my family, without my family support I don't think I would be me at the moment" (Monica)*

3b. Acknowledgement, acceptance and integration of experience

Recovery was understood as identifying and recognising difficulties that occurred and acknowledging the trauma. However, assimilation of experience was feared, as a life beyond PP was unknown and uncertain. After suppression and minimisation of experience was unsuccessful, mothers were encouraged to "make space" (Katie) for their PP experience. All mothers felt able to function on a day-to-day basis but recognised that recovery has no definitive end point.

> *"I think recovery is to be totally at peace with the experience, with myself and accepting who I am and that is just part of something I have been through" (Teresa)*

Jessica made attempts to suppress memories, feelings of intolerable anxiety and battled against negative emotions. She recognised that with greater openness and permission to experience emotions her anxiety had reduced in intensity.

> *"I think recovery is about coming to terms with what has happened and dealing with some of the memories, it's a lifelong thing, I was trying to deny myself feeling anxiety, what you were actually supposed to do was know the feeling, allow it and it goes away pretty much" (Jessica)*

3c. Negotiating space for self

A number of tangible idiosyncratic markers of recovery were identified such as discharge from hospital, coping without medication and having another child. One striking facilitator of recovery was about making time for the self that was shared across six participants. Women felt that recognising their worth and value in a multitude of areas demonstrated that they could revisit hobbies that developed their identity prior to becoming a mother.

> *"Gradually my time has become my own again and I have started to re-explore things I used to" (Jessica)*

For some mothers, regaining the self was understood by going back to 'normality' as it allowed the mothers to recognise their own needs during the stresses of motherhood and demonstrated that PP no longer had a destructive and harmful power over them.

> *"It was about getting back to normal and spending time doing something I enjoyed and kindof allowing a bit of time for me, to recover or recharge or whatever" (Teresa)*

Some mothers spoke about returning to work as a marker of recovery as it gave a sense of accomplishment and achievement that was more tangible than succeeding at motherhood.

> *"I would say certainly working…definitely keeping your mind occupied is a good thing, you've got to know you're an individual as well as a Mum and that's important" (Laura)*

3d. Managing stumbling blocks

Mothers understood recovery as non-linear and recognised that it would be interspersed with achievements and setbacks. Most felt able to adapt to new challenges and were better prepared if faced with problems.

> *"Of course there will be challenges and set-backs but I feel better armed to deal with these in a sensible way" (Jessica)*

Mothers felt they had become more grounded and realistic following PP. They recognised the severity of PP and the lasting impact on their inner strength and resilience and therefore were more able to cope with stumbling blocks along their road to recovery.

> *"I'm not sure recovery has an end point… it feels like something that is always going to be ongoing, there's new stuff that is going all the time about how you assimilate your personal and professional role" (Katie)*

Women expressed recovery as a lifelong journey, even for Angie who experienced PP 27 years ago who identified unanswered questions in her narrative.

> *"You want to try and make sense of it, why did this happen to me, is it my fault, all of this type of stuff I'm still struggling with quite a lot of these issues" (Angie)*

4. Post-traumatic Growth

4a. Positive life changes

Most participants expressed a positive change in response to the trauma of experiencing PP. The extreme nature of PP challenged their beliefs systems and internal model of the world. Following the life changing event, re-engagement with the world was demanding and effortful but rebuilding the self gave a new perspective on life.

> *"To be honest it has completely changed me. I was very molly-coddled and I was brought up to be 'nothing can go wrong' and 'it's a beautiful world' but after I lost my dad and had postpartum psychosis I now have a different image of the world and although it is hard to come to terms with, I am a much stronger person" (Monica)*

Participants had enhanced awareness of their inner resilience and found they no longer took life for granted. Time was spent evaluating individual priorities and mothers became more appreciative of loved ones. Participants felt were more able to cope with uncertainty and developed confidence in managing adversity.

> *"I also realise how unimportant material things are, how unimportant looks are as long as you are content in yourself and truly happy in yourself. I have no doubt life will throw horrible things in my way but after going through this I'm that bit stronger and able to deal with things" (Jessica)*

4b. Impact on relationships

Women found solace in developing meaningful relationships with others and found existing relationships were deepened. Participants reflected on the relationships that were strengthened due to the intense PP experience.

> *"It made us closer basically, so… [husband] and I are even closer, we've always been very close… but he… now I think sees the value of talking more… it's just made us stronger as a couple to know we can go through something as drastic as that" (Cara)*

Developing relationships with other mothers who did not experience PP was difficult. Despite attempts to engage at toddler groups, they were unable to talk about the usual mothering experiences because their stories were different. Mothers were left feeling ashamed, inadequate and isolated. It is therefore not surprising that women found comfort in connecting with other mothers who had experienced PP. Although the presentation of PP is individual and variable across cases, most women expressed that becoming uncensored and modelling honesty was a validating experience.

> *"You have a unique connection being able to talk to other women who had been through the same and had the same illness" (Teresa)*

A strong alliance, mutual respect and understanding were instantly formed which facilitated the later stages of recovery.

> *"The feeling of meeting somebody else who has had the same thing and to be able to tell your story and be accepted and not judged yeah it's just amazing, absolutely amazing, it's just you feel a bond… I just feel I found my tribe, I feel more drawn to these women, it's nice to be with women who understand you" (Angie)*

4c. Using experience to facilitate change

Mothers developed a new sense of meaning and were active in using their experience to facilitate change, influence services and to promote awareness of PP. This provided them with a sense of purpose and satisfaction many calling this as "the final step in recovery" (Teresa). Facilitating change was rewarding and empowering for women and provided self-worth.

> *"You've got to have a voice… I need to, I want to say this is what happened to me… I think it probably just makes me feel better in myself I think and that I've got some sort of purpose (laughs)… you know it's a part of me" (Laura)*

> *"It's really nice, you just realise how much you've got to give and how much you've got to offer, it's very rewarding" (Angie)*

The later stages of recovery involved viewing PP as an asset and a key strength particularly if driven to help others.

> *"Now I have been through it and been at the other end, I feel like I want to help others and I want to help professionals diagnose it and recognise it because obviously it is very rare and it is very hard to pick up on but there are signs and it is about picking it up as soon as you can" (Monica)*

Discussion

The aim of this qualitative study was to explore the experiences of PP and recovery for mothers. A purposive sample of eight mothers were interviewed and four super-ordinate themes were identified: 1) 'becoming unrecognisable'; 2) 'mourning losses'; 3) 'recovery as an on-going process' and 4) 'post-traumatic growth'. This is a growing research area (Engqvist and Nilsson 2013; Glover et al. 2014; Heron et al. 2012; McGrath et al. 2013; Robertson and Lyons 2003) however, this is the first known study to explore PP and the recovery process from the mother's perspective using IPA. This study extends existing knowledge of PP and McGrath et al.'s (2013) model of recovery as it permits a more interpretive understanding of mothers' experiences of PP as well as delving into the idiographic detail of recovery (Smith et al. 2009). Mothers described being pervaded by terror and fear as others became untrustworthy and an unfamiliar, confusing reality surrounded them. Early warning signs included feeling out of depth, feelings of inadequacy, resentment and/or estrangement from the infant. This is consistent with previous research whereby women felt consumed by an overwhelming fear during the early days of PP (Engqvist and Nilsson 2013; Engqvist et al. 2011). These experiences have been recognised as 'red flags' for professionals to act upon in a recent UK report (Mothers and babies: reducing risk through audits and confidential enquiries across the UK [MBRRACE-UK], 2015). Due to the rapid deterioration of mental health in PP early recognition of warning signs is crucial to assess timely specialist support.

In the current study, participants described feelings of disappointment due to an inability to connect to motherhood in a way it was envisaged. This is similar to universal parenting experiences (Choi et al. 2005) and is in accordance with previous PP research where participants felt that they had "missed out on motherhood" (Robertson and Lyons 2003, p. 420). Conflicting emotions towards the baby were also identified in this study. Some participants reported a disinterest in the baby but also intense resentment as the baby precipitated the trauma and despair of PP. The feeling of blaming the child starkly challenges the dominant Western ideology of motherhood (Choi et al. 2005). Mothers found this distressing and reflected that their experiences did not match stereotypical ideals or their envisaged perceptions of motherhood. Although a novel finding for the PP recovery literature, this is consistent with other postnatal clinical samples such as postnatal post-traumatic stress (Ayers et al. 2006) and postnatal depression (Kumar 1997).

Another unique finding in this study was ‘mourning the liberating side of PP’. Mothers reflected on the usefulness and exhilarating side of euphoria and mania. Experiencing high levels of energy and feeling like a *“Supermum”* (Cara) had utility and function in the context of motherhood. This experience appeared to be exacerbated if the mother struggled with confidence and self-esteem prior to childbirth. Mothers described a sense of loss when the euphoria faded particularly as this was followed by an enduring depression. The liberating side of PP provided a world with no restrictions and mothers experienced a new emancipated perspective on life. This is similar to the literature on positive traits of bipolar disorder with a number of self-reported advantages of ‘highs’ including increased problem-solving skills, greater processing speed, excess energy and productivity (Galvez et al. 2011; Simonson 2007). However, mania can often cause interpersonal problems and an over-estimation of competence (Michalak et al. 2007). This is similar to Teresa’s PP narrative; she described a “free world” where she was able spend money and book holidays without worrying about the consequences and no longer felt the need to deprive herself. However, as the ‘high’ phase disintegrated she became consumed by guilt as the impulsive spending habits had produced overwhelming financial debt.

These experiences are consistent with the concept of ‘disenfranchised grief’ which is defined as losses that cannot be publically mourned or are not acknowledged within society (Doka 2002). These profound losses usually occur during a time of transition (i.e. motherhood) and therefore could be viewed as incongruent with societal perceptions of motherhood as a time of intense joy and satisfaction. This emphasises the need for mothers to have their grief recognised and acknowledged in a non-stigmatising environment (Attig 2004).

Post-traumatic growth refers to positive changes that occur as a result of adverse life events (Tedeschi and Calhoun, 2014). Participants' identities were altered dramatically following the distressing nature of PP and they described positive changes. Examples include increased confidence for public speaking and campaigning for improved mental health support. Mothers' belief systems had been shattered by the trauma and rebuilt with more positive evaluations of self and others. Changing the meaning of the traumatic PP experience to facilitate change was imperative to give the women purpose. Most participants became experts by experience and were willing to share personal journeys to benefit other women who had experienced PP. Consistent with the post-traumatic growth literature, health care professionals can help identify ways in which women have grown or changed over and above their previous level of functioning (Tedeschi and Calhoun 2014). However, it is recognised that the recruitment strategy for this study and accompanying self-selection bias (Coolican 2004) may have influenced the findings by attracting people who feel more able to reflect on their recovery due to engaging in positive, campaigning activities.

Consistent with the psychosis recovery literature, certain events overwhelm internal resources and exceed typical coping strategies, particularly when there is a perceived threat to life (Dillon et al. 2012). This experience was apparent in all participants' stories as mothers reflected on feeling unsafe and paralysed by fear during PP. Based on a trauma informed approach, symptoms are better understood as strategies for survival when mothers feel such terror. However, when the threat is no longer prevalent, these strategies may lose their utility (Herman 2015). Clinical implications of working within a trauma informed approach for PP are presented below.

Clinical Implications

Firstly, the priority is to focus on safety, stabilisation and emotional regulation to facilitate the mother's capacity to function. The hyper-vigilance and monopolisation of the mother’s attention towards threat in the environment is caused by overwhelming fear. Strategies to promote safety include the development of trust, consistency and providing a containing environment (Herman 2015; Dillon et al. 2012). The participants in the current study highlighted the safe haven that the MBU provided which facilitated the stabilisation period. However, stability took time to establish due to the pervasive fear and confusion. The second stage of recovery is based on empowerment, acknowledgement and reconstruction of the trauma (consistent with the sub-ordinate theme ‘acknowledgement, acceptance and integration’). This involves remembrance of the individual narrative of PP, the mother’s response, working through grief (i.e. loss of envisaged motherhood) and re-experiencing the memories within a containing therapeutic relationship to change the meaning of the experience. Stage three involves deeper connection with others and engagement with meaningful activities (Herman 2015) which is commensurate with the super-ordinate theme of ‘post-traumatic growth’. This study provides support for the three staged model with a particular emphasis on *using experiences to facilitate change* to promote the later phases of recovery. Not only did the mothers experience a shift in engagement with relationships and activities for themselves, the priority shifted to campaigning for improved mental health care and fostering hope for *others*.

Consistent with McGrath et al.’s (2013) model, some mothers used the PP experience positively to find a sense of purpose. Community outreach services could discuss opportunities to develop therapeutic groups facilitated by peer supporters (Naylor et al. 2016). All women experienced guilt, shame and some mothers were embarrassed by their behaviour and thoughts during PP. Therefore implementing a therapeutic group facilitated by EbEs would reduce feelings of isolation, emphasise shared experiences and provide a sense of purpose for mothers. As demonstrated in the psychosis literature, these groups provide hope, enhanced social networks and foster the belief that recovery is possible (Repper and Carter 2011). It also provides benefits for EbEs by working in a supportive context where personal experience is viewed as an asset. This increases self-confidence, acceptance and continued recovery (Repper and Carter 2011).

The women in this study shared concerns about disconnection and detachment from the infant and loss of confidence in parenting abilities following PP. Therefore, strength based interventions are necessary to restore confidence and autonomy (Cree 2015). Interventions such as Video Interactive Guidance would be ideal to promote maternal sensitivity and positive attunement between the mother and infant through the use of video feedback, observation and modelling (Vik and Hafting 2006). The aim would be to develop mother's parenting skills and improve parent-infant interaction (Cree, 2015). This intervention has shown to be effective in postnatal depression (Vik et al., 2006) and although video feedback interventions are provided in some MBUs, it is not consistently offered across the UK (Wan et al. 2008)[2].

As the women in this study voiced concerns about needing to appear well, the most important clinical implication is for professionals to remain attentive and vigilant when assessing mothers for PP. The sub-ordinate theme of 'wellness as a performance' demonstrates that some mothers will attempt to mask and conceal difficulties to avoid stigma, diagnosis and separation from baby. Reading between the lines to try and understand mothers' true feelings requires a high level of clinical competence to develop a positive working alliance with the mother and work systemically with families. Questions regarding suicidal ideation, the presence of unwanted thoughts (Chotai et al. 2016) and the transition to motherhood are necessary to broach sensitively to encourage mothers to talk about concerns, particularly if the reality of motherhood does not meet expectations.

Strengths and Validity

Evidence adhering to Yardley's (2000) core principles for assessing the validity of qualitative research is presented to demonstrate quality and credibility.

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[2] See Appendix Y for a visual map of current UK MBUs

Sensitivity to context. Adherence to this principle was demonstrated by acknowledging the current socio-cultural climate i.e. increase in funding and growing media attention. The researcher recruited participants across the UK to offer a fairer opportunity to participate in the research and remaining open to differing perspectives offered by participants.

Commitment and rigour. Extracts of all eight transcripts were discussed and verified in supervision and in an IPA group to cross reference themes and ensure justifiable interpretations from the data.

Transparency and coherence. Transparency was shown by using photography and through a detailed account of the research process. Extracts are presented from all participants to demonstrate depth and breadth of analysis.

Impact and importance. The findings will contribute to training for student midwives to increase awareness of PP and long-term implications of PP. Perinatal mental health training improves student midwives confidence in engaging in a dialogue about mental health with the mother and identifying mental health difficulties i.e. PP (Higgins et al. 2016; Posmontier 2010).

Limitations and Future Research

The researcher's aimed to provide an accessible study available to a broad community sample by travelling across the UK to conduct interviews. However, all participants were White British and from higher socio-economic status groups (Table 3). Although this adds to the homogeneity of the sample as recommended for IPA research (Smith et al. 2009) cross cultural conceptualisations of PP and recovery is warranted to assess for similarities and difference, and to represent the true demographic of women living in the UK.

A further limitation was the online recruitment strategy. This may have limited opportunities to include women without computer or internet access. However, this was deemed as the most cost effective and time efficient method to access a wide number of potential participants. Additionally, as the study used a community sample, participants may have been further along the recovery process in comparison to mothers who have recently been discharged from an MBU. It is hypothesised that the sub-ordinate theme ‘using experience to facilitate change’ may not be so prevalent earlier on in recovery. Women in this study were interviewed at one time point. Future research would benefit from exploring the changeable meaning of recovery at different stages to assess how recovery is constructed and re-constructed over time.

Relevance to Clinical Psychology

Psychological formulations can facilitate the sense-making process for women (BPS 2011; Johnstone and Dallos 2013), an ongoing need which was illuminated in this study. However, the main challenge for psychologists is to engage with the current dominant biomedical etiology of PP and promote a detailed assessment of psychosocial factors in the development and maintenance of PP (Kennedy and Tripodi 2014). Psychological formulations informed by social constructionism are based on the premise that there can be multiple realities to one phenomenon developed through engagement with the social environment (BPS 2011). In other words, there are different ways mothers perceive, understand and attribute meaning to the PP experience within their social context. Therefore, assessments should include an in-depth understanding of not only the biological factors, but the psychosocial precipitating, perpetuating and protective factors that contribute to and alleviate the distress associated with PP (Kennedy and Tripodi 2014). In addition to promoting detailed assessments, clinical psychologists can facilitate staff training, supervision and even engage with the media to ensure the psychological perspective is not overlooked (Byron 2005).

Recovery: A Political Agenda?

Although recovery is an idiosyncratic, personal journey it occurs within a social and political context (Perkins 2015). In the current political context and austerity, where there are service cuts and welfare benefits are being restricted, the meaning behind recovery within mental health policies must be questioned (Beresford 2015). The rhetoric that falls alongside the term recovery is one that suggests that when people are ‘recovered’ services can withdraw (Beresford 2015). This conflicts with the findings of this study as recovery was interpreted as an ongoing process and therefore seeking support may be recurring (i.e. following subsequent childbirths).

Conclusion

This qualitative study explored how women made sense of PP and recovery. Semi-structured interviews were conducted with a community sample of eight mothers who self-identified as ‘recovered’ from PP. Consistent with existing literature, recovery was expressed as the rebuilding of a satisfying life, maintaining hope through challenges, having a sense of personal agency and re-engagement with activities to boost self-confidence (Engqvist and Nilsson 2013; Heron et al. 2012; McGrath et al. 2013; Robertson and Lyons 2003). Supportive networks alleviated postnatal distress and support came from a variety of sources including professionals, family and peers. Initial strategies of ignoring the experience were unsuccessful and mothers felt true recovery was facilitated when the PP was recognised and acknowledged as it allowed them to express grief and move forward.

Statement of Human Rights

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

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Paper Three: Commentary and Reflective Review

‘Embracing New Transitions’

This paper is not intended for publication and therefore a standard APA (6th edition) format was adopted.

Word Count: 1,764

Abstract

The purpose of this paper is to provide personal and professional reflections of undertaking a doctoral level research thesis. Material for this paper has been supported by entries from the researcher’s reflective journal maintained throughout the training. Clinical implications and ethical issues are also highlighted alongside personal learning points.

Embracing New Transitions

A major transition is known as a defining moment where one's life takes a new direction requiring re-orientation and adaptation (Salmela-Aro, Nurmi, Saisto, & Halmesmäki, 2001). As this thesis was focused on the transition towards motherhood it seemed fitting to structure this paper to mirror a significant transition in the researcher's life; completing a research thesis and transitioning to become a clinical psychologist.

Comparable to the stages of becoming a parent and as a dynamic and unfolding process, completing a thesis is characterised by successive steps which pose challenges, demands but also opportunities (Salmela-Aro et al., 2002). Such phases during the transition to motherhood include: planning children, pregnancy, delivering the baby and caring for the child (Gloger-Tippelt, 1983). Therefore, this paper will be presented in such a stage-specific manner of parenthood but likened to the personal process of completing the research thesis (Figure 1).

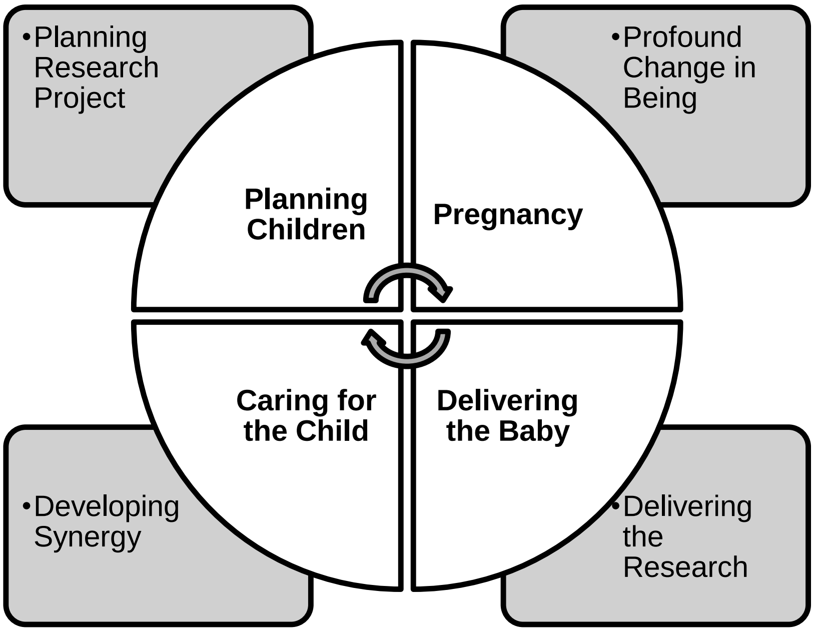

Figure 1. Mirrored process of motherhood and completing the thesis.

Planning Children | Planning the Research Topic

In response to a significant life transition such as parenthood (or conducting research) the act of information-seeking plays an important role prior to the inception of the transition (Deutsch, Ruble, Fleming, Brooks-Gunn, & Stangor, 1988). I spent a substantial amount of time researching gaps in postnatal mental health research. I was re-inspired by a children's early intervention service which demonstrated a genuine desire to improve parental well-being. Therapeutic work with mothers was centered on challenging perceived inadequacy, self-criticism and shame. Inadequacy appeared to be perpetuated by Western constructed ideologies of motherhood as being effortless, a period of instinctive contentment and excitement (Lazarus & Rossouw, 2015).

Motherhood is a transition viewed as traumatic, isolating, exhausting and boring (Aiken, 2000; Chesler, 1998; Figes, 1998; Parker, 1995) but also mixed with deep joy and love (Hartley, 2005). I developed an interest in gaining a deeper understanding of the personal meaning of becoming a mother in the context of postnatal distress. Of particular interest was the assimilation of such a range of emotions and feelings towards an infant, particularly when the experience is incongruent with dominant discourses of motherhood.

Pregnancy | Profound Change in Being

Pregnancy is a time of “identity fuzziness” (Smith, Flowers, & Larkin, 2009, p. 171) but offers an important opportunity to prepare oneself as a mother. Pregnancy is a transformative process whereby women begin to identify themselves in relation to the child they carry (Bergum, 1989). My transformative process was ongoing and my confidence with conducting research evolved through the interviews with participants. I was struck by the level of emotional distress in women's stories. It was a privilege to listen to the women's stories as they reflected on their deepest, darkest fears and being trapped in a frightening world. However, interviewing women when they felt they were recovered or in the recovery process felt like a world away from the person they were describing in their narratives. There was a stark disparity between the descriptions of the person admitted to a mother and baby unit (MBU), unable to take care of their own needs and struggled to function on a day to day basis and the participant sat in front of me. To facilitate my understanding I visited the local MBU to help me get a sense of mothers who are acutely unable to manage independently and the early presentation of postpartum psychosis (PP). This prompted me to think about acting ‘out of character’ and the terror of living in an ‘unreal world’ (Engqvist & Nilsson, 2013), a theme shared across participants. The MBU visit was encouraging as the staff team recognised the role of psychology to support with recovery journeys and help facilitate mother-infant bonding.

During the research process there were a number of emotional changes; doubt, defeatism and stress. These emotions are common during significant transitions (Smith, 1999). I developed an anxious-ambivalent attachment to my thesis (Ainsworth, Blehar, Waters, & Wall, 1978) similar to a child’s response to inconsistent and unpredictable parenting; my role was as the confused infant, unable to form a trusting relationship. I questioned my ability to write coherently and to an appropriate academic level. I was preoccupied with the thought that my performance and ability to write an important piece of work would not meet expected standards. I therefore became avoidant and resented the work as it took me away from social events and relationships. This created feelings of guilt as I was unable to meet deadlines and goals I had set. I explored the unhelpful patterns of self-criticism and feelings of inadequacy in supervision and how these experiences mirrored those in motherhood (Hartley, 2005).

The literature review process was a source of frustration; I persevered through multiple topic changes due to fear of repetition in a growing research area. I grossly underestimated the emotional weight of researching mothers’ experiences of coping with infant harming thoughts, the details of which challenged my perceptions of motherhood. However, I noticed a stark change after a moving interview with ‘Phoebe’. As I listened to her emotional story of despair and anguish, I felt a surge of empathy as she described an attempt to take her life by jumping out of the window whilst holding her child.

The interview gave an insight into the desperation mothers feel when they lose hope and the anxious need to escape the intolerable emotional pain.

Delivering the Baby | Delivering the Research

For mothers, there is increased anxiety as the due date approaches, it represents a landmark experience and there is anticipation about the end creation (Delmore-Ko, Pancer, Husberger, & Pratt, 2000). This experience reminded me of an entry made in my research journal:

> *"I am unsure what consumed my free time prior to embarking on this journey and I'm nervously anticipating other people's perception of my thesis ('my baby')."*

Similar to new mothers, there is anxiety and joy when presenting 'my baby' to the wider world. Left feeling exhausted and drained, the journey does not end here. The responsibility that comes following delivery of the research requires consideration, particularly in regards to dissemination, publication and influencing clinical practice.

Caring for the Child | Developing Synergy

Following childbirth, the baby 'fills the parent's vision' (Hartley, 2005) the mother finds herself preoccupied with thoughts of the child which dampens opportunities to enjoy social situations and increases feelings of resentment (Hartley, 2005). This is a similar experience to enduring the final stages of writing the thesis. Feelings of guilt hampered social opportunities and there was a sense of bitterness towards the work due to my diminished freedom.

Commencing motherhood evokes feelings of vulnerability and dependency as interdependence between the mother and the baby unit is formed (Coates, Ayers, & de Visser, 2014). Likewise, I formed a synergy and interdependence with my thesis. I rely on the success of my thesis to progress through to qualification and the thesis would remain incomplete without me.

As I come to the end of training, a genuine sense of pride comes with the development of my thesis. It coincides with a pivotal period for postnatal mental health including increased funding, publicity and awareness. PP was a main story line on a popular soap opera (Eastenders), a BBC One television documentary ‘My Baby, Psychosis and Me’ (Appendix Z) and the UK government pledged £290 million into maternal mental health (Department of Health, 2016). Of course, I am eager to learn the government's plans to utilise this investment.

Ethical Issues

It was originally stipulated that women must not be experiencing psychotic symptoms to be eligible to participate due to concerns regarding capacity to consent. Following supervision, I recognised that by excluding women who are still currently experiencing psychotic symptoms it implies that being asymptomatic is synonymous with recovery. However, this may not be the case and the study design would have therefore imposed this on the interview responses. Some women may be asymptomatic but not identify with being ‘recovered’ and vice versa. This is further supported by psychosis research which suggests recovery is multi-faceted (Tan, Gould, Combes, & Lehmann, 2014). With the previous exclusion criteria, the research would have excluded women who still experience PP symptoms but find different ways of coping with these. Part of the recovery may be about acceptance and management of symptoms rather than elimination.

According to Koivisto, Janhonen, Latvala and Vaisanen (2001) capacity to consent is the main question for consideration when the participants are recovering from psychosis, because the level of distress may limit the ability to comprehend research involvement. Conversely, other research has found that psychosis had no detrimental effect on decision making for research purposes (Kaup, Dunn, Saks, Jeste, & Palmer, 2001). Given this contradiction, the advantages and risks of removing the exclusion criteria of women still experiencing psychotic symptoms were considered.

The advantage of including women who may still experience PP symptoms is that the study would include a diverse range of women across the spectrum of the recovery process. The aim of the research was to provide knowledge about the continuum of recovery following PP. With the removal of the original criteria there is less bias placed upon the findings as the implied message that recovery is a reflection of symptom reduction is eliminated.

The potential disadvantage is the risk that experiencing PP symptoms may impair the participant's thought processes and understanding of research intentions, therefore affecting informed consent. In accordance with the Mental Capacity Act (MCA: Department of Health, 2005) capacity of the participant was assumed, however, if there was a legitimate reason to doubt capacity an assessment adhering to the five principles of the MCA (2005) was agreed to be conducted prior to the interview. Fortunately this was not necessary in the presented study.

Conclusion

Likewise to motherhood, there has been a period of “profound recognition and discovery” (Hartley, 2005, p. 127) on a personal and professional level. There have been a number of learning points throughout this journey. Most importantly is that PP can be viewed as a functional way to escape when reality is perceived as too overwhelming. This reinforced the importance of providing safety, containment and space for physical and psychological recovery following childbirth. Professionals must focus on co-creating a shared meaning and exploring the sometimes ‘confusing fog of postnatal distress’ as it will promote deeper mutual understandings and foster hope for recovery.

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Appendix A: Author Guidelines for the Infant Mental Health Journal

NIH Public Access Mandate

For those interested in the Wiley-Blackwell policy on the NIH Public Access Mandate, please visit our policy statement

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Reflecting the interdisciplinary nature of the field, its international focus, and its commitment to clinical science, the IMHJ publishes research articles, literature reviews, program descriptions/evaluations, clinical studies, and book reviews on infant social–emotional development, caregiver–infant interactions, and contextual and cultural influences on infant and family development. The Journal is organized into three sections: Research, Clinical Perspectives, and Book Reviews. Research focuses on empirical research. Clinical Perspectives allows for more diversity in types of submissions and is designed to advance infant mental health practice and scholarship. Requests for book reviews should be sent by the author or publisher to the Editor In Chief. Please do not send a copy of the book until the request is approved.

The Journal welcomes a broad perspective and scope of inquiry in infant mental health and has an interdisciplinary and international group of associate editors, consulting editors, and reviewers who participate in the peer review process. In addition to regular submissions to the Journal, proposals for special issues or sections are also welcome. These should be discussed with the Editor In Chief prior to submission.

MANUSCRIPTS for submission to the *Infant Mental Health Journal* should be forwarded to the Editor as follows:

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2. Go to the URL http://mc.manuscriptcentral.com/imhj
3. Register (if you have not done so already).
4. Go to the Author Center and follow the instructions to submit your paper.
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6. The Title Page should include a discussion of any conflicts of interest, human subjects approvals, and funding. Acknowledgements may also appear here. The Infant Mental Health Journal complies with all relevant recommendations from the International Committee of Medical Journal Editors in these areas.
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Manuscripts generally do not exceed 10,000 words and will be assigned for peer review by the Editor or Associate Editor(s) and reviewed by members of the Editorial Board and invited reviewers with special knowledge of the topic addressed in the manuscript. The Editor retains the right to reject articles that do not meet conventional clinical or scientific ethical standards. Normally, the review process is completed in 3 months. Nearly all manuscripts accepted for publication require some degree of revision. There is no charge for

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Proofs will be sent to the corresponding author and must be read carefully because final responsibility for accuracy rests with the author(s). Author(s) must return corrected proofs to the publisher in a timely manner. If the publisher does not receive corrected proofs from the author(s), publication will still proceed as scheduled.

Additional questions with regard to style and submission of manuscripts should be directed to the Editor: Paul Spicer, PhD, at paul.spicer@ou.edu

Appendix B: Overview of Shortlisted Literature

No	Author, Date, Title and Study Country	Study Type and Aim	Study Sample	Data Collection and Analysis (specific to infant harming thoughts)	Findings	Strengths (+) and Limitations (-)
1.	Barr and Beck (2008) Infanticide secrets Australia	Qualitative Examine infanticidal thoughts by women with PND	Snowball sampling Community sample 15 mothers with a diagnosis of depression with postpartum onset	Interview (no further details provided) Thematic analysis and informed by philosophical guidelines of Heidegger and Gadamer	Six themes 1) imagined acts of infanticide 2) the experience of horror 3) distorted sense of responsibility 4) consuming negativity 5) keeping secrets 6) managing the crisis	+ Large number of participants, highlights ethical consideration, confirmation of diagnosis using DSM-IV - Lack of extracts, limited demographic information
2.	Maimon (2012) Ego-dystonic, obsessive thoughts of harm in postpartum Women: an interpretative phenomenological analysis America	Qualitative Understand the experience of ego-dystonic, intrusive thoughts	Five subclinical, postnatal mothers Purposive sample, recruited online	Semi-structured interviews Interpretative Phenomenological Analysis	Three super-ordinate themes 1) Experiencing Intrusive Thoughts of Harm • Quality and details of the intrusive thoughts • Responses – Self-dialogue – Actions taken – Limited linking to others 2) Psychological States • Anxiety, worry, fear and shame • Sadness, anger, loss, and loneliness • Joy, satisfaction, gratitude and love • Empowered to make meaning 3) Pregnancy to Postpartum Life in Retrospect • Negative physical experience	+ Rich, interpretative account, offers reflexivity, provides breadth and depth of extracts - Small sample size, rawness of data lost as intertwined within text

No	Author, Date, Title and Study Country	Study Type and Aim	Study Sample	Data Collection and Analysis (specific to infant harming thoughts)	Findings	Strengths (+) and Limitations (-)
					• Life changes, transitions • Expectations, Support	
3.	Santos Jr, Sandelowski and Gualda (2014) Bad thoughts: Brazilian women's responses to mothering while experiencing postnatal depression Brazil	Qualitative Understand experiences of Brazilian women with including thoughts of harming	Purposive, criterion sampling 15 women diagnoses with postnatal depression in a psychiatric unit	Open-ended, face-to-face interviews Thematic analysis (Braun & Clarke, 2006)	54% of participants identified themselves as potential sources of harm toward the infant Four mothering types as consequences revealed: transferred care (transferring responsibility), shared care (asking family members to share responsibility of infant care), sole care (no available family support) and smother care (hyper-vigilance)	+ Latin-American culture, professional translators, consequences on harming thoughts acknowledges - No reflexivity, no information on how themes were derived
4.	Gutiérrez-Zotes, Farnós, Vilella and Labad (2013) Higher psychoticism as a predictor of thoughts of harming one's infant in postpartum women: A prospective study Spain	Quantitative Assess neuroticism or psychoticism as predictors of infant harming thoughts	137 women who had given birth between December 2003 and October 2004 from Department of Obstetrics and Gynecology Time one assessment two-three days post delivery and time two assessment eighth week postpartum	Measures: - Semi-structured interview to assess infant harming thoughts Chi-square tests, Mann Whitney *U* tests and logistic regression analysis	13% of participants reported thoughts of infant harm during the postpartum period Psychoticism found to be a risk factor for postpartum thoughts of infant harm but thought more of as impulsivity No relationship between depressive symptoms and postpartum thoughts of harm	+ Clear aim, appropriate validated personality measure - Attrition rates not explained, no power calculation

No	Author, Date, Title and Study Country	Study Type and Aim	Study Sample	Data Collection and Analysis (specific to infant harming thoughts)	Findings	Strengths (+) and Limitations (-)
5.	Jennings, Ross, Popper and Elmore (1999) Thoughts of harming infants in depressed and non-depressed mothers America	Quantitative Prevalence of infant harming thoughts, fear of being alone and inability to care for infant	100 depressed mothers (as measured by the Inventory to Diagnose to Depression (IDD) (Zimmerman et al., 1986) and 46 non-depressed mothers Depressed group assessed in the Pregnancy and Infant/Parent Centre (outpatient services)	Measures: - Inventory of Parent's Experience (Crnic et al., 1986) Chi-square Correlation	41% of depressed mothers reported some thoughts of harming their infants (20% reported passing thoughts and 21% reported repeated thoughts) In comparison, 6.5% of mothers reported such thoughts in the control group Trends for thoughts of harm associated with lack of satisfaction in maternal role and pleasure in their infants – however not significant	+ Matched-controlled group, diagnosis validated using IDD - Thoughts of infant harm were only measured by one question, distress or frequency not captured, unequal size of experimental and control group
6.	Fairbrother and Woody (2008) New mothers' thoughts of harm related to the newborn Canada	Quantitative Assess prevalence, nature and predictors or maternal thoughts of infant harm	100 women: prenatal, four weeks, 12 weeks postpartum Recruited from two major hospitals, midwifery offices, physician offices and prenatal education classes.	Measures: - Postpartum Intrusions Interview (Fairbrother & Woody, 2008) Dependent samples t-tests to compare characteristics of accidental and intentional harm thoughts Logistic regression	Unwanted intrusive thoughts of harming one's own infant is a relatively normative experience Accidental harm thoughts were more frequent, time consuming and more likely to actually occur. Intentional harm thoughts were more distressing and evoke feelings of guilt High parenting stress (particularly maternal perception of the mother-infant relationship) and low social support significantly predicted which participants would report thoughts of intentional harm to	+ Internal consistency between the aim and method, recruited from multiple sites - Attrition, unvalidated measure of infant harming thoughts, inconsistent time scales to measure infant harming thoughts

No	Author, Date, Title and Study Country	Study Type and Aim	Study Sample	Data Collection and Analysis (specific to infant harming thoughts)	Findings	Strengths (+) and Limitations (-)
				– demographic characteristics, personality, parenting stress or social support on thoughts of intentional harm Chi-square analyses – harsh parenting behaviour associated with the occurrence of intentionally harming the infant	their infant four weeks postpartum At three months postpartum, more women who reported intentional harm thoughts also reported engaging in harsh parenting, compared with the women who did not report intentional harm thoughts (42.86% versus 24.62%) a difference that was not statistically significant	
7.	Humenik and Fingerhut (2007) A pilot study assessing the relationship between child harming thoughts and postpartum depression America	Quantitative Investigate child harming thoughts and intensity in postpartum women and the links to PND and anxiety.	50 mothers – outpatient paediatric office	Measures: - Child Thoughts Inventory (CTI) Correlation	Postpartum depressive, postpartum anxiety symptoms and prepartum anxiety were positively correlated with frequency and severity of child harming thoughts Negative self-view was also correlated with frequency of child harming thoughts	+ Used power calculation - Measure designed for study - no psychometric properties available, lack of causality due to correlation, unsure if parametric assumptions met

No	Author, Date, Title and Study Country	Study Type and Aim	Study Sample	Data Collection and Analysis (specific to infant harming thoughts)	Findings	Strengths (+) and Limitations (-)
8.	Chandra, Venkatasubramanian and Thomas (2002) Infanticidal ideas and infanticidal behaviour in Indian women with severe postpartum psychiatric disorders India	Quantitative. Assess infanticidal ideas and infanticidal behaviour in an inpatient setting	49 women admitted into a psychiatric hospital for severe mental health issues in the postpartum period	Infanticidal ideas obtained through a) History from significant other b) Nursing observations in the first week of admission c) Psychiatric assessment during first week of admission Chi-square and independent samples *t*-tests (association between presence of infanticidal ideas and socio-demographic and clinical variables) Correlations (aggression, infanticidal ideas and clinical and socio-demographic variables) Logistic regression	43% (20/47) reported infanticidal ideas associated with depression, adverse maternal reaction to separation from infant and psychotic ideas towards infant Infanticidal ideas in 12/18 (67%) depressed mothers in comparison to 8/29 (28%) non-depressed mothers Infanticidal ideas associated with adverse maternal reaction to separation from the infant and more psychotic ideas Predictors: depression (odds ratio – 7.3, $p = .007$) and psychotic ideas (odds ratio = 2.6, $p = .009$) predicted 77% of the variance	+ Novel study with under researched participants, data triangulation - Subjectivity not acknowledged, ethical issues, not mother’s perspective per se

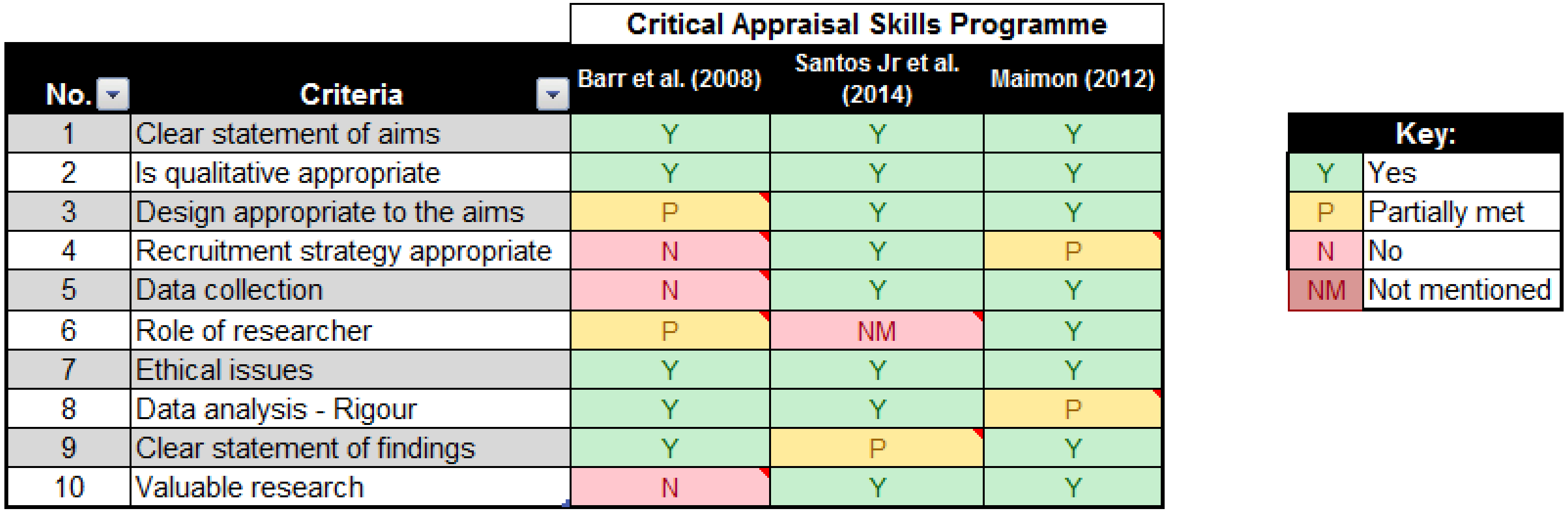
No	Author, Date, Title and Study Country	Study Type and Aim	Study Sample	Data Collection and Analysis (specific to infant harming thoughts)	Findings	Strengths (+) and Limitations (-)
9.	Wisner, Peindl, Gigliotti and Hanusa (1999) Obsessions and compulsions in women with postpartum depression America	Quantitative. Compare the obsessions and compulsions in PND and non-postpartum depressed women	37 mothers with postpartum onset depression. 28 mothers diagnosed with major depression which they presented outside of childbearing	Measures: - Yale-Brown Obsessive Compulsive Scale (Y-BOCS) Chi-square test, Fischer exact tests, Mann Whitney *U* test and Bonferroni adjustments (number and content of obsessional thoughts and compulsions) ANOVAs (presence of obsessions or compulsions and presences of aggressive obsession thoughts for both groups) Phi coefficient (presences of aggressive obsessional thoughts and checking compulsions)	Women with PND experienced intentional infant harming thoughts than those whose depression occurred outside childbearing The most frequent content of aggressive thoughts for women with PND was causing harm to their infants	+ Diagnosis of depression validated through IDD (Zimmerman et al., 1986), recruited adequately - Control group not matched, measure not specific to infants, lack of demographic information

No	Author, Date, Title and Study Country	Study Type and Aim	Study Sample	Data Collection and Analysis (specific to infant harming thoughts)	Findings	Strengths (+) and Limitations (-)
10.	Labad, Vielle, Reynolds, Sans, Cavallé, Valero, Alonso, Mechón, Labad & Gutiérrez-Zotes (2011) Increased morning adrenocorticotrophin hormone (ACTH) levels in women with postpartum thoughts of harming the infant Spain	Quantitative	132 women recruited from Department of Obsetetrics and Gynecology	Semi-structured interview to assess infant harming thoughts	Participants with intentional infant harming thoughts had higher ACTH levels in comparison to those without these thoughts 17 out of 132 (13%) women reported having suffered from intrusive thoughts to harm their infant during the early postpartum period at 8 weeks postpartum such thoughts were observed in 6 of these 17 (35.3%) women.	+ Physiological measures as well as self report, good description of analysis - Same participants at Gutiérrez-Zotes et al. (2013), significant result of life events ignored, no power calculation

Appendix B Continued: Shortlisted Literature - Thoughts of Intentional Infant Harm Prevalence Rates

Non-Clinical Populations (Prevalence Range: 6.5% - 49.5%)		
Study	**Number of mothers experiencing TIIHs / Total number of participants**	
Fairbrother et al. (1998)	45/91 (49.5%) At four weeks postpartum	12/45 (26.7%) At 12 weeks postpartum
Gutiérrez-Zotes et al. (2013)	18/137 (13.1%) At two to three days postpartum	5/18 (27.8%) At eight weeks postpartum
Humenik et al. (2007)	Raw prevalence data not presented	
Jennings et al. (1999)	3/46 (6.5%)	
Labad et al. (2011)	17/132 (12.9%) At two to three days postpartum	6/17 (35.3%) At eight weeks postpartum
Wisner et al. (1999)	6/28 (21.4%)	
Clinical Populations (Prevalence Range: 41% - 54.1%)		
Chandra et al. (2002)	20/47 (42.6%)	
Jennings et al. (1999)	41/100 (41%)	
Wisner et al. (1999)	20/37 (54.1%)	

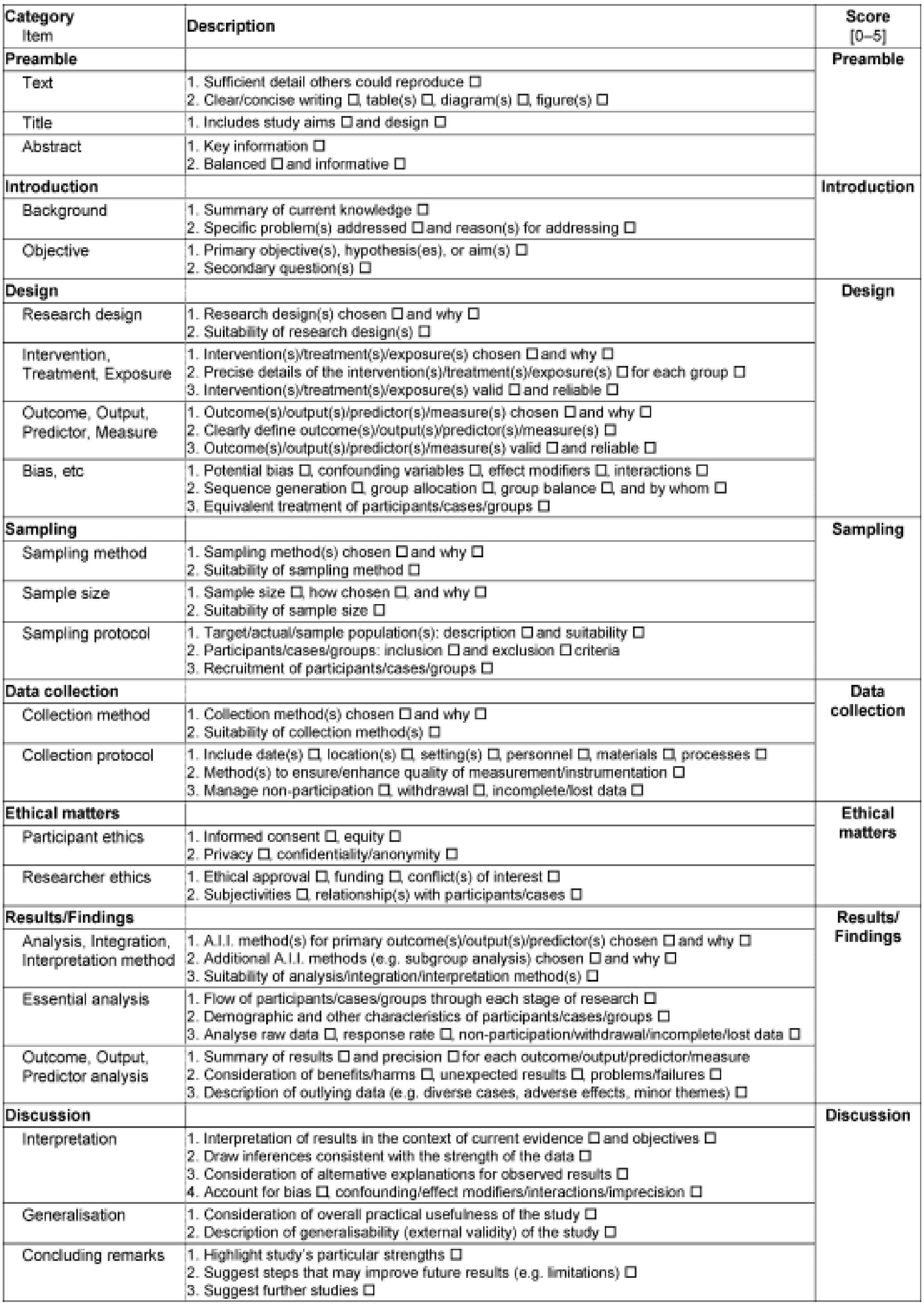
Appendix C: Quality Appraisal Results for Qualitative Studies



		Critical Appraisal Skills Programme		
No.	Criteria	Barr et al. (2008)	Santos Jr et al. (2014)	Maimon (2012)
1	Clear statement of aims	Y	Y	Y
2	Is qualitative appropriate	Y	Y	Y
3	Design appropriate to the aims	P	Y	Y
4	Recruitment strategy appropriate	N	Y	P
5	Data collection	N	Y	Y
6	Role of researcher	P	NM	Y
7	Ethical issues	Y	Y	Y
8	Data analysis - Rigour	Y	Y	P
9	Clear statement of findings	Y	P	Y
10	Valuable research	N	Y	Y

Key:	
Y	Yes
P	Partially met
N	No
NM	Not mentioned

Appendix D: Crowe Critical Appraisal Tool (Crowe, 2013)



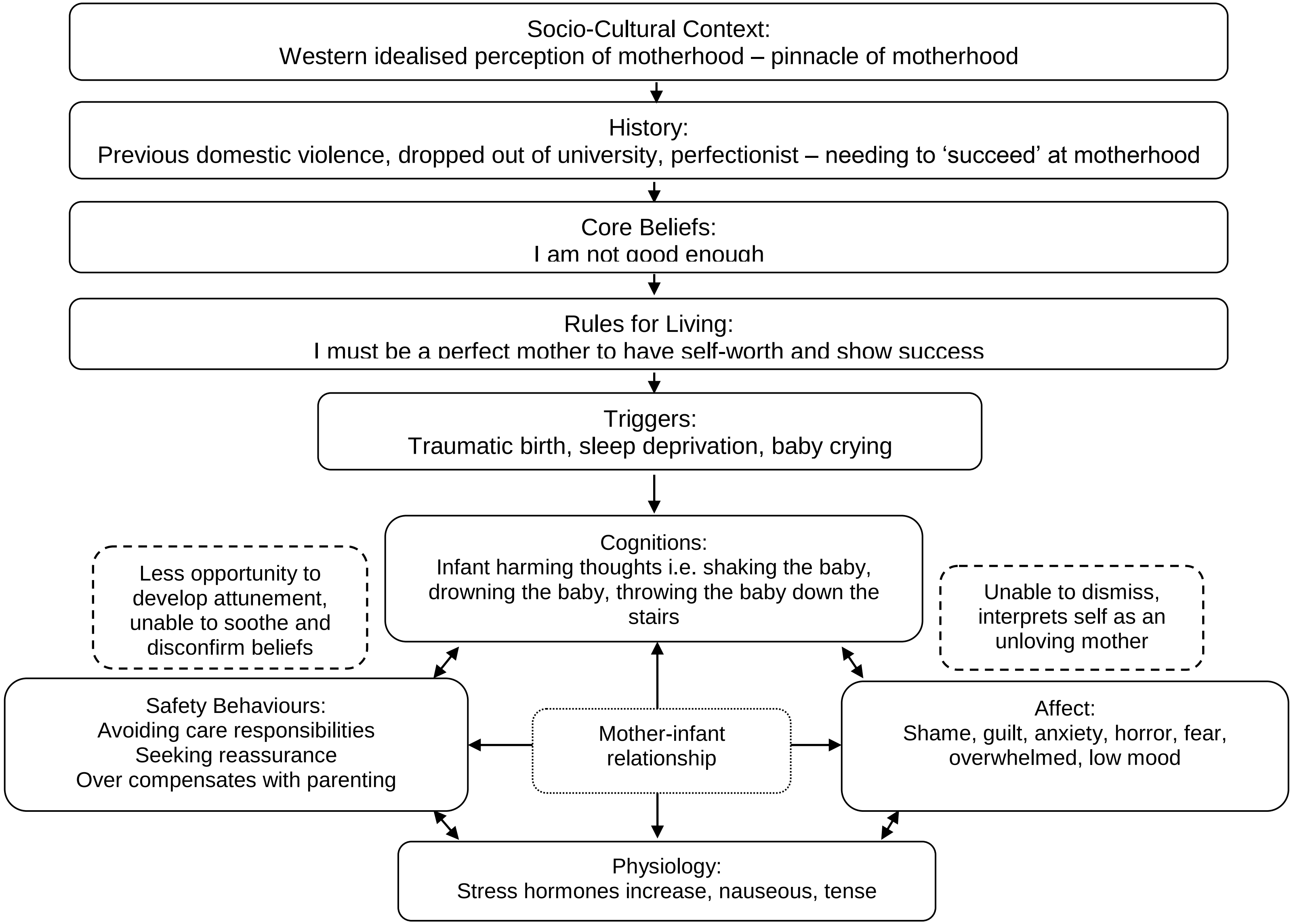
Category Item	Description	Score [0–5]
Preamble		**Preamble**
Text	1. Sufficient detail others could reproduce ☐ 2. Clear/concise writing ☐, table(s) ☐, diagram(s) ☐, figure(s) ☐	
Title	1. Includes study aims ☐ and design ☐	
Abstract	1. Key information ☐ 2. Balanced ☐ and informative ☐	
Introduction		**Introduction**
Background	1. Summary of current knowledge ☐ 2. Specific problem(s) addressed ☐ and reason(s) for addressing ☐	
Objective	1. Primary objective(s), hypothesis(es), or aim(s) ☐ 2. Secondary question(s) ☐	
Design		**Design**
Research design	1. Research design(s) chosen ☐ and why ☐ 2. Suitability of research design(s) ☐	
Intervention, Treatment, Exposure	1. Intervention(s)/treatment(s)/exposure(s) chosen ☐ and why ☐ 2. Precise details of the intervention(s)/treatment(s)/exposure(s) ☐ for each group ☐ 3. Intervention(s)/treatment(s)/exposure(s) valid ☐ and reliable ☐	
Outcome, Output, Predictor, Measure	1. Outcome(s)/output(s)/predictor(s)/measure(s) chosen ☐ and why ☐ 2. Clearly define outcome(s)/output(s)/predictor(s)/measure(s) ☐ 3. Outcome(s)/output(s)/predictor(s)/measure(s) valid ☐ and reliable ☐	
Bias, etc	1. Potential bias ☐, confounding variables ☐, effect modifiers ☐, interactions ☐ 2. Sequence generation ☐, group allocation ☐, group balance ☐, and by whom ☐ 3. Equivalent treatment of participants/cases/groups ☐	
Sampling		**Sampling**
Sampling method	1. Sampling method(s) chosen ☐ and why ☐ 2. Suitability of sampling method ☐	
Sample size	1. Sample size ☐, how chosen ☐, and why ☐ 2. Suitability of sample size ☐	
Sampling protocol	1. Target/actual/sample population(s): description ☐ and suitability ☐ 2. Participants/cases/groups: inclusion ☐ and exclusion ☐ criteria 3. Recruitment of participants/cases/groups ☐	
Data collection		**Data collection**
Collection method	1. Collection method(s) chosen ☐ and why ☐ 2. Suitability of collection method(s) ☐	
Collection protocol	1. Include date(s) ☐, location(s) ☐, setting(s) ☐, personnel ☐, materials ☐, processes ☐ 2. Method(s) to ensure/enhance quality of measurement/instrumentation ☐ 3. Manage non-participation ☐, withdrawal ☐, incomplete/lost data ☐	
Ethical matters		**Ethical matters**
Participant ethics	1. Informed consent ☐, equity ☐ 2. Privacy ☐, confidentiality/anonymity ☐	
Researcher ethics	1. Ethical approval ☐, funding ☐, conflict(s) of interest ☐ 2. Subjectivities ☐, relationship(s) with participants/cases ☐	
Results/Findings		**Results/ Findings**
Analysis, Integration, Interpretation method	1. A.I.I. method(s) for primary outcome(s)/output(s)/predictor(s) chosen ☐ and why ☐ 2. Additional A.I.I. methods (e.g. subgroup analysis) chosen ☐ and why ☐ 3. Suitability of analysis/integration/interpretation method(s) ☐	
Essential analysis	1. Flow of participants/cases/groups through each stage of research ☐ 2. Demographic and other characteristics of participants/cases/groups ☐ 3. Analyse raw data ☐, response rate ☐, non-participation/withdrawal/incomplete/lost data ☐	
Outcome, Output, Predictor analysis	1. Summary of results ☐ and precision ☐ for each outcome/output/predictor/measure 2. Consideration of benefits/harms ☐, unexpected results ☐, problems/failures ☐ 3. Description of outlying data (e.g. diverse cases, adverse effects, minor themes) ☐	
Discussion		**Discussion**
Interpretation	1. Interpretation of results in the context of current evidence ☐ and objectives ☐ 2. Draw inferences consistent with the strength of the data ☐ 3. Consideration of alternative explanations for observed results ☐ 4. Account for bias ☐, confounding/effect modifiers/interactions/imprecision ☐	
Generalisation	1. Consideration of overall practical usefulness of the study ☐ 2. Description of generalisability (external validity) of the study ☐	
Concluding remarks	1. Highlight study's particular strengths ☐ 2. Suggest steps that may improve future results (e.g. limitations) ☐ 3. Suggest further studies ☐	

Appendix E: Quality Appraisal Results for Quantitative Studies

Crowe Critical Appraisal Tool (Crowe, 2013)

Category	Fairbrother et al. (2008)	Chandra et al. (2002)	Gutiérrez-Zotes et al. (2013)	Humenik et al. (2007)	Labad et al. (2011)	Jennings et al. (1999)	Wisner et al. (1999)
1. Preamble	4	4	4	4	4	4	3
2. Introduction	5	5	5	5	5	5	3
3. Design	4	4	4	4	2	2	3
4. Sampling	4	5	3	4	3	5	4
5. Data collection	4	4	5	5	4	2	4
6. Ethical matters	4	3	3	4	4	2	3
7. Results	5	4	5	3	4	4	4
8. Discussion	5	5	5	4	5	5	4
9. Total	35	34	34	33	31	29	28
Combined Total %	**88%**	**85%**	**85%**	**83%**	**78%**	**73%**	**70%**

Appendix F: Example CBT Formulation of Infant Harming Thoughts (adapted from Beck, 1976)



Appendix G: Author Guidelines for Archives of Women's Mental Health

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

Abstract:

Not to exceed 150–200 words

Keywords:

Not more than five

Word limit:

There is no word limit for Original Contributions.

Introduction:

To include the background literature as well as the objective (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

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.

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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

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 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).

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 on the title page. The names of funding organizations should be written in full.

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

Gamelin FX, Baquet G, Berthoin S, Thevenet D, Nourry C, Nottin S, Bosquet L (2009) Effect of high intensity intermittent training on heart rate variability in prepubescent children. Eur J Appl Physiol 105:731-738. doi: 10.1007/s00421-008-0955-8

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

Smith J, Jones M Jr, Houghton L et al (1999) Future of health insurance. N Engl J Med 965:325–329

- Article by DOI

Slifka MK, Whitton JL (2000) Clinical implications of dysregulated cytokine production. J Mol Med. doi:10.1007/s001090000086

- Book

South J, Blass B (2001) The future of modern genomics. Blackwell, London

- Book chapter

Brown B, Aaron M (2001) The politics of nature. In: Smith J (ed) The rise of modern genomics, 3rd edn. Wiley, New York, pp 230-257

- Online document

Cartwright J (2007) Big stars have weather too. IOP Publishing PhysicsWeb. http://physicsweb.org/articles/news/11/6/16/1. Accessed 26 June 2007

- 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 LTWA

If you are unsure, please use the full journal title.
For authors using EndNote, Springer provides an output style that supports the formatting of in-text citations and reference list.

- All tables are to be numbered using Arabic numerals.
- Tables should always be cited in text in consecutive numerical order.
- For each table, please supply a table caption (title) explaining the components of the table.
- Identify any previously published material by giving the original source in the form of a reference at the end of the table caption.
- Footnotes to tables should be indicated by superscript lower-case letters (or asterisks for significance values and other statistical data) and included beneath the table body.

Electronic Figure Submission

- Supply all figures electronically.
- Indicate what graphics program was used to create the artwork.
- For vector graphics, the preferred format is EPS; for halftones, please use TIFF format. MSOffice files are also acceptable.
- Vector graphics containing fonts must have the fonts embedded in the files.
- Name your figure files with "Fig" and the figure number, e.g., Fig1.eps.

Line Art

- Definition: Black and white graphic with no shading.

- Do not use faint lines and/or lettering and check that all lines and lettering within the figures are legible at final size.
- All lines should be at least 0.1 mm (0.3 pt) wide.
- Scanned line drawings and line drawings in bitmap format should have a minimum resolution of 1200 dpi.
- Vector graphics containing fonts must have the fonts embedded in the files.

Color Art

- Color art is free of charge for online publication.
- If black and white will be shown in the print version, make sure that the main information will still be visible. Many colors are not distinguishable from one another when converted to black and white. A simple way to check this is to make a xerographic copy to see if the necessary distinctions between the different colors are still apparent.
- If the figures will be printed in black and white, do not refer to color in the captions.
- Color illustrations should be submitted as RGB (8 bits per channel).

Figure Lettering

- To add lettering, it is best to use Helvetica or Arial (sans serif fonts).
- Keep lettering consistently sized throughout your final-sized artwork, usually about 2–3 mm (8–12 pt).
- Variance of type size within an illustration should be minimal, e.g., do not use 8-pt type on an axis and 20-pt type for the axis label.
- Avoid effects such as shading, outline letters, etc.
- Do not include titles or captions within your illustrations.

Figure Numbering

- All figures are to be numbered using Arabic numerals.
- Figures should always be cited in text in consecutive numerical order.
- Figure parts should be denoted by lowercase letters (a, b, c, etc.).
- If an appendix appears in your article and it contains one or more figures, continue the consecutive numbering of the main text. Do not number the appendix figures,
  "A1, A2, A3, etc." Figures in online appendices (Electronic Supplementary Material) should, however, be numbered separately.

Figure Captions

- Each figure should have a concise caption describing accurately what the figure depicts. Include the captions in the text file of the manuscript, not in the figure file.
- Figure captions begin with the term Fig. in bold type, followed by the figure number, also in bold type.
- No punctuation is to be included after the number, nor is any punctuation to be placed at the end of the caption.
- Identify all elements found in the figure in the figure caption; and use boxes, circles, etc., as coordinate points in graphs.

- Identify previously published material by giving the original source in the form of a reference citation at the end of the figure caption.

Figure Placement and Size

- Figures should be submitted separately from the text, if possible.
- When preparing your figures, size figures to fit in the column width.
- For most journals the figures should be 39 mm, 84 mm, 129 mm, or 174 mm wide and not higher than 234 mm.
- For books and book-sized journals, the figures should be 80 mm or 122 mm wide and not higher than 198 mm.

Permissions

If you include figures that have already been published elsewhere, you must obtain permission from the copyright owner(s) for both the print and online format. Please be aware that some publishers do not grant electronic rights for free and that Springer will not be able to refund any costs that may have occurred to receive these permissions. In such cases, material from other sources should be used.

Submission

- Supply all supplementary material in standard file formats.
- Please include in each file the following information: article title, journal name, author names; affiliation and e-mail address of the corresponding author.
- To accommodate user downloads, please keep in mind that larger-sized files may require very long download times and that some users may experience other problems during downloading.

Text and Presentations

- Submit your material in PDF format; .doc or .ppt files are not suitable for long-term viability.
- A collection of figures may also be combined in a PDF file.

Spreadsheets

- Spreadsheets should be converted to PDF if no interaction with the data is intended.
- If the readers should be encouraged to make their own calculations, spreadsheets should be submitted as .xls files (MS Excel).

Numbering

- If supplying any supplementary material, the text must make specific mention of the material as a citation, similar to that of figures and tables.
- Refer to the supplementary files as “Online Resource”, e.g., "... as shown in the animation (Online Resource 3)", “... additional data are given in Online Resource 4”.
- Name the files consecutively, e.g. “ESM_3.mpg”, “ESM_4.pdf”.

Captions

- For each supplementary material, please supply a concise caption describing the content of the file.

Accessibility

In order to give people of all abilities and disabilities access to the content of your supplementary files, please make sure that

- The manuscript contains a descriptive caption for each supplementary material
- Video files do not contain anything that flashes more than three times per second (so that users prone to seizures caused by such effects are not put at risk)

This journal is committed to upholding the integrity of the scientific record. As a member of the Committee on Publication Ethics (COPE) the journal will follow the COPE guidelines on how to deal with potential acts of misconduct.

Authors should refrain from misrepresenting research results which could damage the trust in the journal, the professionalism of scientific authorship, and ultimately the entire scientific endeavour. Maintaining integrity of the research and its presentation can be achieved by following the rules of good scientific practice, which include:

- The manuscript has not been submitted to more than one journal for simultaneous consideration.
- The manuscript has not been published previously (partly or in full), unless the new work concerns an expansion of previous work (please provide transparency on the re-use of material to avoid the hint of text-recycling (“self-plagiarism”)).
- A single study is not split up into several parts to increase the quantity of submissions and submitted to various journals or to one journal over time (e.g. “salami-publishing”).
- No data have been fabricated or manipulated (including images) to support your conclusions
- No data, text, or theories by others are presented as if they were the author’s own (“plagiarism”). Proper acknowledgements to other works must be given (this includes material that is closely copied (near verbatim), summarized and/or paraphrased), quotation marks are used for verbatim copying of material, and permissions are secured for material that is copyrighted.

  Important note: the journal may use software to screen for plagiarism.
- Consent to submit has been received explicitly from all co-authors, as well as from the responsible authorities - tacitly or explicitly - at the institute/organization where the work has been carried out, **before** the work is submitted.
- Authors whose names appear on the submission have contributed sufficiently to the scientific work and therefore share collective responsibility and accountability for the results.

In addition:

- Changes of authorship or in the order of authors are not accepted **after** acceptance of a manuscript.
- Requesting to add or delete authors at revision stage, proof stage, or after publication is a serious matter and may be considered when justifiably

warranted. Justification for changes in authorship must be compelling and may be considered only after receipt of written approval from all authors and a convincing, detailed explanation about the role/deletion of the new/deleted author. In case of changes at revision stage, a letter must accompany the revised manuscript. In case of changes after acceptance or publication, the request and documentation must be sent via the Publisher to the Editor-in-Chief. In all cases, further documentation may be required to support your request. The decision on accepting the change rests with the Editor-in-Chief of the journal and may be turned down. Therefore authors are strongly advised to ensure the correct author group, corresponding author, and order of authors at submission.

- Upon request authors should be prepared to send relevant documentation or data in order to verify the validity of the results. This could be in the form of raw data, samples, records, etc.

If there is a suspicion of misconduct, the journal will carry out an investigation following the COPE guidelines. If, after investigation, the allegation seems to raise valid concerns, the accused author will be contacted and given an opportunity to address the issue. If misconduct has been established beyond reasonable doubt, this may result in the Editor-in-Chief's implementation of the following measures, including, but not limited to:

- If the article is still under consideration, it may be rejected and returned to the author.
- If the article has already been published online, depending on the nature and severity of the infraction, either an erratum will be placed with the article or in severe cases complete retraction of the article will occur. The reason must be given in the published erratum or retraction note.
- The author's institution may be informed.

Compliance with Ethical Standards

To ensure objectivity and transparency in research and to ensure that accepted principles of ethical and professional conduct have been followed, authors should include information regarding sources of funding, potential conflicts of interest (financial or non-financial), informed consent if the research involved human participants, and a statement on welfare of animals if the research involved animals.

Authors should include the following statements (if applicable) in a separate section entitled "Compliance with Ethical Standards" when submitting a paper:

- Disclosure of potential conflicts of interest
- Research involving Human Participants and/or Animals
- Informed consent

Please note that standards could vary slightly per journal dependent on their peer review policies (i.e. single or double blind peer review) as well as per journal subject discipline. Before submitting your article check the instructions following this section carefully.

The corresponding author should be prepared to collect documentation of compliance with ethical standards and send if requested during peer review or after publication.

The Editors reserve the right to reject manuscripts that do not comply with the above-mentioned guidelines. The author will be held responsible for false statements or failure to fulfill the above-mentioned guidelines.

Disclosure of potential conflicts of interest

Authors must disclose all relationships or interests that could influence or bias the work. Although an author may not feel there are conflicts, disclosure of relationships and interests affords a more transparent process, leading to an accurate and objective assessment of the work. Awareness of real or perceived conflicts of interests is a perspective to which the readers are entitled and is not meant to imply that a financial relationship with an organization that sponsored the research or compensation for consultancy work is inappropriate. Examples of potential conflicts of interests **that are directly or indirectly related to the research** may include but are not limited to the following:

- Research grants from funding agencies (please give the research funder and the grant number)
- Honoraria for speaking at symposia
- Financial support for attending symposia
- Financial support for educational programs
- Employment or consultation
- Support from a project sponsor
- Position on advisory board or board of directors or other type of management relationships
- Multiple affiliations
- Financial relationships, for example equity ownership or investment interest
- Intellectual property rights (e.g. patents, copyrights and royalties from such rights)
- Holdings of spouse and/or children that may have financial interest in the work

In addition, interests that go beyond financial interests and compensation (non-financial interests) that may be important to readers should be disclosed. These may include but are not limited to personal relationships or competing interests directly or indirectly tied to this research, or professional interests or personal beliefs that may influence your research.

The corresponding author collects the conflict of interest disclosure forms from all authors. (**Please note that each author should complete a disclosure form.**)

The corresponding author will include a summary statement **on the title page that is separate from their manuscript,** that reflects what is recorded in the potential conflict of interest disclosure form(s).

See below examples of disclosures:

Funding: This study was funded by X (grant number X).

Conflict of Interest: Author A has received research grants from Company A. Author B has received a speaker honorarium from Company X and owns stock in Company Y. Author C is a member of committee Z.

If no conflict exists, the authors should state:
Conflict of Interest: Author A, Author B, and Author C declare that they have no conflict of interest.

Research involving human participants and/or animals

1) Statement of human rights

When reporting studies that involve human participants, authors should include a statement that the studies have been approved by the appropriate institutional and/or national research ethics committee and have been performed in accordance with the ethical standards as laid down in the 1964 Declaration of Helsinki and its later amendments or comparable ethical standards.

If doubt exists whether the research was conducted in accordance with the 1964 Helsinki Declaration or comparable standards, the authors must explain the reasons for their approach, and demonstrate that the independent ethics committee or institutional review board explicitly approved the doubtful aspects of the study.
The following statements should be included in the text before the References section:

Ethical approval: "All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards."
For retrospective studies, please add the following sentence:
"For this type of study formal consent is not required."

Informed consent: All individuals have individual rights that are not to be infringed. Individual participants in studies have, for example, the right to decide what happens to the (identifiable) personal data gathered, to what they have said during a study or an interview, as well as to any photograph that was taken. Hence it is important that all participants gave their informed consent in writing prior to inclusion in the study. Identifying details (names, dates of birth, identity numbers and other information) of the participants that were studied should not be published in written descriptions, photographs, and genetic profiles unless the information is essential for scientific purposes and the participant (or parent or guardian if the participant is incapable) gave written informed consent for publication. Complete anonymity is difficult to achieve in some cases, and informed consent should be obtained if there is any doubt. For example, masking the eye region in photographs of participants is inadequate protection of anonymity. If identifying characteristics are altered to protect anonymity, such as in genetic profiles, authors should provide assurance that alterations do not distort scientific meaning.

The following statement should be included:

Informed consent: "Informed consent was obtained from all individual participants included in the study." If identifying information about participants is available in the article, the following statement should be included: "Additional informed consent was obtained from all individual participants for whom identifying information is included in this article."

Appendix H: Ethical Approval

STAFFORDSHIRE
UNIVERSITY

Faculty of Health Sciences

INDEPENDENT PEER REVIEW APPROVAL FEEDBACK

ETHICAL APPROVAL FEEDBACK

Researcher name:	Shivani Chotai
Title of Study:	Experiences of Puerperal Psychosis and Recovery
Award Pathway:	DClinPsy
Status of approval:	Approved

Action now needed:

Your project proposal has now been approved by the Faculty's Ethics Panel and you may now commence the implementation phase of your study. You do not need to approach the Local Research Ethics Committee. You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel of any significant divergence from this approved proposal.

You should arrange to meet with your supervisor for support during the process of completing your study and writing your dissertation.

Comments for your consideration:

Thank you for addressing the comments raised by the committee. It was clear that you had thought carefully about your responses and have gone over and above what was asked, which will make your study much stronger.

We wish you well with your research.

Karen

Signed: Professor Karen Rodham
Chair of the Faculty of Health Sciences Ethics Panel

Date: 23rd October 2014

Appendix I: Ethical Approval Letter Following Amendments

STAFFORDSHIRE UNIVERSITY

Faculty of Health Sciences

ETHICAL APPROVAL FEEDBACK

Researcher name:	Shivani Chotai
Title of Study:	Experiences of Puerperal Psychosis and Recovery
Award Pathway:	Prof Doc Clinical Psychology
Status of approval:	Amendment approved

Dear Shiv,
Thank you for your correspondence requesting approval of a minor amendment to your recruitment. Your application was sent out to review.

There reviewers summarise that there are two changes here: 1) to include women who do not have a formal diagnosis, and 2) to include those who are still experiencing symptoms.

The committee did not see any problem with the first change, as it relies on volunteers who officially are fine to participate.

We identified concerns about the second group, but on reflection think that there are sufficient safeguards in place.

We would have been much more concerned if the study involved an intervention rather than simply the collection of anonymisable interview data. But for this study, we could not see that there would be any real additional risk for this group (or for you, the researcher); and in general we would prefer to assume capacity to consent than to assume that somebody with a mental health issue lacks it.

As such, your amended application is approved and we wish you will with your research.

Action now needed: Your amendment has now been approved by the Faculty's Ethics Panel. You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel in writing of any significant divergence from this approved proposal.

You should arrange to meet with your supervisor for support during the process of completing your study and writing your dissertation.

When your study is complete, please send the ethics committee an end of study report. A template can be found on the ethics BlackBoard site

Karen Rod

Signed: Prof Karen Rodham **Date: 29th October 2015**
Chair of the Faculty of Health Sciences Ethics Panel

Appendix J: Invitation to Participate

Invitation to Participate

(Version 3, 28th September 2015)

Dear Forum Members,

Can you help with a research project on Postpartum Psychosis?

I am looking to talk mothers who have recovered from Postpartum Psychosis. The study will involve arranging a session together where I can ask you questions about your experience. Participation will take around one hour and I am happy to meet wherever is most convenient for you.

Being involved in this study is completely voluntary but would be greatly appreciated. There is no right or wrong answer to the questions, but I am hoping it will help us understand what recovering from Postpartum Psychosis was like for you. Some participants may find it helpful and cathartic to talk about their experiences. It could contribute to raise awareness of Postpartum Psychosis and it is hoped that the findings from the study will also help healthcare professionals understand what factors are important in recovery.

If you have any further questions, please contact me on
c030771c@student.staffs.ac.uk.

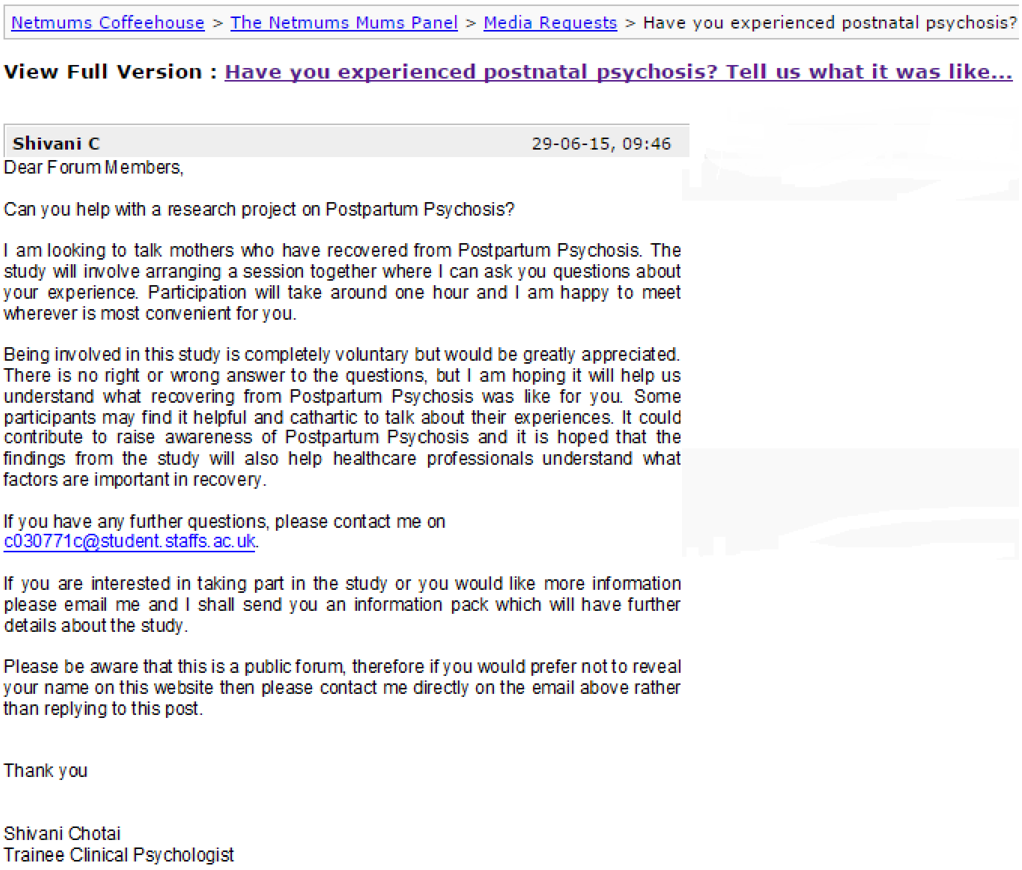
If you are interested in taking part in the study or you would like more information please email me and I shall send you an information pack which will have further details about the study.

Please be aware that this is a public forum, therefore if you would prefer not to reveal your name on this website then please contact me directly on the email above rather than replying to this post.

Thank you

Shivani Chotai
Trainee Clinical Psychologist

Appendix K: Invitation to Study Participation Posted Online



Netmums Coffeehouse > The Netmums Mums Panel > Media Requests > Have you experienced postnatal psychosis?

View Full Version : Have you experienced postnatal psychosis? Tell us what it was like...

Shivani C 29-06-15, 09:46

Dear Forum Members,

Can you help with a research project on Postpartum Psychosis?

I am looking to talk mothers who have recovered from Postpartum Psychosis. The study will involve arranging a session together where I can ask you questions about your experience. Participation will take around one hour and I am happy to meet wherever is most convenient for you.

Being involved in this study is completely voluntary but would be greatly appreciated. There is no right or wrong answer to the questions, but I am hoping it will help us understand what recovering from Postpartum Psychosis was like for you. Some participants may find it helpful and cathartic to talk about their experiences. It could contribute to raise awareness of Postpartum Psychosis and it is hoped that the findings from the study will also help healthcare professionals understand what factors are important in recovery.

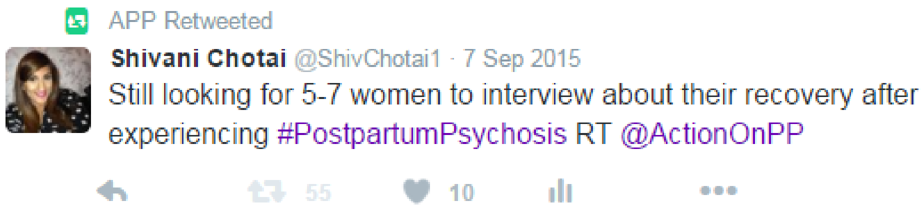
If you have any further questions, please contact me on
c030771c@student.staffs.ac.uk.

If you are interested in taking part in the study or you would like more information please email me and I shall send you an information pack which will have further details about the study.

Please be aware that this is a public forum, therefore if you would prefer not to reveal your name on this website then please contact me directly on the email above rather than replying to this post.

Thank you

Shivani Chotai
Trainee Clinical Psychologist



APP Retweeted

Shivani Chotai @ShivChotai1 · 7 Sep 2015

Still looking for 5-7 women to interview about their recovery after experiencing #PostpartumPsychosis RT @ActionOnPP

Appendix L: Participant Information Sheet

Participant Information Sheet

(Version 3, 28th September 2015)

Title: Life after Postpartum Psychosis: Experiences of Recovery
Research Team: Shivani Chotai, Elizabeth Boath, Vanessa Hewitt and Stephanie Hutton.

You have been invited to take part in this research study about postpartum psychosis (also known as postpartum/postnatal psychosis). This study is being undertaken as part of a Doctorate of Clinical Psychology qualification at Staffordshire and Keele Universities. The project will be led by Shivani Chotai. The following information outlines what the study will involve, please read this information sheet carefully before you decide to participate. If you have any questions or would like further information please contact Shivani on the details listed at the end of this information sheet. You are also welcome to discuss participating in this study with significant others.

What is this research study about?

This study is about exploring the experiences of mothers who have had postpartum psychosis. We would like to better understand how mothers make sense of this experience and to understand their road to recovery.

Who will be taking part?

I am recruiting women who are over 18 years old who have recovered from postpartum psychosis.
Women who are prescribed psychiatric medication in reaction to an episode of postpartum psychosis are able to participate in this study.

What will it involve?

If you decide you would like to take part in this study, please contact me to let me know and we can arrange a date, time and venue to meet to conduct the interview which is convenient for you. I am happy to meet you at a local building which is close by to you. For example we could meet in the local library. If you are unable to travel we could arrange to meet at your house.

When we meet I may also ask you a few questions about yourself and to find out if you are aware of what the study involves just to ensure you are happy to take part. If so, you will be asked to read and sign a consent form prior to the interview.

You will then take part in an interview with a female researcher. The interview will involve you describing your experience of postpartum psychosis and recovery with the help of some prompt questions. There is no right or wrong way to tell me about your experience but it would be really helpful to include all the information that you feel is relevant to your recovery for example what you feel has helped or hindered your recovery. The interview will take around one hour and will be digitally recorded and transcribed (typed into text). This will be done by the researcher and all information that could potentially identify you (e.g. names, services) will be taken out for confidentiality purposes.

What will happen to the results of the study?

Parts of the transcripts may be shared with supervisors in the research team for training and analysis purposes but all identifiable information will be taken out prior to this. Participant's information will not be used for any other research studies. Your responses from the interview will remain completely confidential and no identifiable information will be published as part of the presentation of findings and pseudonyms will be used to protect your identity.

Copies of the findings will be made available on request (by leaving your email address at the bottom of this information sheet). The full thesis is expected to be completed by July

2016 and the researcher will also aim to publish the findings in an academic journal which could be used to inform future research and clinical practice.

The data may need to be made available to the University for audit purposes however the data will be anonymised and contain no identifiable information. In line with Staffordshire University's research requirements the data will be stored for five years at the University and then destroyed securely. Another colleague will need to be made aware of the location of the interview to abide by lone working policies, however the location details will be destroyed securely when the interview has been completed. No other personal information or other identifying material will be stored.

What are the disadvantages and advantages of taking part?
The interview is expected to take one hour of your time and may involve you travelling to a local interview venue. Some participants may find it difficult to talk about their experience of postpartum psychosis. If you feel that participation in this study is affecting your well-being you have the right to take breaks during the interview or you can withdraw from the interview at any time. Following participation you have the right to withdraw up until the point of which the data has been published (expected date July 2016). You will not need to give a reason to withdraw your data. Contact details of the charity Action on Postpartum Psychosis (APP) are also provided below for further signposting. Additionally, telephone consultation with an NHS employed Clinical Psychologist can be arranged at a mutually convenient time if you feel your wellbeing has been directly affected through participating in this study.

On the other hand, some women may find it helpful to talk about their experience and may want their story of recovery to be told and shared. It is hoped that this research will increase understanding of the individual experience of postpartum psychosis and how women make sense of their recovery.

Do I have to take part?
No, you are under no obligation to participate in this research, participation is entirely voluntary. However, if you would like to take part the next stage is to contact me to organise a suitable date and time to meet.

What if there is a problem?
If you would like to talk more about the research or have any questions please contact Shivani Chotai on the contact details below. For further information about treatment or recovery from postpartum psychosis you may access the Action on Postpartum Psychosis website (http://www.app-network.org) which also hosts an online forum for support.

If you feel more urgent help is required you may wish to contact your local perinatal or parent-infant mental health service. If this service does not exist in your area and there are concerns about your well-being or your child's well-being please share these with your GP.

Who has reviewed this study?
This study has been reviewed and obtained ethical approved by Staffordshire University's Ethics Panel.

Researcher Contact Details
Shivani Chotai c030771c@student.staffs.ac.uk
Staffordshire University
Staffordshire and Keele Clinical Doctorate Training
Faculty of Sciences, Staffordshire University
Leek Road, Stoke-on-Trent, ST4 2DF

Supervised by Dr. Elizabeth Boath, E.Boath@staffs.ac.uk

If you would like a copy of the findings when the research has completed please provide an email contact: ____

Appendix M: Consent Form

Consent Form

(Version 3, 28th September 2015)

Title: Life after Postpartum Psychosis: Experiences of Recovery

Research Team: Shivani Chotai, Elizabeth Boath, Vanessa Hewitt, and Stephanie Hutton

Please tick each box to indicate your consent.

Consent Form

I confirm that I have read and that I understand the participant information sheet dated 28th September 2015 (Version 3) for the above study. I have had the opportunity to consider the information and have had these answered satisfactorily. ☐

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without my rights being affected. ☐

I understand that anonymised direct quotations may be used in the presentation of the findings. ☐

I understand that only the research team will have access to the transcripts and that any identifiable information will be removed. ☐

I agree to take part in the above study. ☐

Name of Participant	Signature	Date
Name of Researcher	Signature	Date

Appendix N: Topic Guide

Title: Life after Postpartum Psychosis: Experiences of Recovery
(Version 3, 28th September 2015)

Procedure for constructing the interview schedule

- Interview questions developed through discussion topics on support forums for PP.
- Following ethical approval an expert by experience has been identified to provide input regarding these questions.
- The questions will then be verified by professionals in the field.
- Changes to the topic guide will be submitted as an amendment for review.

Introduction

- **Explain rationale and procedure, right to take breaks and withdraw**
- **Explain confidentiality and limits of confidentiality i.e. safeguarding concerns and risk**
- **Capacity assessment?**
- **Obtain verbal consent and check participant has signed consent form**
- **Ask if the participant has any questions**
- **Rapport building**

Topics

1) Postpartum Psychosis (PP)

Was your pregnancy planned or unplanned?
How did you feel about your pregnancy?
How was your mental health antenatally?
Can you tell me about what your experience was like following the birth of your child?

Were you aware of PP?
Prompt: Had you heard of it?
Prompt: Did you know anything about it?

Please could you tell me about your experience of PP?
Prompt: If you had to describe what having PP was like for you, what would you say?
Prompt: Can you describe how you felt during your experience of PP?

Thinking back to your experience of PP, what do you remember first noticing?

What did your loved ones in your life notice?

How did other people react to what was happening?

What did you make of their responses at the time?

Can you tell me how you felt when you were told you had PP?
Prompt: How/what were you told?
Prompt: What did it mean to get the diagnosis?

Prompt: What was it like to raise a child after being told you had PP?
Prompt: What happened when you were told you had PP?

What were your main concerns following your experience of PP?
Prompt: What were your fears?

What influenced how you coped with things?
Prompt: How did you cope with PP?
Prompt: What were you strengths?
Prompt: What were your resources?
Prompt: What did you struggle to cope with?
Prompt: What helped give you hope?

2) Recovery

What does the term ‘recovery’ mean to you?

How did your recovery begin?

What things were important to you during your recovery?
Prompt: What was helpful in your recovery?
Prompt: Was there anything to make the recovery easier?
Prompt: What other things helped with your recovery?

What things got in the way of, or slowed down your recovery?

How would you change/have changed your recovery process?

Has having PP made a difference to how you see yourself?
Prompt: In what way?

How do you consider your future?

How do you think your life would be if you did not have PP?

Have you noticed any changes in other people’s reaction to you?
Prompt: Have you noticed any changes in your relationships?

Have you any advice for women who are in a similar situation?

3) Other topics

Is there anything else pertinent to this topic that you feel is important to share?
Please could you tell me what interested you in taking part in this study?

General Prompts:
Can you tell me more about that?
Tell me what you were thinking?
How did you feel?

What was it like when PP was at its worst?

What is life like now?

Participant Number:__________

Appendix O: Demographic Questionnaire

Demographic Questionnaire

(Version 3, 28th September 2015)

Title: Life after Postpartum Psychosis: Experiences of Recovery

Research Team: Shivani Chotai, Elizabeth Boath, Vanessa Hewitt, and Stephanie Hutton

1. What is your age?

____

2. How would you describe your ethnicity?

____

3. What type of delivery did you have? E.g. Emergency/Planned Caesarean/Vaginal

____

4. At child birth where there any complications that you did not anticipate? If yes, what were they?

____

____

5. Please select your relationship status at the time of giving birth (you can select more than one if applicable)

☐ Single ☐ In relationship with/married to the father of the child

☐ In relationship with/married to someone who is not the father of the child

☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Other:

____

What is your current relationship status? (you can select more than one if applicable)

☐ Single ☐ In relationship with/married to the father of the child delivered when I experienced postpartum psychosis

☐ In relationship with/married to someone who is not the father of the child delivered when I experienced postpartum psychosis

☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Other:

____

Symptoms

What symptoms did you notice during postpartum psychosis?
(List obtained from http://www.app-network.org/early-symptoms/)

☐ Excited, elated, high, ‘over the moon’ giggly
☐ Active, energetic, overactive
☐ Chatty, sociable, talking more
☐ Busy mind, racing thoughts, lots of ideas
☐ Muddled thinking, mixed up, confused, disorientated
☐ No need for sleep
☐ Not able to sleep
☐ Irritable, people getting on nerves, arguing, angry, impatient
☐ Anxious
☐ In a dream world, detached from world
☐ Efficient, organising, making lists, lots of jobs
☐ Distractible, getting nothing finished
☐ Fearful, ‘paranoid’
☐ Disinhibited, saying/doing things would not normally say/do
☐ Looking after baby easy, feeling extremely confident and capable
☐ Tearful, sad
☐ Heightened perception, things more beautiful/interesting
☐ Alert, clear minded
☐ Creative, writing more, knitting
☐ Up and down, crying and laughing
☐ Low mood, depressed
☐ Tired, no energy
☐ Agitated, stressed, tense
☐ Overemotional, over sentimental
☐ Increased libido
☐ Decreased libido
☐ Excessive worries
☐ Tearful but not sad
☐ Spending more money
☐ Not coping
☐ Impulsive
☐ Feeling more spiritual
☐ Experiencing nightmares, vivid dreams
☐ Disconnected from baby, baby does not feel like it is mine
☐ Self-harm
☐ Aggression/Violence to others
☐ Inappropriate dress/nakedness
☐ Difficulties with self-care
☐ Changes in usual personality

Other____

How soon after childbirth did you experience symptoms of postpartum psychosis?

____

Do you still experience any of the symptoms that you believe are associated with postpartum psychosis?

____

Diagnosis

Did you receive a formal diagnosis of Postpartum Psychosis?

☐ Yes ☐ No ☐ Don't know

☐ I received a different diagnosis ____________________

If you received a diagnosis, how soon after childbirth did you receive the diagnosis?

____

How long ago did you receive the diagnosis (e.g. May 2004)

____

Treatment

Where were you cared for during your episode of Postpartum Psychosis?

Location		**Time spent here**
General mental health ward	☐	____________________
Mother and Baby Unit	☐	____________________
Maternity Ward	☐	____________________
Community/At home	☐	____________________
Other	☐	____________________

How many children do you have in total?

____

How old are your children?

____

Did you have subsequent births following the episode of postpartum psychosis?

____

Did postpartum psychosis occur again?

____

Have you had any previous mental health difficulties? If yes, please could you provide more information about the difficulties you had and your current situation in relation to these difficulties.

Yes / No

Did you access/are you currently accessing any psychological support related to the postpartum psychosis? If yes, what support did you access and where from (e.g. CBT from Community Mental Health Team, counselling from private therapist)

☐ No, I feel psychological support is not necessary at the current moment

☐ No, but I would like to access psychological support in relation to the postpartum psychosis

☐ Yes, I previously accessed psychological support

☐ Yes, I am currently accessing psychological support

13. Are you currently taking any medication as a result of the postpartum psychosis, if so please describe what medication you are currently taking and how long you have been taking it?

14. Can you tell me the highest educational or school qualification you have obtained?

☐ No qualifications, did not finish school
☐ Other professional-vocational qualification
☐ City & Guilds low level qualification
☐ Royal Society of Arts (RSA) low level qualification.
☐ BTEC, BEC general certificate, YT certificate
☐ CSE, GCSE, and other SCE lower level
☐ O-level, CSE grade 1 (or equiv. GCSE or SCE)
☐ City & Guilds craft; BTEC, etc. 1st diploma
☐ RSA diploma
☐ SCE higher, Certificate of 6th year studies
☐ City & Guilds advanced craft
☐ RSA Adv., BTEC, BEC National ONC-OND
☐ A-level or equivalent
☐ RSA higher diploma, higher educ. below degree
☐ Nursing or similar medical qualification
☐ Teaching qualification
☐ HNC-HND, higher level BTEC, BEC
☐ Diplomas in higher education
☐ Other degree level qualification
☐ First university degree
☐ Higher degree

Other: ____________________________________

Current Employment Status

☐ Employed full-time
☐ Employed part-time
☐ Self-employed
☐ Carer
☐ Voluntary work
☐ Maternity Leave
☐ Student
☐ Unemployed
☐ Other:______________________________

Appendix P: Debrief

Debrief
(Version 3, 28th September 2015)

Title: Life after Postpartum Psychosis: Experiences of Recovery

Thank you for participating in the above study, your time and involvement is appreciated. As outlined in the information sheet, this research aims to find out more about mothers' experiences of recovery following Postpartum Psychosis (PP). It is hoped that it will provide insight into how mothers have made sense of their individual experience and that the findings should increase our understanding of the recovery needs of women who have experienced PP.

The information you have provided as part of your interview will be transcribed (typed into writing) onto an encrypted laptop and will be kept confidential. All other data such as the demographic questionnaire you completed will be stored in a locked filing cabinet separate from your signed consent form so your data will not be kept with your name.

What if I feel upset or distressed after my participation in the study?

The researcher is keen to ensure that you are not distressed as a result of participating in the study. If you are feeling upset, please communicate this with the researcher so we can decide whether further support is necessary.

If you feel immediate support is required and you feel distressed as a direct result of being involved in this study we can arrange a telephone consultation with a local NHS employed Clinical Psychologist, Dr. Stephanie Hutton. Alternatively you may wish to contact your local perinatal or parent-infant mental health service. If this service does not exist in your area and there are concerns about your well-being or your child's well-being please share these with your GP.

Please remember that there are a number of support forums that are free to register to, including:

Action on Postpartum Psychosis: www.**app**-network.org
PANDAS: www.**pandas**foundation.org.uk
Mumsnet: www.**mumsnet**.com
Netmums: www.**netmums**.com

How do I withdraw my data?

You can withdraw your data up to the point of publication (expected date – July 2016). If you would like to do this, please contact the researcher by email and give your name and all information relating to your participation in the study will be destroyed securely. You will not be asked to provide a reason for withdrawing.

Many thanks and best wishes

Shivani Chotai (Trainee Clinical Psychologist)

Email: c030771c@student.staffs.ac.uk

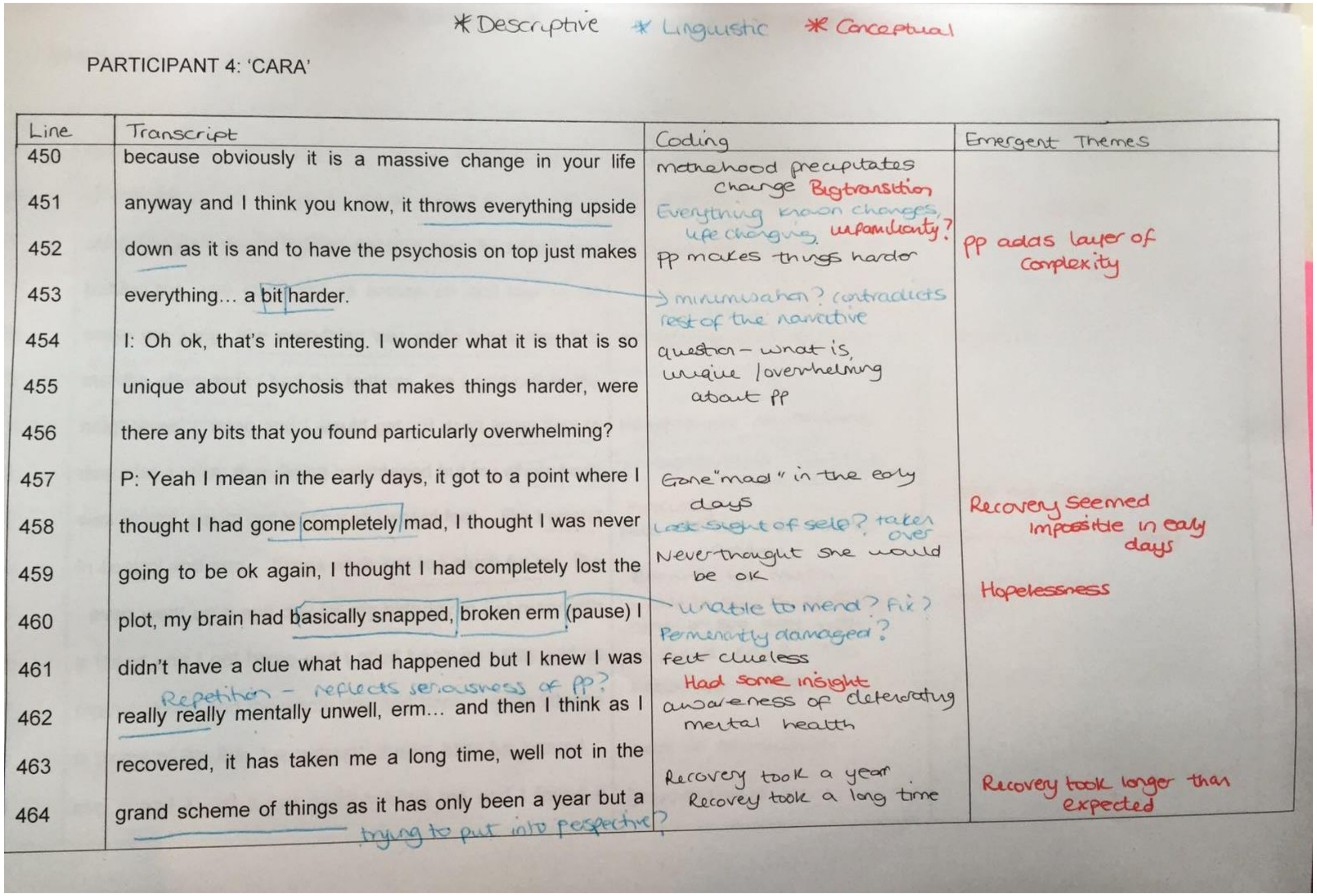
Appendix Q: Early Symptoms of PP

	Pseudonyms							
Symptoms	Phoebe	Teresa	Monica	Cara	Laura	Katie	Jessica	Angie
Excited, elated, high		✓	✓	✓	✓	✓	✓	
Active, energetic	✓	✓	✓	✓	✓		✓	
Chatty, sociable, talking more		✓		✓	✓	✓		
Busy mind, racing thoughts	✓	✓	✓	✓	✓	✓	✓	
Muddled thinking, confusion	✓	✓	✓	✓		✓		✓
No need for sleep			✓	✓				
Not able to sleep	✓	✓	✓	✓	✓	✓	✓	
Irritable		✓		✓		✓		
Anxious	✓	✓	✓	✓		✓	✓	✓
Dream world, detached from world	✓		✓	✓	✓	✓	✓	✓
Efficient, organising	✓	✓	✓	✓	✓	✓	✓	
Distractable	✓			✓		✓		
Fearful, 'paranoid'	✓		✓	✓		✓	✓	✓
Disinhibited	✓	✓	✓	✓	✓	✓	✓	
Feeling extremely confident and capable				✓		✓		
Tearful, sad		✓				✓		✓
Heightened perception		✓		✓		✓	✓	
Alert, clear minded								
Creative, writing more								
Up and down, crying and laughing		✓		✓	✓	✓	✓	
Low mood, depressed	✓	✓		✓		✓		✓
Tired, no energy		✓		✓		✓		✓
Agitated, stressed, tense	✓	✓		✓	✓	✓	✓	✓
Overemotional, oversentimental	✓	✓		✓		✓	✓	

	Pseudonyms							
Symptoms	Phoebe	Teresa	Monica	Cara	Laura	Katie	Jessica	Angie
Increased libido					✓	✓		
Decreased libido				✓			✓	✓
Excessive worries	✓	✓		✓		✓		✓
Tearful but not sad								
Spending more money		✓			✓			
Not coping	✓		✓	✓	✓	✓	✓	✓
Impulsive			✓			✓		
Feeling more spiritual	✓		✓	✓				
Experiencing nightmares, vivid dreams				✓	✓	✓	✓	
Disconnected from baby	✓			✓				
Self-harm				✓			✓	✓
Aggression/Violence to others	✓			✓				
Inappropriate dress/nakedness					✓			
Difficulties with self-care	✓	✓	✓	✓	✓	✓	✓	✓
Changes in usual personality	✓	✓	✓	✓	✓			✓
Other: Delusions								✓
Other: Cleaning compulsions								
Other: Intrusive thoughts of infant harm						✓	✓	

Appendix R: Stage One: Line by Line Coding

Example: Cara



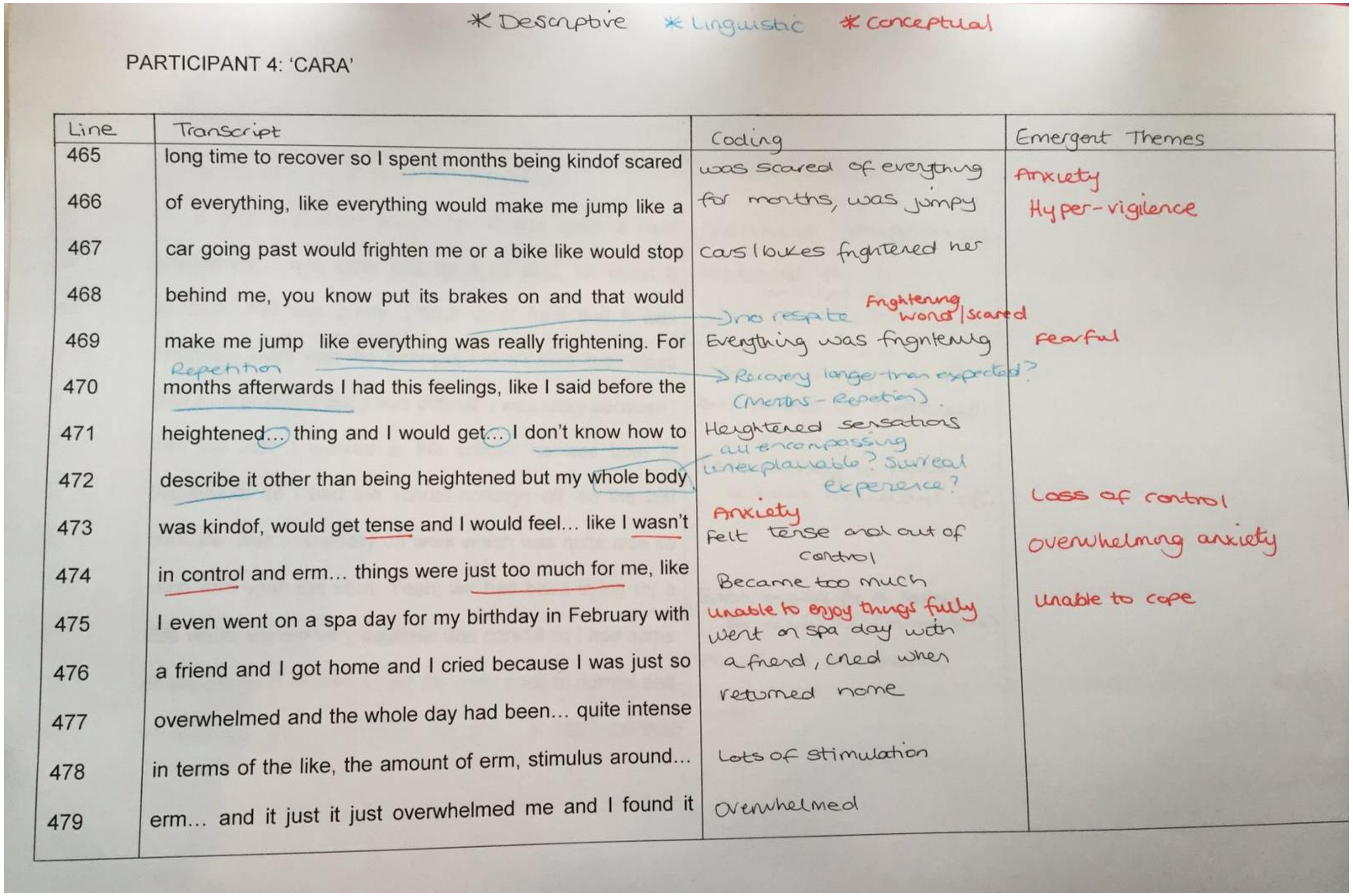
* Descriptive * Linguistic * Conceptual

PARTICIPANT 4: 'CARA'

Line	Transcript	Coding	Emergent Themes
450	because obviously it is a massive change in your life	motherhood precipitates change Big transition	
451	anyway and I think you know, it throws everything upside	Everything known changes, life changing. unfamiliarity?	
452	down as it is and to have the psychosis on top just makes	PP makes things harder	PP adds layer of complexity
453	everything… a bit harder.	minimisation? contradicts rest of the narrative	
454	I: Oh ok, that's interesting. I wonder what it is that is so	question – what is, unique / overwhelming about PP	
455	unique about psychosis that makes things harder, were		
456	there any bits that you found particularly overwhelming?		
457	P: Yeah I mean in the early days, it got to a point where I	Gone "mad" in the early days	
458	thought I had gone completely mad, I thought I was never	Lost sight of self? taken over	Recovery seemed impossible in early days
459	going to be ok again, I thought I had completely lost the	Never thought she would be ok	
460	plot, my brain had basically snapped, broken erm (pause) I	unable to mend? Fix? Permanently damaged?	Hopelessness
461	didn't have a clue what had happened but I knew I was	felt clueless Had some insight	
462	really really mentally unwell, erm… and then I think as I Repetition – reflects seriousness of PP?	awareness of deteriorating mental health	
463	recovered, it has taken me a long time, well not in the	Recovery took a year	
464	grand scheme of things as it has only been a year but a trying to put into perspective?	Recovey took a long time	Recovery took longer than expected

Appendix R: Stage One: Line by Line Coding

Example: Cara (continued)



✱ Descriptive ✱ Linguistic ✱ Conceptual

PARTICIPANT 4: 'CARA'

Line	Transcript	Coding	Emergent Themes
465	long time to recover so I spent months being kindof scared	was scared of everything	Anxiety
466	of everything, like everything would make me jump like a	for months, was jumpy	Hyper-vigilence
467	car going past would frighten me or a bike like would stop	cars/bikes frightened her	
468	behind me, you know put its brakes on and that would	no respite Frightening word/scared	
469	make me jump like everything was really frightening. For	Everything was frightening	Fearful
470	Repetition months afterwards I had this feelings, like I said before the	Recovery longer than expected? (Months - Repetition).	
471	heightened… thing and I would get… I don't know how to	Heightened sensations all encompassing	
472	describe it other than being heightened but my whole body	unexplainable? Surreal experience?	Loss of control
473	was kindof, would get tense and I would feel… like I wasn't	Anxiety Felt tense and out of control	overwhelming anxiety
474	in control and erm… things were just too much for me, like	Became too much	Unable to cope
475	I even went on a spa day for my birthday in February with	unable to enjoy things fully went on spa day with	
476	a friend and I got home and I cried because I was just so	a friend, cried when	
477	overwhelmed and the whole day had been… quite intense	returned home	
478	in terms of the like, the amount of erm, stimulus around…	Lots of stimulation	
479	erm… and it just it just overwhelmed me and I found it	Overwhelmed	

Appendix S: Stage Two: Emergent Themes in Chronological Order

Example: Cara

Emergent Theme	Line No.
Too good to be true, coping "too well"	57
Performing Supermum	58
Proving competence as a mother	66
Strange situation	74-76
Let down by services	89-90, 378, 563, 611, 827
Reliant on services	91
"Something is not quite right"	96
Confusion	L99
Lack of insight	109-112
Feeling unprepared	116-118
Feeling out of depth	112-125, 196
Stigma	134-135
Fear of unknown	136
Love	138-140
Rationalisation	143
Overwhelming support	146-148
Negative perception of mental health	153-154
Lacked safety and trust in others	157-160
Suspicious of others	170-171
Effects on relationship	173
Isolating experience	177

Emergent Theme	Line No.
Increased sensitivity	178
Unexplainable and unfamiliar experience	197-198
Feeling out of control	204
PP takes over	206
Limited awareness of PP	215-217
Power between professionals	221, 880
PP less known than PND	224
Worried about separation of baby	234
Frustration at lack of specialist services	238
Decision made about me not with me	250
Trust rebuilding	262
Handing over responsibility	264
Feeling scared	275
Grateful of MBU support	282
Shared experience / distress	286
Feeling less of a burden with professional support	291
Consistent care	294
Renegotiating normal life	303
MBU created opportunities to do embrace motherhood	306
Physical needs easier to meet than emotional	309

Emergent Theme	Line No.
Unable to trust own instincts	327
Reassurance	328
Fear of abandonment	332,549
Communication struggles – unexplainable?	335
Over-applying significance to things	341
Positive effects of PP – stronger bond	372
Concerned about attachment	374
Guilt	387-388
Reconnection	394
Fought for relationship, bonding as a conscious effort	398
Compensating for lost time	401-402
Conflict of emotions towards baby	415
Blame	420
Regret	424
Protection	427
Connection	428
Similarities across ‘normal motherhood’	440
PP adds layer of complexity	440
Hopeless – recovery felt impossible	448
Anxiety	465
Overwhelming	474-477
Unable to cope	478

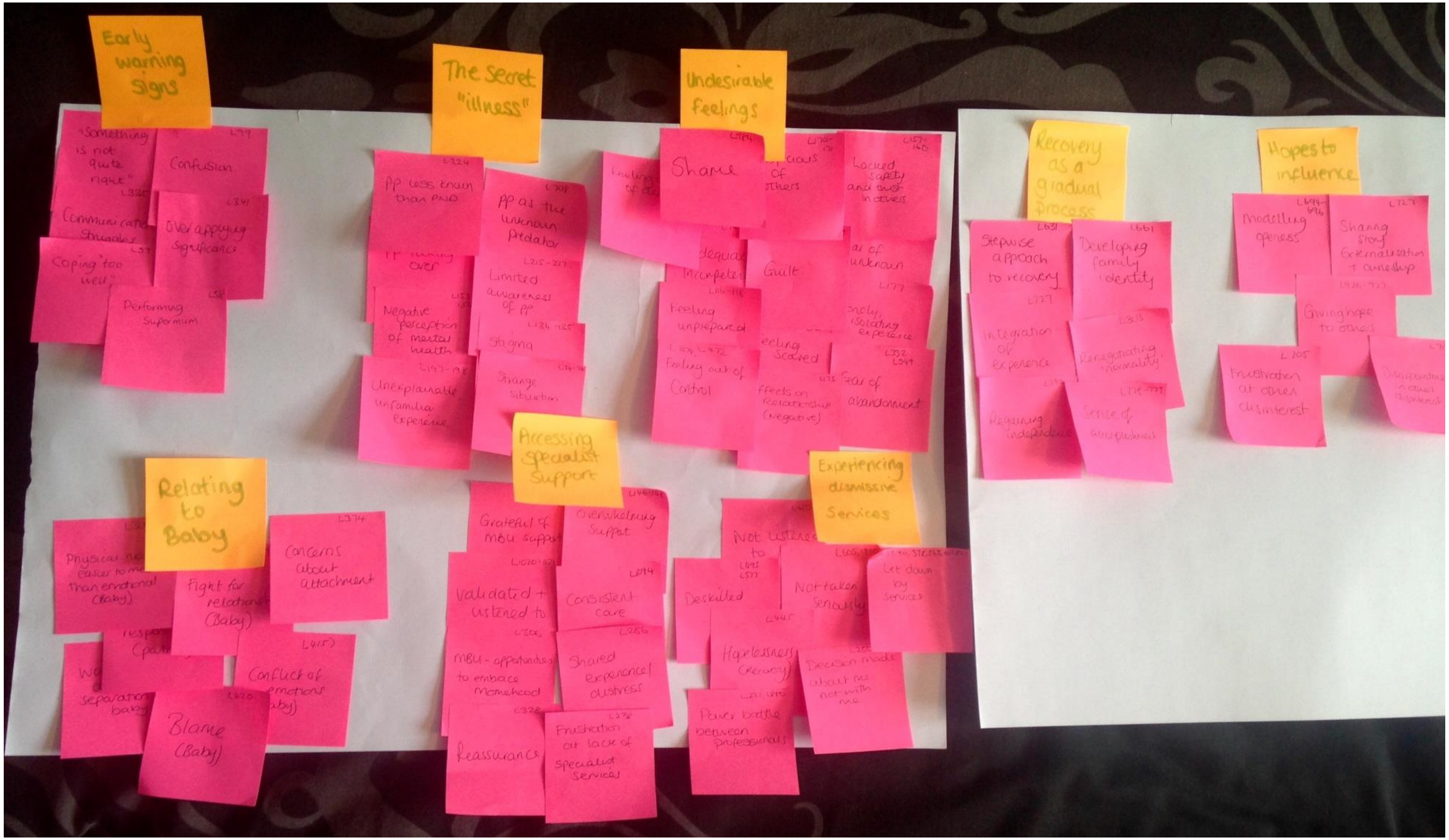
Emergent Theme	Line No.
Loss of independence	486
Deskilled	493, 517
Surreal experience	497
Self harm/punishment	584
Numbness	585
Not taken seriously	605, 990
Not listened to	610
Stepwise approach to recovery, different stages	631
Positive impact on relationships	641-643
Developing family identity	661
Modelling openness	694-696
Supportive relationships	698
Frustration at other’s disinterest	705
Lack of awareness	707
PP as the unknown predator after birth	708
Disappointment in others reactions – disinterested	717
Sharing personal story – externalisation and ownership of experience	727
Self as a whole – integration of experience	732
Regaining independence	740
Felt reliant and incompetent	743
Flourishing as a mother	748-749
Empowerment	754
Increased confidence	755

Emergent Theme	Line No.
Inadequacy	760
Self-criticism	761
Black and white thinking	765
Self-doubt	767
High expectations of motherhood	769
Self-identity	769
Sense of accomplishment	778-779
Feeling different – hard to connect with others	810
Need for training and early identification	810
Poor communication between services	829

Emergent Theme	Line No.
Frustrated at the lack of knowledge	855, 862
Sharing experience	900
Peer support	915, 945
Giving hope to others	926-927
Developing empathy	928
Hope for recovery	934
Embarrassment	983
Shame	984
Pride	1005
Understanding from others	1016
Professional support	1019
Validated and listened to	1020-1022

Appendix T: Stage Three: Mapping Provisional Themes

Example: Cara

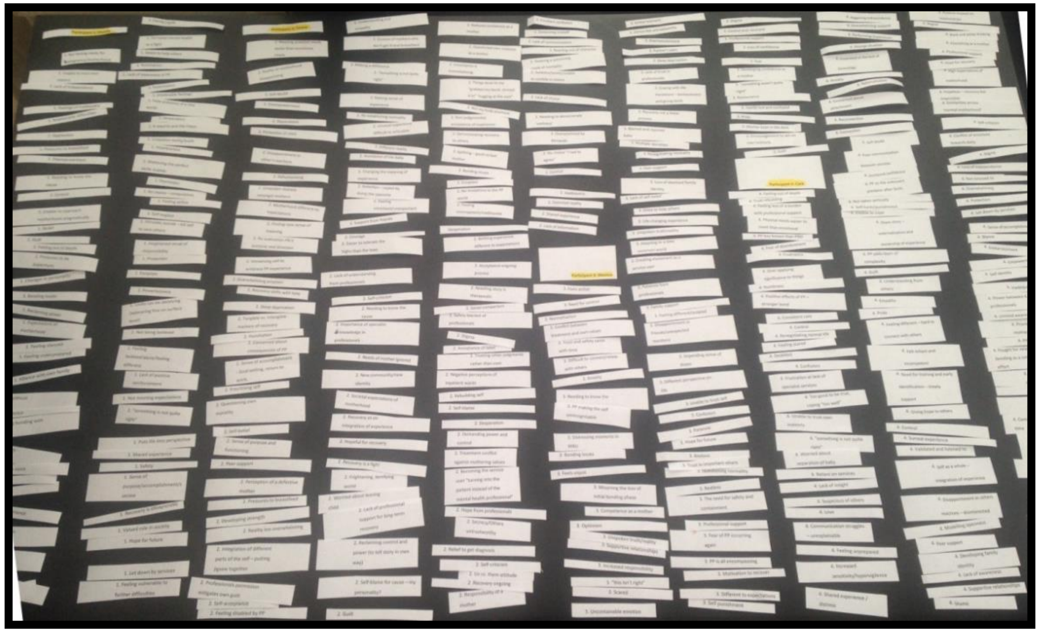


Appendix U: Stage Four: Clustering Emergent Themes

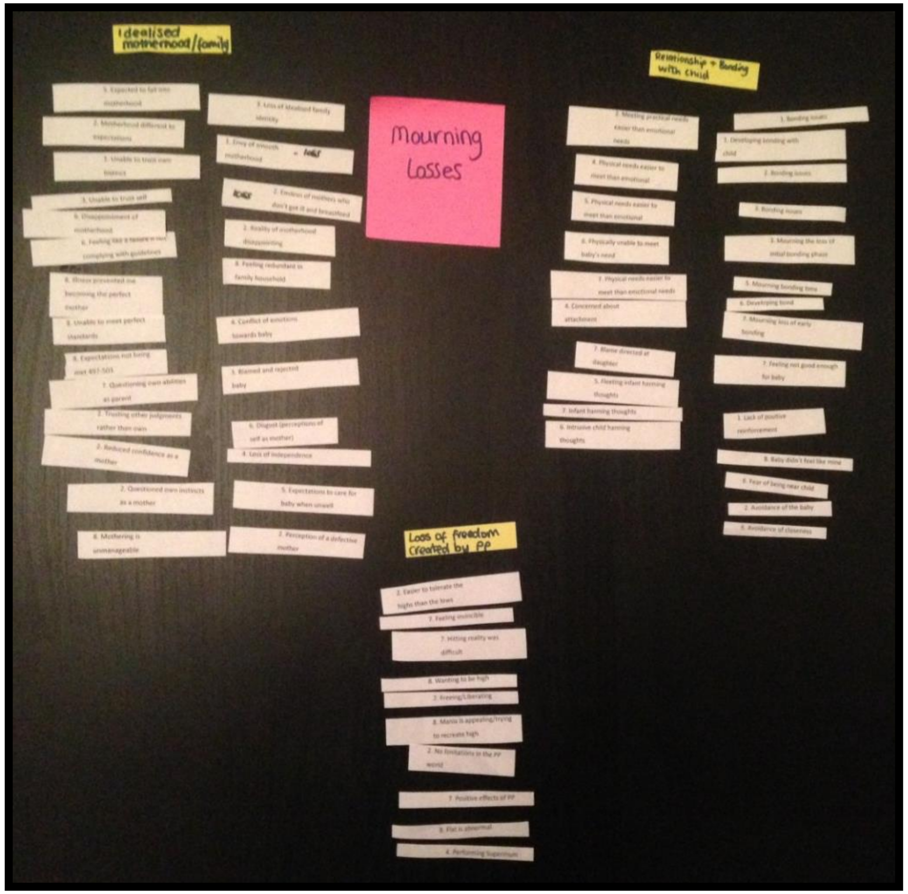
Example: Cara

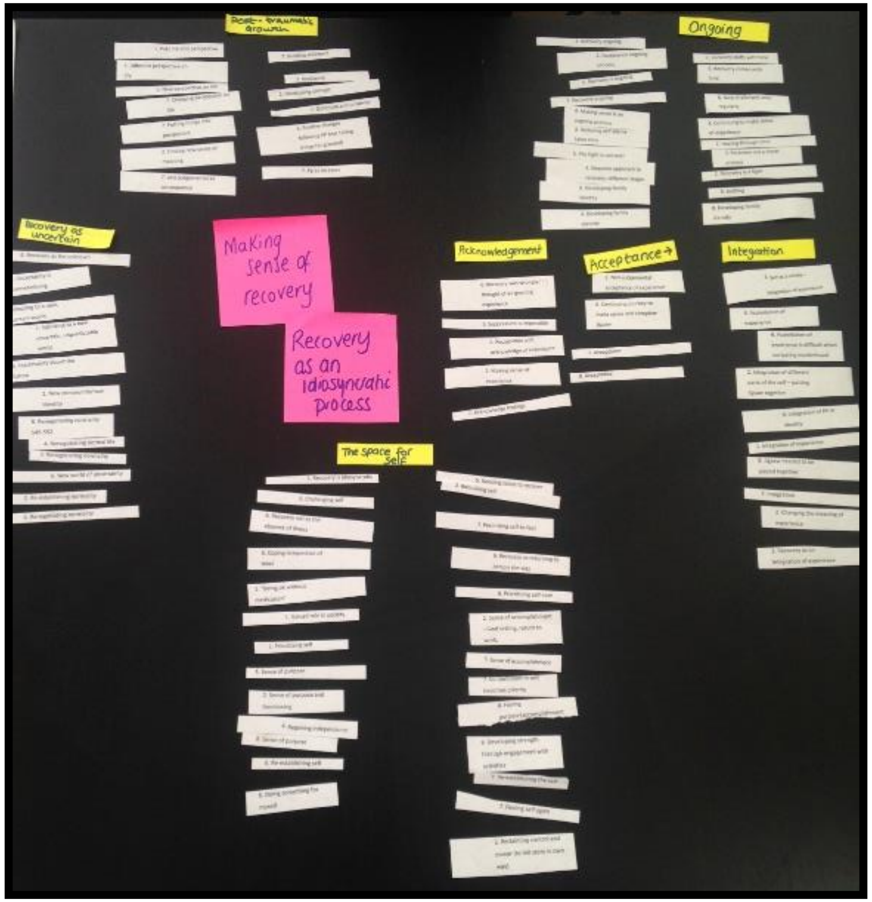
Provisional Themes	Line(s)
Early warning signs	
"Something is not quite right"	96
Communication struggles	335
Feeling out of control	204
Coping "too well"	57
Performing SuperMum	58
Confusion	99, 109-112
Over applying significance to things	341
Relating to the baby	
Conflicting emotions	374, 138-140
Concerns about separation	234, 238
Fighting for relationship	398
Physical needs easier to meet than emotional	66, 309
Concerns about attachment	374
Stronger bond	372
Compensating for lost time	401-402
The secret "illness"	
PP less known about than postnatal depression	224
Negative perceptions of mental health	153-154
Stigma	134-135
PP as the unknown predator	708
Surreal experience	74-76, 197-198, 497
Limited awareness of PP	215-217, 855, 862
Undesirable feelings	
Lack safety and trust in others	157-160
Suspicious of others	170-171
Lonely, isolating experience	177, 810
Feeling scared	116-118, 112-125, 196, 275
Shame, guilt, inadequacy	387-388, 984
Fear of abandonment	332, 549
Recovery as a gradual process	
Stepwise approach to recovery	631
Developing family identity	372, 394, 601
Integration of experience	732, 727
Renegotiating normality	303, 769
Regaining independence	740, 754
Sense of accomplishment	748-749, 778-779
Hopes to influence	
Modelling openness	694-696
Sharing story	727
Promoting hope for recovery	926-927
Barriers - Disappointment in others' reactions	105, 717

Appendix V: Stage Four: Emergent Themes in Choronological Order across Participants



Appendix W: Stage Five: Clustering Themes across Participants





Appendix X: Stage Six: Integrative Analysis Table

Super-ordinate Theme One: Becoming Unrecognisable

Participants	Sub-ordinate Themes	Key Cross-References	Indicative Quotations	Notes
All	1a) "Something is not quite right"	Phoebe (112-113, 279-280)	Phoebe: "I knew there was something wrong you know but there's not much awareness of it, it's not like postnatal depression"	Intrinsically aware that they are losing sense of self
		Teresa (176-177)	Teresa: "I just knew things weren't right with me… I don't feel right"	
		Monica (224)	Monica: "I was too afraid, I knew something wasn't right"	
		Cara (96, 197-200)	Cara: "something was not quite right with me… I didn't have a clue what I was doing with the baby… so I think I started to realise something was wrong but I didn't know what was wrong"	
		Laura (146-147)	Laura: "I just said [to midwife] there's something wrong with me, I'm not right"	
		Katie (568-569)	Katie: "I wasn't right"	
		Jessica (400-401)	Jessica: "Something wasn't quite right"	
Teresa, Cara, Katie, Angie	1b) Wellness as a performance	Teresa (286-390)	Teresa: "I just wanted to kind of show I could be well, I could show myself more than anyone else really, a few weeks on the medication I took myself off, I came off it	Participants described various functions of demonstrating wellness including avoiding separation

Participants	Sub-ordinate Themes	Key Cross-References	Indicative Quotations	Notes
			without speaking to the psychiatrist… I just wanted to convince them and myself that I was normal”	of child, avoidance of diagnosis and being viewed as ‘normal’.
		Cara (84-85, 201)	Cara: “I think it was going ‘too well’ like everything was really good” “I was really scared they were going to take [child] away”	
		Katie (605-613) (969-973) (1128-1130)	Katie: “I thought no, I don’t want to be involved with mental health services, I don’t want to be involved with psychiatry… I need to avoid that at all costs so the next day I needed to convince [community midwife] that I’m fine, so I got up, had a shower and I sat up right in the chair talking really brightly telling her I was fine”	
			“I went to mother and baby groups, it was really hard, it was like this big secret that I had over me and one day these people are going to find out I’m a psycho and stop talking to me”	
			“I know everyone finds it hard but I was holding back in saying exactly how I had found it”	
		Angie (358-362)	Angie: “I couldn’t take [son] to the weekly clinic, I couldn’t face other women I just felt like a complete and utter *freak*… I hadn’t had a normal experience”	
Teresa, Cara,	1c) “Losing grip	Teresa (207)	Teresa: “I was frightened, it did seem like	Fear, terror, confusion

Participants	Sub-ordinate Themes	Key Cross-References	Indicative Quotations	Notes
Laura, Katie, Jessica	of reality” (Katie)		the world wasn’t right.	
		Cara (74-75) (457-462)	Cara: “I had four days without any sleep at all and things just started to get a little bit strange I suppose” “it got to a point where I thought I had gone completely mad, I thought I was never going to be ok again, I thought I had completely lost the plot, my brain had basically snapped, broken, I didn’t have a clue what had happened but I knew I was really really mentally unwell”	
		Laura (99-104) (743-746)	Laura: “…there were all these strange things going on that weren’t normal like things were speeded up or slowed down, just my whole (pause) brain chemistry seemed to have just (pause) gone to pot… and it was like my body had shut down and I cannot look after this baby. “It is horrendous at the time to have postpartum psychosis and to feel like you’re on another planet and you can’t cope”	
		Katie (643-647)	Katie: “…then I realised I was really unwell and I just felt like I was right on the edge of losing my grip of reality, it was almost like I was holding on with my fingernails”	
		Jessica (184-192)	Jessica: “I found myself desperate for some distance my thoughts were muddled and conflicted, I remember feeling like I had woken up but in a different version of reality	

Participants	Sub-ordinate Themes	Key Cross-References	Indicative Quotations	Notes
			to the one I had previously known”	
		Teresa (207)	Teresa: “I was frightened, it did seem like the world wasn’t right.	
		Cara (74-75) (457-462)	Cara: “I had four days without any sleep at all and things just started to get a little bit strange I suppose” “it got to a point where I thought I had gone completely mad, I thought I was never going to be ok again, I thought I had completely lost the plot, my brain had basically snapped, broken, I didn’t have a clue what had happened but I knew I was really really mentally unwell”	
		Laura (99-104) (743-746)	Laura: “…there were all these strange things going on that weren’t normal like things were speeded up or slowed down, just my whole (pause) brain chemistry seemed to have just (pause) gone to pot… and it was like my body had shut down and I cannot look after this baby. “It is horrendous at the time to have postpartum psychosis and to feel like you’re on another planet and you can’t cope”	
All	1d) The “terrifying and surreal world” of postpartum psychosis	Phoebe (160-167)	Phoebe:”I was hearing my own voice but it was heightened, it was like a bell going off and once it had gone off it was in my mind that I had to do something. It was me commanding myself to do things and if I didn’t do these things then it would mean I	Escaping fear, fear of abandonment, perceived threat of self, lack of perceived safety

Participants	**Sub-ordinate Themes**	**Key Cross-References**	**Indicative Quotations**	**Notes**
			was selfish and it would cause harm to others. So if I didn't kill myself and jump out of the window then my family would die. I felt compelled to do them"	
		Teresa (294-298)	Teresa: "I didn't understand the emotions that were going on. It was terrifying, feeling out of control and not understanding what was going on, seeing different faces and everything. I can't think of any other ways to describe it but a terrifying world"	
		Monica (160-167, 276-278)	Monica: "I had a fear of everything, I was scared that I was going to die and nothing was normal and I feared everything… it was extraordinary fear, racing fear, didn't trust anyone, didn't want to be there, didn't want to take their pills, I didn't want to. I just had this massive irrational fear that they [staff] were going to kill me. I was very, very scared."	
		Cara (152-154)	Cara: "I was convinced that once I realised I was poorly I thought I was going to get taken away in a padded van and locked away in a mental hospital"	
		Laura (501-506)	Laura: "It's almost like you go into a strange dream state with the psychosis, erm, and reality just goes out of the window… when you're in the psychosis, it's a terrifying,	

Participants	Sub-ordinate Themes	Key Cross-References	Indicative Quotations	Notes
			surreal world… all normality goes out of the window”	
		Katie (666-673)	Katie: “I’m not safe, you’re not safe, nothing in the world is safe… I’m going to kill you… I’m going to kill my baby (deep breath) I could hear myself saying it and I had no idea where it came from, I just know that I didn’t feel safe in any way and I didn’t feel safe to be around other people, like I was dangerous”	
		Jessica (303-310)	Jessica: “I had no idea whether I was in purgatory, hell or a nightmare whether I was causing the danger and threat, I could not express my fears to the midwives, nurses or doctors or were caring for me”	
		Angie (302-305)	Angie “I just felt the whole world was against me… that somebody has got a vendetta against you”	

Super-ordinate Theme Two: “At the time it felt like a death sentence”: Mourning Losses

Participants	Sub-ordinate Themes	Key Cross-References	Indicative Quotations	Notes
Phoebe, Teresa, Monica, Cara, Katie, Angie	2a) Loss of envisaged motherhood	Phoebe (281-283)	Phoebe: “I was ultimately a part-time mum, I couldn’t give her my everything because I wasn’t in the right head space”	Motherhood does not meet expectations, disappointment and guilt
		Teresa (564-568)	Teresa: “feeling inferior to other Mums, never feeling like I was a good enough parent, definitely stopped me feeling confident in my parenting skills and stopped me feeling confident enough to trust my instincts about parenting” “At first I saw myself as a weak person, someone who couldn’t cope who wasn’t cut out to be a Mum, should never had children because children made me unwell”	
		Monica (97-100) (362-364) (367-374)	Monica: “Since having it, it’s broke my heart because I feel like I’ve missed out on the beginning of her little life because I was too concerned with what was going on with me that I didn’t really take any notice of her, my little baby” “The bonding was very hard, I didn’t know how to play with her, it was very strange. I’d sit and think what do I do with her, what do I say to her. Basics like nappy changing, clothes changing came quite naturally to me but it was the bonding process that I really struggled with, what do I say to her, what do I do to her? I thought am I really a capable Mother”	
		Cara (329-331) (760-771)	Cara: “I wouldn’t let them leave me on my own, erm… so we had to always have someone else there, my Mum or his Mum or somebody else so they could look	

Participants	Sub-ordinate Themes	Key Cross-References	Indicative Quotations	Notes
			after [child]" "I felt like I was being an inadequate mother, I felt like I wasn't… fulfilling my role properly… I felt like I wasn't being a good Mum, like for months and months… motherhood was the thing I could be good at so… when I wasn't as good as I wanted to be because of the illness and it hit me really hard"	
		Laura (174-176)	Laura: "I think those first few months, not being able to be with him and him coming with his dad visiting once a week… that is bonding time that will never come back"	
		Katie (577-582) (704-710)	Katie: "I just started to feel really trapped, there was no way out and like I had ruined my life, and it was a stupid decision to have a baby which I clearly wasn't good enough for because I couldn't do it and there this little thought crept into my mind that the only way out was the kill myself" "I couldn't be near [child] I was so frightened I was going to hurt her somehow I didn't know how to be a mother to her (sniff)…I felt absolutely disgusted and ashamed of myself that I wasn't able to do this thing that so many other women were able to do"	
		Angie (230-235)	Angie: "My drive was to have my son to have the best mother and I felt I couldn't be the best mother for him because I was so ill, I felt I wasn't able to look after him… I just kept thinking yeah he deserves a better mother and I'm not a fit mother"	

Participants	Sub-ordinate Themes	Key Cross-References	Indicative Quotations	Notes
Teresa, Monica, Cara, Jessica	2a cont.) Loss of early bonding and idealised love with baby	Teresa (76-82) (430-435)	Teresa: “I just remember thinking ‘god I don’t want to hold that as well, I feel crappy here, I’m in pain, I’m uncomfortable, I just want to be left alone now I don’t want to look after that thing I had no bond at all I didn’t have any sense of (pause) everyone was giving him to me because that was the right thing to do but I wasn’t feeling it… I didn’t feel at all like it was all supposed to feel, like the books said, the rush of love, the bond, the breastfeeding. I felt terrible inside all the time… I look after him physically but emotional I just couldn’t build that bond” “I did have thoughts of harming [child], they were going around in my mind at the time. If I killed myself should I take [child] with me, erm will that save him from the trauma growing up and knowing that he had a Mum who committed suicide or would it be best left”	Shame and self-criticism
		Monica (470-495)	Monica: “I remember at points, I blamed her everything that had happened, I blamed her for the psychosis, I felt that she must have been the fault and I remember at times trying to get rid of her. I said I didn’t want her anymore, I didn’t want anything to do with her”	
		Cara (100-125)	Cara: “I did feel love for him... erm... but not all the time... so... yeah, I was very connected to him in the beginning I think when he was first born and then I had some issues with the fact obviously my whole life had been turned upside down so there was a little bit	

Participants	Sub-ordinate Themes	Key Cross-References	Indicative Quotations	Notes
			of.. maybe blame towards him and like I wish I hadn't had him and it hadn't happened"	
		Jessica (10-11) (74-76) (232-235) (330)	Jessica: "I thought [child] was too perfect, definitely too perfect to have me as her mother, I didn't deserve her and I found myself becoming more distant" "I felt that my mind and body had been invaded and I blamed [child] for this because it was happening because I had given birth to her" "It hurts to think about what I missed out on being so ill" "I didn't know how to love her, developing a relationship was terrifying, just being with her, entertaining her, sharing life with her, I wasn't sure I was capable"	
Teresa, Cara, Jessica, Angie	2b) Loss of the liberating side of PP	Teresa (222-225)	Teresa: "I started to get really confused and deluded about our finances and started thinking we had loads more money than we did, that we could afford loads of holidays because we've got all this money, thinking why have we deprived ourselves of all these things for so long so I went from being high and crashed to low and I was obsessed with the guilt of what I had done"	Enhanced productivity, efficiency, confidence but different for family.
		Cara (420-425)	Cara: "Once I could move I was up and about and just being a SuperMum straight away, doing everything, breastfeeding was going perfectly, it was all brilliant… I just felt this amazing euphoria like everything had been brilliant"	

Participants	Sub-ordinate Themes	Key Cross-References	Indicative Quotations	Notes
		Jessica (4-9) (22-25)	Jessica: “Everything was wonderful, I felt that I was doing brilliantly, I was able to do my work, my chores, physically care for [child], I had an unbelievable amount of energy and brain power (pause) until I broke down”	
			“For the first time in my life I was confident and had self-belief, life was fantastic but for people around me it was a living nightmare, to lose all that adrenaline was painful”	
		Angie (997-1004)	Angie: “I felt quite flat, fed up and struggling and life was hard and missed the high, euphoric feeling I had in the past where I actually felt confident and that’s how everybody felt, that was normal, what I was feeling most of the time wasn’t normal”	

Super-ordinate Theme Three: “Recovery still goes on” (Teresa): Recovery as an Ongoing Process

Participants	Sub-ordinate Themes	Key Cross-References	Indicative Quotations	Notes
Teresa, Monica, Cara, Katie, Jessica, Angie	3a) Support from others	Teresa (482-492) (507-510)	Teresa: “Finally I got to see the perinatal psychiatrist, such relief when she told me what postpartum psychosis was, a huge relief to know this was a thing that sort of happened to women and some of the states and to know that people recover from” “being given hope by a healthcare professional was the thing that turned a corner and made me have hope and want to fight to recover and move away from having the suicidal thoughts”	Specialist support important, highlights shared experiences across motherhood. Family support. Timely, local support necessarily. Collaboration. Varied experiences of support
		Monica (550-552)	Monica: “The biggest help I have had is my family, without my family support I don’t think I would be me at the moment”	
		Cara (277-300)	Cara: “Yeah the MBU was amazing I can’t recommend it enough for somewhere for people to go when they have had psychosis… I really think going to the MBU was a massive thing in my recovery…there was things like (pause) the opportunity to be normal, to be a normal Mum”	
		Katie (990-994)	Katie: “Finding the right help was hard… it felt like an eternity at the time”	
		Jessica (100-105)	Jessica: “I felt rejected from services because the only way to access support was to get worse and there was no incentive to recovery because then you’re on your own”	
		Angie (519-525)	Angie: “I had a lovely health visitor actually who kept	

Participants	Sub-ordinate Themes	Key Cross-References	Indicative Quotations	Notes
		(653-658)	in touch… it was so important that she kept in touch, she helped in my recovery” “I changed my GP… she was so so positive and it actually changed my whole attitude towards GP’s she actually said this is you and me together, that we’re a team here”	
Phoebe, Teresa, Katie, Jessica	3b) Acknowledgement, acceptance and integration of experience	Phoebe (252-253)	Phoebe: “I can never fully let go of the experience because it was hard and there are lots of raw emotions there”	Ongoing experience and developing independence, no definitive end point. Katie knew about the ‘theory of recovery’ but the vision of recovery for her was uncertain and unknown. Suppression is impossible?
		Teresa (529-535) (655-666)	Teresa: “functioning as you normally would, coming to terms with what happened, being able to kindof move on without being obsessed with that, accepting what has happened, accepting that as an experience that I went thought, being able to feel good about myself again in terms of self-esteem and self-belief, being about to be confident to do things again instead of being anxious about the most basic things” “I used to think I would know I was fully recovered if I was really successful in my career but in the last year or two I have been thinking a bit more differently, I think recovery is to be totally at peace with the experience, with myself and accepting who I am and that is just part of something I have been through”	
		Katie (830-834) (905-915)	Katie: “I knew it meant adjusting and assimilating what had happened to have a new kind of life but I didn’t know what that life was going to look like. I	

Participants	Sub-ordinate Themes	Key Cross-References	Indicative Quotations	Notes
			certainly thought my career was over”	
			“I had been holding onto this idea that recovery meant getting over it and pretending like it never happened, ignore it as an experience and forget about it then that would mean getting better. It’s not going to happen, yeah, it’s just not possible, this is about making space for having had this experience in my life’	
		Jessica (241-245)	Jessica: “I think recovery is about coming to terms with what has happened and dealing with some of the memories, it’s a lifelong thing, I was trying to deny myself feeling anxiety, what you were actually supposed to do was know the feeling, allow it and it goes away pretty much”	
Phoebe, Teresa, Laura, Cara, Katie, Jessica, Angie	3c) Negotiating space for self	Phoebe (339-341)	Phoebe: “I found that going back to work was helpful, keeping your mind active and focused on something that gives you a sense of accomplishment”	Engaging in previously enjoyable activities gave women purpose and accomplishment
		Teresa (621-630)	Teresa: “It was about getting back to normal and spending time doing something I enjoyed and kindof allowing a bit of time for me, to recover or recharge or whatever.	
		Laura (574-575)	Laura: “I would say certainly working, being at home all the time not doing terribly much, definitely keeping your mind occupied is a good thing, you’ve got to know you’re an individual as well as a Mum and	

Participants	Sub-ordinate Themes	Key Cross-References	Indicative Quotations	Notes
			that's important"	
		Katie (981-986)	Katie: "I started to go back to music, I made myself to back to that, I need to do something I'm good at, that's not just about being a mum and I think it really helped to get back in touch with old parts of myself whilst realising I am a different person now but it doesn't mean I have to be completely new or forget everything I previously enjoyed"	
		Jessica (397-399)	Jessica: "Gradually my time has become my own again and I have started to re-explore things I used to"	
		Angie (890-891)	Angie: "that was part of my recovery really to have something to do every day"	
	3c cont) Idiosyncratic markers of recovery	Phoebe (295-299) (336-338)	Phoebe: "For me I suppose it was about being ok without the medication, I know that some people can become quite addicted to anti-depressants and I didn't want that to happen to me" "Other people might have the opinion that I'm not recovered but I feel recovered and that's all you can go off"	Jessica relying on professionals' opinions to judge recovery? Tangible vs. intangible markers of recovery.
		Teresa (646-650)	Teresa: "going back to work was definitely important as well… and realising I could still function and get things done professionally and realising I could get back what I had had before"	
		Cara (619-624)	Cara: "I think it feels like, being recovery for me, is like feeling like myself again, now I do feel like myself because I think a few months ago I thought I was going to have to adapt to feeling like a different	

Participants	Sub-ordinate Themes	Key Cross-References	Indicative Quotations	Notes
			person”	
		Jessica (79-86)	Jessica: “My CPN said I am doing really well and that I have made a good recovery”	
		Angie (611-614)	Angie: “I must have felt recovered because we talked about having another child” “I would say my recovery is complete by saying what it was, it’s enabling me now to say to other people this is what happened, this is what it was… I didn’t just have a breakdown, it has a name”	
Teresa, Katie, Jessica, Angie	3d) Managing stumbling blocks	Teresa (371-375) (721-728)	Teresa: “I was really caught up in the stigma of the whole thing and I really didn’t want to accept that label of being on the other side of the tracks, turning into the patient instead of the mental health professional” “another barrier of recovery is expectation of society about how you are going to be as a mother or as a parent… everyone else seems to be feeling ok, really positive about their baby and coping really well, it’s like a competition all the time”	Stigma, unspoken reality vs. Societal expectations. Guilt, self-blame
		Katie (1020-1027) (1096-1108)	Katie: “I’m not sure recovery has an end point to be honest… it feels like something that is always going to be ongoing, there’s new stuff that is going all the time about how you assimilate your personal and professional role” “I do have some anxieties about whether everything is going to be seen under the lens of mental illness [after second child], I still need the space to have the baby blues and to that not to be seen as me being	

Participants	Sub-ordinate Themes	Key Cross-References	Indicative Quotations	Notes
			mentally ill again. I’m still allowed to have some negative emotions”	
		Jessica (114-118)(411-415)	Jessica: “How do I find myself again? How do I get my confident back up as a mother? I feel so guilty about what has happened that somehow I have damaged [child] and I don’t know what to do with that feeling, how can I move on when I’m consumed with guilt”	
			“Of course there will be challenges and set-backs but I feel better armed to deal with these in a sensible way”	
		Angie (723-726)	Angie: “You want to try and make sense of it, why did this happen to me, is it my fault, all of this type of stuff I’m still struggling with quite a lot of these issues”	

Super-ordinate Theme Four: Post-traumatic Growth

Participants	Sub-ordinate Themes	Key Cross-References	Indicative Quotations	Notes
Teresa, Monica, Katie, Jessica	4a) Positive life changes	Teresa (755-760)	Teresa: "I actually see myself as stronger now or stronger than other people who haven't been through that or have had to overcome that, somebody who has got a unique contribution to bring about what my experiences were"	PP experience as an asset. Developing resilience. Life perspective
		Monica (458-463) (690-692)	Monica: "To be honest it has completely changed me. I was very molly-coddled and I was brought up to be 'nothing can go wrong' and 'it's a beautiful world' but after I lost my dad and had postpartum psychosis I now have a different image of the world and although it is hard to come to terms with, I am a much stronger person" "It has made me a stronger person coming out of it and I can say that I must be a fighter to come through it all"	
		Katie (911-915)	Katie: "It does change me as a person but actually so far, I think it has changed me for the better. I don't think I take as much for granted anymore… it has become quite humbling and quite freeing actually"	
		Jessica (123-128)	Jessica: "I also realise how unimportant material things are, how unimportant looks are as long as you are content in yourself and truly happy in yourself, I have no doubt life will throw horrible things in my way but after going through this I'm that bit stronger and able to deal with things"	

Participants	Sub-ordinate Themes	Key Cross-References	Indicative Quotations	Notes
Teresa, Cara, Katie, Angie	4b) Impact on relationships	Teresa (961-975)	Teresa: “You have a unique connection being able to talk to other women who had been through the same and had the same illness. It is very lonely you feel more abnormal on your own, I do think peer support is really important in recovery and it helped in later stages of recovery”	Peer relationships, partners, families, child. Disclosure as a test of trustworthiness and friendship
		Cara (371-410) (647-656)	Cara: “I think that I would be less bonded with him if I hadn’t had psychosis I actually think I bonded with him more because of it…we’ve done all kinds of stuff I don’t know how much of that I would have done if I hadn’t have been poorly, I kindof made… more of an effort to bond with him because I was conscious I wasn’t bonding with him, whereas if I think it had been more natural I don’t know if it would have been as deep. “It made us closer basically, so… [husband] and I are even closer, we’ve always been very close… but he… now I think sees the value of talking more… it’s just made us stronger as a couple to know we can go through something as drastic as that”	
		Katie (1126-1134)	Katie: “Just being around those women and being honest with each other to say ‘yeah I had intrusive thoughts about harming my child as well, it happened to me too’	

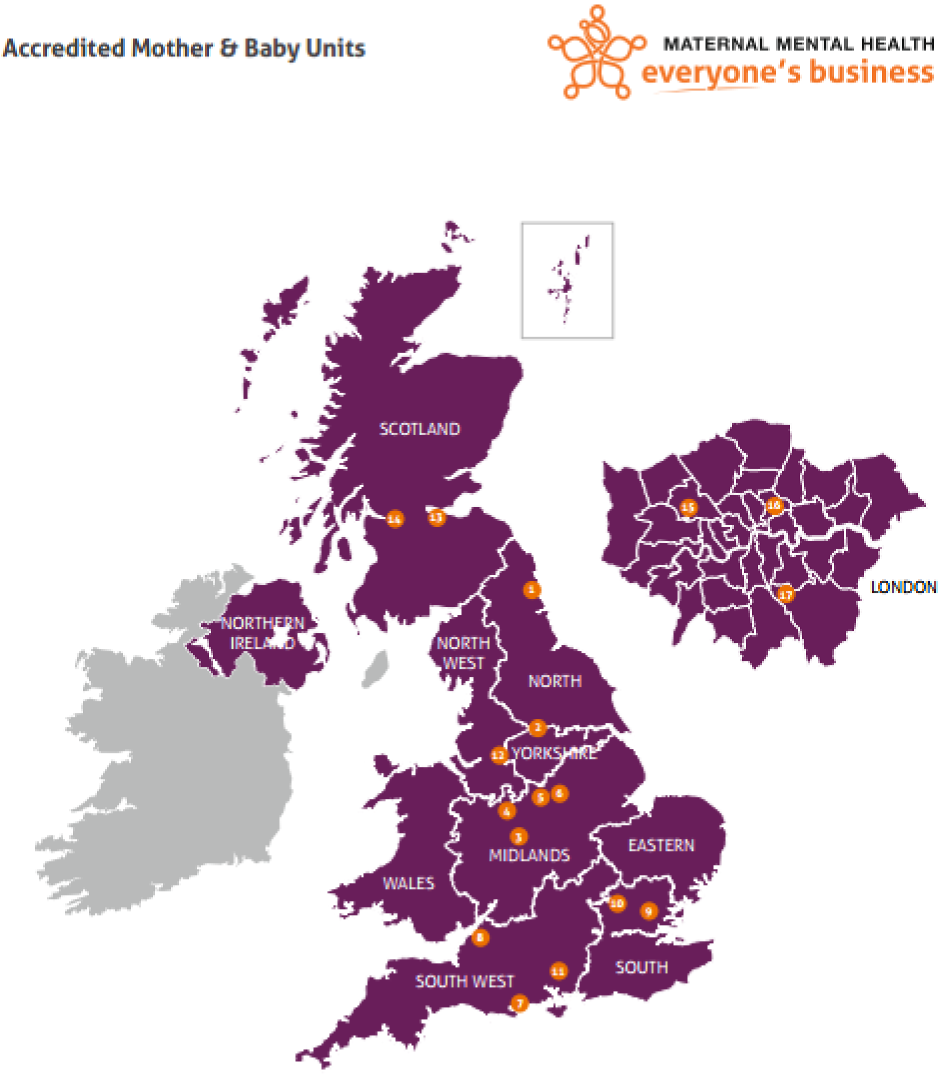
Participants	Sub-ordinate Themes	Key Cross-References	Indicative Quotations	Notes
		Angie (570-575) (942-947) (1087-1094) (1261-1266)	Angie: "It's almost like a challenge, well if you think the worse of me because of this [PP] then I don't think I want to be friends with you… so I made friends with those who understood and stuck with them" "It's only now since I've met other women with postpartum psychosis I have thought these are the people that understand and to now work somewhere where my mental health issues are an asset is unbelievable"	
			"For my husband, it's been really good to talk about it and we've laughed, some of the things were just so bizarre" "The feeling of meeting somebody else who has had the same thing and to be able to tell your story and be accepted and not judge yeah it's just amazing, absolutely amazing, it's just you feel a bond… I just feel I found my tribe, I feel more drawn to these women, it's nice to be with women who understand you"	
Teresa, Monica, Cara, Katie, Angie	4c) Using experience to facilitate change	Teresa (676-683) (815-820) (845-863)	Teresa: "I didn't want to own being in that box, or having that label but now it's going a lot better I think, almost like throwing myself into embracing the experience and getting involved in lots of things with telling my story… if I could do something good and positive with that experience and give something back it makes it into purpose rather than a horrible, traumatic time that I want to put in a box in the back of	Changing the meaning of the experience

Participants	Sub-ordinate Themes	Key Cross-References	Indicative Quotations	Notes
			my memory and not think about or identify with. “my counsellor was questioning about why I feel driven to do this and I said I think it is the final step in my recovery, it is about making a difference joining huge numbers of people across the country that want change and to make it better for other people”	
		Monica (412-413) (666-669)	Monica: “Now I have been through it and been at the other end, I feel like I want to help others and I want to help professionals diagnose it and recognise it because obviously it is very rare and it is very hard to pick up on but there are signs and it is about picking it up as soon as you can”	
		Cara (718-731) (922-928)	Cara: “I just think people just don’t want to know, I think I would be quite happy to tell people… erm… I think in a way it’s because there is so much to tell, that it is hard to order, so I have actually written my story, I will probably do a blog post… I think that’s the best way for people to read about it because then they can read about it in their own time and then they can ask me questions” “I feel quite passionate about the peer support thing that it would be more helpful to kindof I don’t know have more involvement in seeing someone who is recovery, so I feel if there was someone now who had PP I would quite happily go and meet them and say to them look I’ve been there”	
		Laura (663-665) (707-712)	Laura: “I just think now I can be more, it’s almost like I want to help young vulnerable Mums who might… go	

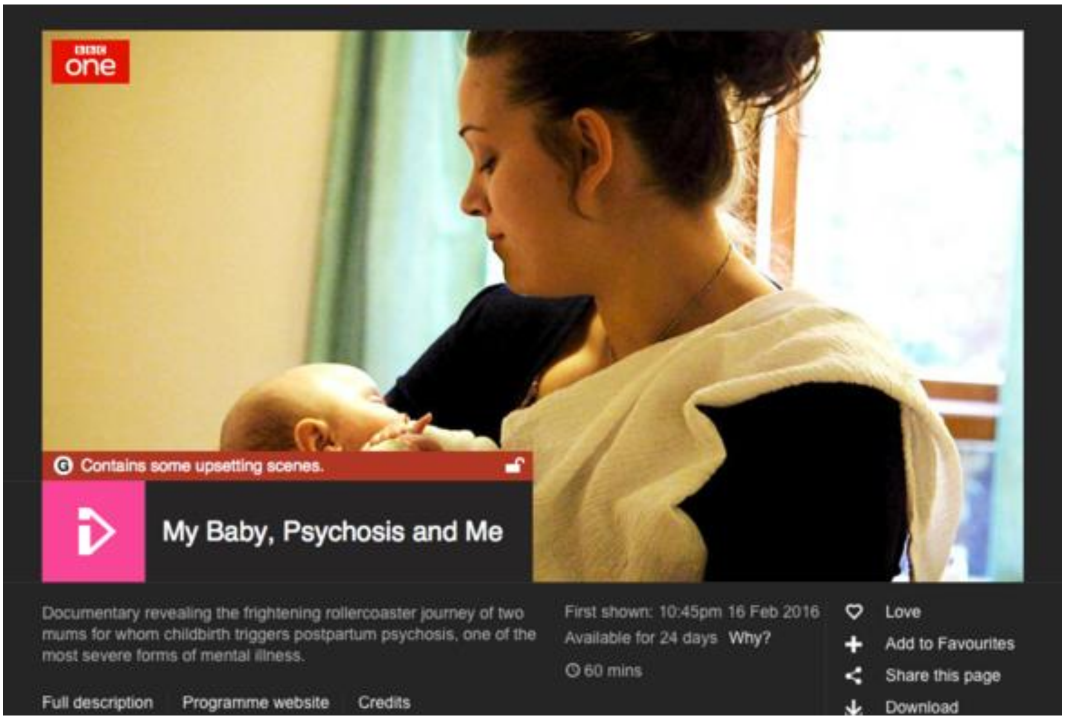
Participants	Sub-ordinate Themes	Key Cross-References	Indicative Quotations	Notes
			through that… similar experience and talk about it now it's like I've just kept it in for all those years, you've got to have a voice… I need to, I want to say this is what happened to me and you will be fine" "I think it probably just makes me feel better in myself I think and that I've got some sort of purpose (laughs)… you know it's a part of me"	
		Katie (1006-1012)	Katie: "I feel that I've wanted to make some meaning out of this experience by using it and one of the ways I have been able to do that is feeling like I can help other women who might go through a similar thing"	
		Angie (1344-1349)	Angie: "It's really nice, you just realise how much you've got to give and how much you've got to offer, it's very rewarding"	

Appendix Y: Accredited* Mother and Baby Units in United Kingdom (Maternal Mental Health Alliance, 2015)

* accredited by the Royal College of Psychiatrists quality network for perinatal services



Appendix Z: BBC One Documentary (2016) ‘My Baby, Psychosis and Me’



G Contains some upsetting scenes.

My Baby, Psychosis and Me

Documentary revealing the frightening rollercoaster journey of two mums for whom childbirth triggers postpartum psychosis, one of the most severe forms of mental illness.

First shown: 10:45pm 16 Feb 2016

Available for 24 days Why?

60 mins